IN THE UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

DISABILITY RIGHTS NEW JERSEY **210 South Broad Street, 3rd Floor** **Trenton New Jersey 08608** **Plaintiff,** **v.** **ALLIANCE HC 11 LLC** **d/b/a WOODLAND BEHAVIORAL AND NURSING CENTER** **99 Mulford Road** **Andover, New Jersey 07821** **Defendant.**	: : : : : : : : : : : : : : : : :	**Case No. 2:22-cv-01240** **Judge: Brian R. Martinotti** **Magistrate Judge:** **James B. Clark**

BRIEF IN SUPPORT OF PRELIMINARY INJUNCTION PURSUANT TO RULE 65

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PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

Pursuant to Fed. R. Civ. P. 65, Plaintiff Disability Rights New Jersey ("Disability Rights NJ") seeks to enjoin Defendant Woodland Behavioral and Nursing Center ("Woodland") from restricting its statutorily-mandated authority to speak confidentially with individuals who reside at its facility. Plaintiff requests that this Court issue a preliminary injunction, requiring Woodland to permit Plaintiff to have reasonable unaccompanied access to the facility, to the full extent permitted by federal law. Plaintiff's Memorandum in Support of this Motion is attached along with supporting declarations.

Dated: March 8, 2022

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MEMORANDUM IN SUPPORT

Plaintiff Disability Rights New Jersey ("Disability Rights NJ") seeks a preliminary injunction because Defendant Alliance HC 11 LLC, doing business as Woodland Behavioral Center and Nursing Home ("Woodland") is violating federal law by prohibiting Disability Rights NJ from accessing the facility and speaking confidentially with individuals with disabilities who reside at the facility. Disability Rights NJ requests that this Court enter a preliminary injunction to allow it to fulfill its mandate as the protection and advocacy system for people with disabilities in New Jersey.

I. BACKGROUND AND FACTS

A. Congress created the protection and advocacy system as a safeguard for people with disabilities.

In response to national reports uncovering serious abuse and neglect of people with disabilities in segregated facilities, Congress created the Protection and Advocacy ("P & A") system, a national network of independent agencies that serve as a safeguard for people with disabilities. *See generally*, 42 U.S.C. § 15041 *et seq*. (developmental disabilities), 42 U.S.C. § 10801 *et seq*. (mental illness), 29 U.S.C. § 794e (other physical or mental impairments), collectively, the "P & A statutes." Congress enacted these statutes "after concluding that state systems for protecting the rights of individuals with disabilities varied widely and were in many cases inadequate." *Disability Rights*

Wisconsin, Inc. v. State of Wisconsin Dep't of Pub. Instruction, 463 F.3d 719, 722 (7th Cir. 2006); *see also Alabama Disabilities Advocacy Program v. SafetyNet Youthcare, Inc.*, 65 F. Supp. 3d 1312, 1317-21 (S.D. Ala. 2014).

As a condition of receiving federal funding for people with disabilities, the P & A statutes require each state to establish an effective protection and advocacy agency to protect the rights of individuals with disabilities and respond to allegations of abuse and neglect. *Virginia Office for Prot. & Advocacy v. Stewart*, 563 U.S. 247, 247, 131 S. Ct. 1632, 1633-34, 179 L. Ed. 2d 675 (2011); *Disability Rights Wisconsin*, 463 F.3d at 722–23. There is a P & A agency in "every state and U.S. territory, as well as one serving the Native American population in the four corners region." See National Disability Rights Network, NDRN Member Agencies, available at http://www.ndrn.org/en/ndrn-member-agencies.html (last visited on March 3, 2022). Disability Rights NJ is designated by the Governor of the State of New Jersey as the protection and advocacy system for people with disabilities in New Jersey.

To carry out their responsibilities, "including the authority to 'pursue legal, administrative, and other appropriate remedies on behalf of individuals with disabilities," P &A agencies have broad authority to access individuals, records, and facilities that provide care or treatment to individuals with disabilities, and authority to conduct investigations of suspected abuse or neglect of individuals with disabilities. 42 U.S.C. §10805(A)(1)(a).

Investigation is a critical component of P & A access authority because it directly protects the most vulnerable from abuse, and assists in identifying those practices of a facility that pose the greatest danger to residents. Disability Rights NJ monitors and investigates residential treatment facilities because people with disabilities who reside in institutions are more vulnerable to abuse, neglect, and rights violations. Many individuals with disabilities are unaware of their rights, and very few are familiar with Disability Rights NJ's role as the P & A Agency. During investigation visits, Disability Rights NJ observes physical conditions, gathers information from staff, and speaks privately with residents so they have an opportunity to confidentially discuss concerns about their experiences at the facility.

Disability Rights NJ has no law enforcement authority. It cannot charge the institutions it investigates with crimes. It is required to make its own assessment of whether there is probable cause to seek access to records and individuals, but its determination of probable cause will not result in criminal of civil enforcement proceedings by the state. When a facility like Woodland denies Disability Rights NJ access, such as was the case here, Disability Rights NJ's recourse is to seek an order from a court allowing it to receive records and to interview victims and witnesses. Disability Rights NJ and other P&A's do not have independent authority to impose penalties or to otherwise compel compliance with state or federal laws.

B. Defendant denied Disability Rights New Jersey access to individuals with disabilities residing at its facility.

Woodland operates a nursing home and long-term care facility (i.e., class one facility) for individuals with disabilities. Its residential treatment facility is licensed by the New Jersey Department of Health. Hundreds of people with disabilities are served by Defendant's licensed residential facility. Individuals with mental illness, developmental disabilities, and other physical and mental impairments that substantially limit one or more major life activities of such individuals are institutionalized at Defendant Woodland.

Plaintiff Disability Rights NJ is the state-designated Protection and Advocacy system for the State of New Jersey. (*See* Declaration of Gloria Jill Hoegel ("Hoegel Decl.", ¶ 1).) In April 2020, The New York Times published a story indicating that a high percentage of residents at Woodland, then known as Andover II, had died from COVID-19 and bodies were being stored on site.[1] Disability Rights NJ requested information from the New Jersey Department of Health over the course of 2020 and learned that Woodland housed a disproportionately high number of residents with serious mental illness and traumatic brain injury. (Hoegel Decl., ¶ 8).

On or around July 12, 2021, Disability Rights NJ wrote to Woodland, notified the administrator of its intent to monitor, and provided an explanation and references

[1] *See After Anonymous Tip, 17 Bodies Found at Nursing Home Hit by Virus*, N.Y. Times, Apr. 15, 2020, *available at* https://www.nytimes.com/2020/04/15/nyregion/coronavirus-nj-andover-nursing-home-deaths.html

for Disability Rights NJ's legal authority to do so. (Hoegel Decl., ¶ 12). On July 26 and August 17, 2021, Disability Rights NJ staff conducted initial monitoring visits at Woodland. This monitoring activity raised concerns that residents that needed specialized services for serious mental illness and developmental disability were inappropriately placed at the facility. (Hoegel Decl., ¶ 13). Disability Rights NJ began collecting Preadmission Screening and Resident Review (PASRR) information from the state suspecting there was an issue with the unnecessary placement of disabled residents in long term care facilities. (Hoegel Decl., ¶ 13).

As monitoring activities continued, Disability Rights NJ became aware of additional reports of serious and acute health and safety violations. The New Jersey Department of Health issued "Notice of Violations, Corrective Action, and State Monitoring" dated February 10, 2022. (Hoegel Decl., ¶ 14, Ex. A). The Department of Health notice documented numerous instances of verbal abuse of patients by staff. The report also documented numerous serious instances of neglect, including an instance where a patient was left soiled in feces for more than ten hours and another instance where staff failed to assist a resident who called for help due to a stuck catheter. The report also identified numerous instances in which staff failed to provide any life saving emergency response, including an instance where staff failed to initiate CPR, call 911, or utilize a defibrillator after finding a 55 year old resident unresponsive. The report also identified serious deficiencies in COVID prevention and treatment protocols,

unsecured storage of dangerous medications, and that the facility failed to maintain sufficient levels of properly trained and qualified staff. (*Id.*)

Based on the detailed instances of abuse and neglect reported in the New Jersey Department of Health notice, Disability Rights NJ determined there was probable cause to suspect that all residents at Woodland have been subject to ongoing abuse, neglect, and rights violations. (Hoegel Dec., ¶ 19; *see also* Declaration of Gwen Orlowski ("Orlowski") Decl. ¶ 16.)

On February 18, 2022, Disability Rights NJ Director of Investigations and Monitoring Gloria Jill Hoegel, Disability Rights NJ Senior Advocate Elena Kravitz, and Disability Rights NJ Staff Advocate Mary Ciallela visited the Woodland facility as part of Disability Rights NJ's investigation. (Hoegel Decl., ¶ 18). They spent much of that morning observing conditions and interviewing residents on the third floor of the facility, where most residents with mental illness resided. (Hoegel Decl., ¶ 19). During the visit, Disability Rights NJ staff witnessed an instance of staff verbal abuse of a resident who sought assistance. Woodland staff dismissed the resident's concerns as attention seeking. (Hoegel Decl. ¶ 27.) The same staff member confronted the Disability Rights NJ monitoring team as they were leaving the facility, addressing Disability Rights NJ staff with a raised voice while claiming that their presence was upsetting people and falsely claiming that members of the Disability Rights NJ monitoring team were telling staff to "sharpen up their resumes". (Hoegel Decl. ¶ 30.)

On February 20, 2022, a Disability Rights NJ team which included Executive Director Gwen Orlowski, made another in person visit to the facility. (Orlowski Decl. ¶ 22.) The team was met at the door by an individual who identified himself as "Mutty" Scheinbaum, who stated that he was one of the owners of the facility. (Orlowski Decl. ¶ 25.) The Disability Rights NJ team introduced themselves, provided photo identification, and explained the purpose and authority for the visit. (Orlowski Decl. ¶ 25.)

Mr. Scheinbaum delayed the Disability Rights NJ investigative team for nearly two hours. (Orlowski Decl. ¶ 37.) Mr. Scheinbaum insisted that the team go directly to his office without speaking to residents. (Orlowski Decl. ¶ 25.) Mr. Scheinbaum indicated that the team needed to stay in his office while he spoke with staff and his attorney. (Orlowski Decl. ¶ 27.) After twenty minutes waiting in the office, Mr. Scheinbaum returned as the team was attempting to leave. (Orlowski Decl. ¶ 28.)

Mr. Scheinbaum challenged Disability Rights NJ's access authority, even though the team had previously visited the facility and had provided written correspondence to Woodland informing the facility of Disability Rights NJ's access authority. (Orlowski Decl. ¶ 29.) Mr. Scheinbaum demanded that the Disability Rights NJ team remain confined to his office and threatened to call the police if they left. (Orlowski Decl. ¶ 30.) Mr. Scheinbaum told Disability Rights NJ's team that his attorney advised him that Disability Rights NJ's team did not have authority to monitor, and that Disability

Rights NJ's authority to investigate was limited. Mr. Scheinbaum claimed that he could deny access authority due to COVID, and he claimed that the Disability Rights NJ team was not who they said they were, despite the fact that they each presented personal identification. (Orlowski Decl. ¶ 31.)

During the course of this confrontation, Disability Rights NJ's Legal Director Michael Brower provided November 2021 regulatory guidance from the Centers for Medicare & Medicaid which stated that nursing home facilities must provide "immediate access" by any representative of the protection and advocacy system regardless of the COVID public health emergency. (Orlowski Decl. ¶ 32.)

Despite this, Mr. Scheinbaum continued to deny access to the facility and demanded that Disability Rights NJ speak to his attorney, Peter Slocum. (Orlowski Decl. ¶ 33.) Disability Rights NJ staff communicated with Mr. Slocum via telephone and provided him with legal authority on Disability Rights NJ's access authority. At the conclusion of the discussion, Mr. Slocum acknowledged Disability Rights NJ's access rights and stated that he would instruct his client not to interfere further with the investigation. (Declaration of Michael Brower ("Brower") Decl. ¶¶ 22-24; Orlowski Decl. ¶ 35) Mr. Scheinbaum then allowed the Disability Rights NJ team to begin their work, two hours after they had arrived at the facility, but followed within sight of the team throughout the visit. (Declaration of Elena Kravitz ("Kravitz") Decl. ¶ 27.)

On February 23, 2022, a Disability Rights NJ team which included Legal Director Michael Brower and Elena Kravitz made another in person visit to the facility. (Kravitz Decl. ¶ 29.) As the Disability Rights NJ team was conducting interviews with residents, they were approached by two men who identified themselves as Joey and Michael, who stated that they were owners and administrators at the facility. (Brower Decl. ¶ 30.) Joey and Michael asked Disability Rights NJ staff to go to the third floor of the facility and to intervene in what they described as a behavioral crisis, and to explain to residents that they were not allowed to leave the facility. (Brower Decl. ¶ 32.) Disability Rights NJ declined to do so, but accompanied Joey and Michael to the third floor to observe the situation. (Brower Decl. ¶ 33.) On the third floor, Joey and Michael were joined by a member of the nursing staff who told Disability Rights NJ that their presence was disruptive to residents because it made them want to leave the facility. (Brower Decl. ¶ 34.) Woodland staff claimed that Woodland staff were "like family" to the residents and knew how to interact with them. (Brower Decl. ¶ 36.) Woodland staff demanded that Disability Rights NJ agree not to engage in any further interactions or interviews with residents without Woodland staff present. (*Id.*)

On March 1, 2022, a Disability Rights NJ team which included Elena Kravitz made another in person visit to the facility. (Kravitz Decl. ¶ 29.) As part of the visit, Ms. Kravitz interviewed residents and then took photographs of an unoccupied shower facility. (Kravitz Decl. ¶ 31.) Soon after, Ms. Kravitz was confronted by Mr.

Scheinbaum, who raised his voice in anger and falsely accused Disability Rights NJ staff of photographing residents, upsetting staff, and disrupting the facility. (Kravitz Decl. ¶ 32.) Mr. Scheinbaum and a second administrator who identified himself as "Michael" physically intimidated Ms. Kravitz by yelling at her and leaning towards her as though they were going to physically strike her. (Kravitz Decl. ¶ 35.) Michael then insisted that Disability Rights NJ staff accompany him to the facility's administrative office, where other administrators were also present. (Kravitz Decl. ¶ 36) Ms. Kravitz left the building to contact her supervisor, Ms. Hoegel. When she returned to the facility a few minutes later to complete the visit, Mr. Scheinbaum continued to keep Disability Rights NJ staff within line of sight surveillance. (Kravitz Decl. ¶ 38.)

On March 2, 2022, a Disability Rights NJ team which included Elena Kravitz made another in person visit to the facility. (Kravitz Decl. ¶ 40.) As Ms. Kravitz was communicating with a resident, she overheard a second resident complain that a nurse had given her the wrong dose of medication. (Kravitz Decl. ¶ 41.) The nurse then confronted Ms. Kravitz and yelled "This is all your fault! They were never like this before you came here. Everything is because of you. I can't do this anymore!" The nurse then refused to dispense medication while Disability Rights NJ staff were present. (Kravitz Decl. ¶ 43.)

Woodland has engaged in a pattern and practice of impeding Disability Rights NJ's access to the facility and to residents. Woodland's attempts to bar Disability

Rights NJ staff from speaking with residents confidentially and privately and its ongoing practice of confronting and interrupting Disability Rights NJ staff has stymied the ability of Disability Rights NJ to collect candid information from residents on the care they are receiving, violations of their rights, and whether or not they are subject to ongoing abuse or neglect. (Brower Decl. ¶ 38.) The conduct has interfered with and impeded Disability Rights NJ's ability to investigate abuse and neglect of residents with disabilities at the facility.

II. ARGUMENT

Disability Rights NJ seeks a preliminary injunction because Woodland's continuing violation of federal law prevents Disability Rights NJ from fulfilling its mandate as the protection and advocacy system for people with disabilities in New Jersey. A preliminary injunction is appropriate in this case because Disability Rights NJ's legal authority to speak confidentially with individuals at Woodland is clear under federal law, and the factors for issuing a preliminary injunction in favor of Disability Rights NJ.

"A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of the equities tips in his favor, and that an injunction is in the public interest." *Obama for Am. v. Husted*, 697 F.3d 423, 428 (6th Cir. 2012) (*quoting Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20, 129 S. Ct. 365, 374, 172

L. Ed. 2d 249 (2008)); *Reilly v. City of Harrisburg*, 858 F. 3d 173, 176 (3d Cir. 2017); *see also, State of Connecticut Office of Prot. & Advocacy for Persons with Disabilities v. Hartford Bd. of Educ*., 355 F. Supp. 2d 649, 653

(D. Conn. 2005); *Ohio Legal Rights Serv. v. BR, Inc*., 365 F. Supp. 2d 877, 883 (S.D.Ohio 2005);*Wisconsin Coal. for Advocacy, Inc. v. Czaplewski*, 131 F. Supp. 2d 1039, 1051 (E.D.Wis. 2001); *Prot. & Advocacy For Persons With Disabilities v. Armstrong*, 266 F. Supp. 2d 303, 311 (D.Conn. 2003)).

The Third Circuit has noted that the first two factors—likelihood of success on the merits and irreparable harm—are the key factors for injunctive relief:

> . . . a movant for preliminary equitable relief must meet the threshold for the first two 'most critical' factors: it must demonstrate that it can win on the merits (which requires a showing significantly better than negligible but not necessarily more likely than not and that it is more likely than not to suffer irreparable harm in the absence of preliminary relief. If these gateway factors are met, a court then considers the remaining two factors and determines in its sound discretion if all four factors, taken together, balance in favor of granting the requested preliminary relief. In assessing these factors, Judge Easterbrook's observation bears repeating: 'How strong a claim on the merits is enough depends on the balance of the harms: the more net harm an injunction can prevent, the weaker the plaintiff's claim on the merits can be while still supporting some preliminary relief.' *Hoosier Energy*, 582 F.3d at 725.

Reilly v. City of Harrisburg, 858 F.3d 173, 179 (3d Cir. 2017).

A. Disability Rights New Jersey is likely to succeed on the merits of its claims.

1. Disability Rights New Jersey is likely to succeed on the merits of its

claims pursuant to federal law.

Disability Rights NJ has asserted claims pursuant to three federal P & A statutes. The law surrounding P & A access authority is well-settled, and Disability Rights NJ is likely to succeed on the merits of its claims. The Third Circuit has held "we do not require at the preliminary stage a more-likely-than-not showing of success on the merits because a 'likelihood' [of success on the merits] does not mean more likely than not.'" *Reilly*, 858 F.3d at 179 n.3.

Under the P&A Acts, Disability Rights NJ is authorized to investigate suspected incidents of abuse and neglect of individuals with disabilities, 42 U.S.C. § 15043(a)(2)(B), as well as to "pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for . . . such individuals." 42 U.S.C. § 15043(a)(2)(A)(i). In enacting the original Protection and Advocacy for Persons with Mental Illnesses ("PAIMI") Act, Congress recognized that P&As would need broad access to fulfill their mandate. Congress expressed its intent to grant P&As the fullest and broadest possible access: "The Committee recognizes the need for full access to facilities and clients and to their records in order to ensure the protection of mentally ill persons. It is the intent of the Committee that the [P&A system] have the fullest possible access to client records . . . ." S. Rep. 109, 99th Cong., Sess. 10 (1985) (emphasis added), reprinted in 1986 U.S.C.C.A.N. 1361, 1370.

Congress mandates this broad P&A access authority for two main purposes: (1) access for the purpose of investigating allegations of abuse and/or neglect, 42 U.S.C. 10802(2), 42 U.S.C. § 10805(a)(3), 45 C.F.R. § 1386.22(f), 42 C.F.R. § 52.42(b), and (2) access for the purpose of monitoring the facility and the treatment of its residents. 42 U.S.C. § 15043(a)(2)(H), 42 U.S.C. § 10805(a)(3), 45 C.F.R. § 1386.22(g), 42 C.F.R. § 51.42(c).

Disability Rights NJ asserts its access rights to investigate allegations of abuse and neglect. Congress has found that "individuals with mental illness are vulnerable to abuse and serious injury" as well as "neglect, including lack of treatment . . . ." 42 U.S.C. § 10801(a)(1) and (3). Moreover, Congress found that "[s]tate systems for monitoring compliance with respect to the rights of individuals with mental illness vary widely and are frequently inadequate." 42 U.S.C. § 10801(a)(4). Accordingly, Congress has granted P&As, such as Disability Rights NJ, with the power to "investigate incidents of abuse and neglect of persons with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred." 42 U.S.C. § 10805(a)(1)(A).

PAIMI's implementing regulations reflect the intention for broad access as they clearly contemplate unaccompanied access to individuals for purposes of investigating incidents of abuse and neglect. "The P&A system shall have reasonable unaccompanied access to residents at all times necessary to conduct a full investigation of an incident

of abuse or neglect. This authority shall include the opportunity to interview any facility service recipient, employee, or other persons, including the person thought to be the victim of such abuse, who might be reasonably believed by the system to have knowledge of the incident under investigation." 42 C.F.R. § 51.42(b).

Disability Rights NJ's access authority includes private interviews with minors, and Disability Rights NJ is not required to obtain parent/guardian consent prior to its interviews. *See* 42 C.F.R. §§ 51.42(c), (d), and (e); 45 C.F.R §§ 1326.27(c)(1) and (d); *Conn. Office of Prot. & Advocacy for Persons with Disabilities v. Hartford Bd. Of Educ*., 464 F.3d 229, 242-43 ("Nothing in the statutory language of either the DD Act or PAIMI conditions this access on the consent of an individual's parents or guardians.").

Private interviews are a critical component of monitoring facilities for potential abuse or neglect. *Equip for Equality*, 292 F. Supp. 2d at 1101 ("Private meetings with patients are important to the success of the P & A system because it gives patients the opportunity to be candid about their experiences at the facility."). Similarly, for individuals with developmental disabilities, 42 U.S.C. § 15043(a)(2)(H)
grants Disability Rights NJ "access at reasonable times to any individual with a developmental disability in a location in which services, supports, and other assistance are provided." For individuals with other physical or mental impairments that

substantially limit a major life activity, 29 U.S.C. § 794e(f)(2) extends to Disability Rights NJ "the same general authorities" as in 42 U.S.C. § 1504.

Courts have taken a broad view of P&A access authority by consistently holding that they must permit the P&A to operate effectively and with broad discretion and independence in accessing individuals, facilities, and records for investigative purposes. *See, e.g., Disability Rights Wis. Inc. v. Wis. Dep't of Pub. Instruction*, 463 F.3d 719, 728-30 (7th Cir. 2006) (authorizing P&A access to records related to a state agency investigation into use of seclusion rooms for disciplining

students at an elementary school); *Conn. Office of Prot. & Advocacy for Persons with Disabilities v. Hartford Bd. Of Educ*., 464 F.3d 229, 240-45 (2nd Cir. 2006) (finding that a P&A system was authorized to obtain the names of all students in a therapeutic educational program for students who require special education and the name and contact information for parents and legal guardians of the students).

Here, Disability Rights NJ has probable cause to believe that incidents of abuse and neglect have occurred and are still occurring at Woodland. Disability Rights NJ is independently authorized by federal law to investigate, and is not bound by the fact that other state and county agencies have not yet taken final action against the facility.

The Act not only describes the range of services to be provided by the protection and advocacy systems, it also states that the systems must have the authority to perform those services. The state cannot satisfy the requirements of the [DD and PAIMI Acts]

by establishing a protection and advocacy system which has the authority in theory, but then taking action which prevents the system from exercising that authority. *Miss. Prot. & Advocacy Sys., Inc. v. Cotten*, 929 F.2d 1054, 1059 (5th Cir. 1991) (emphasis in original). Any other reading of the Acts "would attribute to Congress an intent to pass an ineffective law." *Ala. Disabilities Advocacy Program v. Tarwater Developmental Ctr.*, 894 F. Supp. 424, 429 (M.D. Ala. 1995), aff'd, 97 F.3d 492 (11th Cir. 1996).

Woodland is a "facility" that falls under the scope of Disability Rights NJ's access authority. It is also a "location in which services, supports, and other assistance are provided" to individuals with disabilities. See 42 U.S.C. § 15043(a)(2)(H). Woodland wrongfully denied access to Disability Rights NJ.

Consequently, there is a substantial likelihood that Disability Rights NJ will prevail on its claim.

B. Disability Rights New Jersey will suffer irreparable harm if it is unable to access and speak confidentially with individuals at the facility

Disability Rights NJ meets this prong of the preliminary injunction test because courts have concluded that a P & A agency's inability to meet its federal statutory mandate to protect and advocate for the rights of individuals with disabilities is an irreparable harm for purposes of injunctive relief. *Ohio Legal Rights*, 365 F. Supp. 2d at 883 ("There is no dispute that a protection and advocacy agency's inability to meet

its federal statutory mandate to protect and advocate the rights of disabled people constitutes irreparable harm."); *Connecticut Office*, 464 F.3d at 234 (2d Cir. 2006).

Woodland's refusal to allow Disability Rights NJ to speak confidentially with institutionalized residents threatens Disability Rights NJ's ability to discharge its statutorily-mandated obligations. *See Wisconsin Coal*, 131 F. Supp. 2d at 1051 (holding that denial of access to records "does, in a very real and readily identifiable way, pose a threat to the plaintiff's being able to discharge its obligations" and "no amount of damages will remedy that sustained harm").

This threat is particularly irreparable for residents at the facility during the time that Disability Rights NJ is denied access because those individuals are at a high risk of death or serious injury due to abuse and neglect and will not be aware of Disability Rights NJ's services or have an opportunity to request assistance.

Without a preliminary injunction, Disability Rights NJ will continue to be unable to fulfill its mandate to protect and advocate for people with disabilities who reside at Woodland. This harm cannot be addressed through monetary damages at a later date, so injunctive relief is necessary.

C. The balance of equities tips in Disability Rights New Jersey's favor.

The balance of equities tips in the favor of Disability Rights NJ because Woodland will not suffer substantial harm if this Court issues a preliminary injunction, while Disability Rights NJ's access authority and ability to carry out its federally

mandated duties will be severely compromised absent injunctive relief from this Court. "In each case, courts must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief." *Winter v. Nat. Res. Def. Council*, Inc., 555 U.S. 7, 24, 129 S. Ct. 365, 376, 172 L. Ed. 2d 249 (2008) (quotation marks and citation omitted).

Issuance of an injunction against Woodland does not subject the Defendant to a penalty or hardship because it requires them to do exactly what the P & A statutes require: allow Disability Rights NJ access to people with disabilities. *See Advocacy Ctr. v. Stalder*, 128 F. Supp. 2d 358, 368 (M.D. La. 1999).

On the other hand, Defendant's refusal to allow Disability Rights NJ access to the facility does, in a very real and readily identifiable way, pose a threat to Disability Rights NJ's ability to discharge its statutorily mandated obligations. *See Wisconsin Coal*, 131 F. Supp. 2d at 1051.

Nor would an injunction harm any third parties, especially the individuals with disabilities who reside at Woodland. Disability Rights NJ routinely conducts investigative visits of facilities in New Jersey without adverse effects to Disability Rights NJ's constituents, who benefit from the education, resources, and services that Disability Rights NJ provides. Disability Rights NJ respects the privacy of the individuals with disabilities with whom it meets.

D. The public interest will be served by this Court granting a preliminary injunction.

The public interest is served by the fulfillment of Disability Rights NJ's mandate as the protection and advocacy agency, as evidenced by Congress's findings regarding the need for the P & A system. In determining the public interests that are relevant to a motion for a preliminary injunction, this Court may consider Congress's statements about the public interest. *See* 11A Charles A. Wright, Arthur R. Miller & Mary Kay Kane, Federal Practice and Procedure § 2948.4 (2d ed.1995) ("The public interest may be declared in the form of a statute."); *see also, NACCO Materials Handling Group, Inc. v. Toyota Materials Handling USA, Inc*., 246 F. App'x. 929, 944 (6th Cir. 2007), *citing id*.

By passing the P & A statutes, Congress made an explicit finding that "[s]tate systems for monitoring compliance with respect to the rights of individuals with mental illness vary widely and are frequently inadequate." 42 U.S.C. § 10801. Congress created the P & A system, funded it, and granted it broad access authority because individuals with disabilities are "vulnerable to abuse, injury, and neglect." *Pennsylvania Prot. & Advocacy, Inc. v. Houstoun*, 228 F.3d 423, 425 (3d Cir. 2000).

By passing the P & A statutes, Congress has expressed that the public interest is satisfied by allowing P & A agencies like Disability Rights NJ access to individuals at Woodland.

Other courts have agreed that the public interest is served by granting P & A systems injunctive relief under similar circumstances. *See, e.g., Michigan Protection*

and Advocacy Services v. Evans, Case No. 06-13273 2010 WL 3906259, at *5 (E.D. Mich. April 11, 2007) ("It is in the public's interest to have agencies such as Plaintiff able to access the necessary records to ensure individuals with disabilities are not suffering from abuse or neglect.") (issuing permanent injunction and awarding attorney's fees); *Advocacy Inc. v. Tarrant Cty. Hosp. Dist*., No. 4:01-CV- 062-BE, 2001 WL 1297688, at *6 (N.D. Tex. Oct. 11, 2001) ("Nor is the public interest done a disservice by the timely investigation and resolution of concerns about the treatment of the more vulnerable members of society."). Thus, congressional findings and purpose, as well as federal courts' interpretation of the P & A statutes, demonstrate that the issuance of a preliminary injunction in this matter is in the public interest.

III. DISABILITY RIGHTS NEW JERSEY SHOULD NOT BE REQUIRED TO POST A BOND

The Third Circuit has interpreted Fed. R. Civ. P. 65(c) to provide the district judge discretion to determine whether a bond is required for security. In certain narrowly drawn circumstances in cases involving enforcement of important federal rights and public interest, bond may be waived. *Temple University v. White*, 941 F. 2d 201, 220 (3d Cir. 1991) *cert. denied sub. nom, Snider v. Temple Univ*., 502 U.S. 1032, 112 S.Ct. 873, 116 L.Ed.2d 778 (1992) (holding that waiver of a bond may be appropriate in cases involving enforcement of important federal rights or public interests arising out of federal health and welfare statutes); *McCormack v. Tp. of Clinton*, 872 F. Supp. 1320, 1327 (D.N.J. 1994) ("[T]he court first should weigh the

potential loss to the enjoined party against the hardship that a bond requirement would impose on the applicant. Second, the court should consider whether the application seeks to enforce a significant federal right or a matter of public interest."); *see also South Camden Citizens v. NJ Dept. of Environ*., 145 F. Supp. 2d 446, 503-505 (D.N.J. 2001) (waiving bond in case involving significant public interest).

Disability Rights NJ's underlying case is strong, as evidenced by extensive precedent supporting P & A access authority. Disability Rights NJ is a non-profit organization attempting to enforce its federally-mandated access authority, which Congress created to ensure that the rights of individuals with disabilities would be enforced and protected. There is a strong public interest

component in this case. Disability Rights NJ respectfully asks that the bond requirement be waived.

IV. CONCLUSION

For these reasons, Disability Rights New Jersey respectfully requests that this Court issue a preliminary injunction against Defendants, requiring Defendant Woodland to permit Plaintiff Disability Rights New Jersey to have reasonable unaccompanied access to individuals at Woodland, to the full extent permitted by law.

Respectfully submitted,

/s/ Javier L. Merino
Javier L. Merino, Esq.
Andrew R. Wolf, Esq.
The Dann Law Firm, PC

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Telephone: (201) 355-3440
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Counsel for Plaintiff Disability Rights of New Jersey

CERTIFICATE OF SERVICE

The undersigned attorney certifies that copies of the foregoing Plaintiff Disability Rights New Jersey's Motion for Preliminary Injunction was served by UPS Overnight mail upon:

ALLIANCE HC 11 LLC
d/b/a WOODLAND BEHAVIORAL AND NURSING CENTER
c/o Chaim Scheinbaum
99 Mulford Road
Andover, New Jersey 07821

Christopher Porrino, Esq. (Also served via email)
Lowenstein Sandler
One Lowenstein Drive
Roseland, New Jersey 07068
cporrino@lowenstein.com

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Dated: March 8, 2022

/s/ Javier L. Merino
Javier L. Merino, Esq.

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

DISABILITY RIGHTS NEW JERSEY	:	
	:	**Case No.** 2:22-cv-01240
	:	
Plaintiff,	:	**Judge:** Brian R. Martinotti
	:	
v.	:	**Magistrate Judge:** James B. Clark
	:	
ALLIANCE HC 11 LLC d/b/a WOODLAND BEHAVIORAL AND NURSING CENTER	:	**Declaration of Gloria Jill Hoegel in Support of Motion for Preliminary Injunction**
	:	
Defendant.	:	

I, Gloria Jill Hoegel, of full age, in lieu of Affidavit, hereby state and declare as follows:

1. I am the Director of Investigations and Monitoring at Disability Rights New Jersey.

2. I make this Declaration in further support of the motion for preliminary injunction against Woodland Behavioral and Nursing Center ("Woodland").

3. Disability Rights New Jersey is the state-designated Protection and Advocacy system for the State of New Jersey.

4. As Director of Investigations and Monitoring at Disability Rights New Jersey, my job duties include monitoring facilities and places serving people with disabilities, investigating reports of abuse and neglect involving people with disabilities, and supervising staff who investigate reports of abuse and neglect involving people with disabilities.

5. Disability Rights New Jersey temporarily suspended its in-person monitoring activities in March 2020 because of the COVID-19 pandemic and the risk that monitoring would transmit the virus to vulnerable persons with disabilities.

6. In April 2020, The New York Times ran a story indicating that a high percentage of residents at Woodland, then known as Andover II, had died from COVID-19 and bodies were being stored on site.[1]

7. Disability Rights New Jersey requested information from the Woodland, then doing business as Andover Subacute and Rehabilitation Center II over the course of Spring 2020. Woodland responded through counsel in a letter dated May 13, 2020. *See* Declaration of Gwen Orlowski ("Orlowski Decl."), Exhibit A.

8. Disability Rights New Jersey learned from Woodland's May 13, 2020 letter that Woodland houses a disproportionately high number of residents with serious mental illness and traumatic brain injury.

9. In May 2021, based on availability of the COVID-19 vaccine, Disability Rights NJ resumed in-person monitoring in a limited capacity.

10. Disability Rights New Jersey prioritized monitoring long term care facilities that purported to serve residents with mental health needs, behavioral needs, and other facilities that had received notoriety during the pandemic when in-person monitoring was suspended.

11. Because of ongoing COVID-19 precautions, Disability Rights New Jersey provided courtesy notice to all facilities chosen for monitoring, though our access authority does not require any notice.

12. Disability Rights New Jersey selected Woodland for monitoring because it housed a high proportion of individuals with disabilities, and because of media reports about this facility released during the height of the pandemic.

[1] See https://www.nytimes.com/2020/04/15/nyregion/coronavirus-nj-andover-nursing-home-deaths.html

13. On July 12, 2021, Disability Rights New Jersey wrote to Woodland notifying the administrator of its intent to monitor, and provided an explanation and references for our legal authority to do so. *See* Orlowski Dec., Exhibit B.

14. Because Woodland houses individuals with intellectual and developmental disabilities, serious mental illness, traumatic brain injuries, and a range of other physical or mental disabilities, Woodland is within Disability Rights New Jersey's authority to monitor under our PADD (Protection and Advocacy for Individuals with Developmental Disabilities), PAIMI (Protection sand Advocacy for Individuals with Mental Illness), PATBI (Protection and Advocacy for Individuals with Traumatic Brain Injury), and PAIR (Protection and Advocacy for Individual Rights) programs.

15. On July 26 and August 17, 2021, Disability Rights New Jersey staff conducted initial monitoring visits at Woodland. This monitoring activity raised concerns that residents that needed specialized services for serious mental illness and developmental disability were inappropriately placed at the facility. We began collecting Preadmission Screening and Resident Review (PASRR) information from the state suspecting there was an issue with the unnecessary placement of disabled residents in long term care facilities.

16. As monitoring activities continued, Disability Rights New Jersey became aware of additional reports of serious and acute health and safety violations. The New Jersey Department of Health issued "Notice of Violations, Corrective Action, and State Monitoring" dated February 10, 2022.

17. I received a copy of the New Jersey Department of Health Notice on Monday, February 14, and learned that it was distributed to all Woodland residents between February 10 and February 14, 2022.

18. The Department of Health notice documented numerous instances of verbal abuse of patients by staff. The report also documented numerous serious instances of neglect, including an instance where a patient was left soiled in feces for more than ten hours and another instance where staff failed to assist a resident who called for help due to a stuck catheter. The report also identified numerous instances in which staff failed to provide any life saving emergency response, including an instance where staff failed to initiate

CPR, call 911, or utilize a defibrillator after finding a 55 year old resident unresponsive. The report also identified serious deficiencies in COVID prevention and treatment protocols, unsecured storage of dangerous medications, and found that the facility failed to maintain sufficient levels of properly trained and qualified staff.

19. Based on the detailed instances of abuse and neglect reported in the New Jersey Department of Health Notice, Disability Rights NJ Executive Director Gwen Orlowski determined there is probable cause to suspect that all residents at Woodland have been subject to ongoing abuse and neglect, and rights violations. Ms. Orlowski instructed me to begin an investigation immediately.

20. Because Woodland houses individuals with intellectual and developmental disabilities, serious mental illness, traumatic brain injuries, and a range of other physical or mental disabilities, Woodland is within Disability Rights New Jersey's authority to investigate with probable cause under our PADD (Protection and Advocacy for Individuals with Developmental Disabilities), PAIMI (Protection and Advocacy for Individuals with Mental Illness), PATBI (Protection and Advocacy for Individuals with Traumatic Brain Injury), and PAIR (Protection and Advocacy for Individual Rights) programs.

21. Specifically, the February 10, 2022 Notice indicates that residents are subject to widespread neglect, and that the facility is severely understaffed compared to licensure requirements. The Department of Health surveyors also reported observing specific incidents of abuse by staff against residents. *See* Orlowski Decl., Exhibit C.

22. Disability Rights NJ has been investigating the situation at Woodland since February 14, 2022, including conducting site visits to determine whether corrective actions are effectively addressing abuse and neglect in the facility, whether Woodland unlawfully confines residents to their floors, whether Woodland uses restraints unlawfully, whether Woodland delivers specialized services to residents who need them, and whether Woodland is initiating involuntary transfers from the facility in violation of resident rights.

23. I was onsite at Woodland on Friday February 18, 2022, along with my Disability Rights New Jersey colleagues Elena Kravitz and Marie Ciallella.

24. We spent much of the morning of February 18, 2022 observing conditions and interviewing residents on the third floor of the facility, where most residents with mental illness reside.

25. Around approximately 2:00pm, while I was on the third floor, I was approached by a resident (AS) who asked me for assistance. She stated she needed an inhaler, but she could not find her nurse.

26. I inquired at the nurse's station and soon after, a nurse arrived who appeared to be taking AS's vitals. The nurse had a name tag of "Allison" and was wearing light blue scrubs.

27. Allison clearly showed agitation towards us and informed me that AS had borderline personality disorder and was likely seeking attention. I responded that I was just looking for a nurse to assist AS, as she asked.

28. Allison and AS went down one of the wings where I assumed Allison was going to get AS's inhaler. About ten minutes later, I went down the hall to follow up.

29. At that time, Ms. Kravitz had joined me and a Woodland staff member, along with Allison, stated the person in charge of AS's medication had either gone to lunch or taken a break. The Woodland staff member and Allison stated that whoever is in charge of the medication does not hand off the keys to another person when leaving the station because the person leaving the station would have to count all the medications every time keys were handed over.

30. At that time, we approached the elevators to leave the unit. Allison and about three other Woodland staff were in the hall near us. Allison raised her voice and asked what we were trying to do there and why we were upsetting everyone. Another staff member who was next to Allison asked why we were telling staff to "sharpen up their resumes". I responded and advised that these statements were untrue.

31. A security officer arrived on the floor and was attempting to move us along.

32. The elevator arrived and we left the unit.

33. I was again onsite at Woodland on Wednesday, February 23, 2022, with colleagues Elena Kravitz and Michael Brower.

34. At approximately 12:30pm, I was on the second floor, along with Mr. Brower Brower. I was interviewing a resident when I saw two men approach Mr. Brower and begin speaking with him.

35. Several minutes later, Mr. Brower and the two men approached me and asked to speak with me. I did not obtain their names, but I understood they were either owners or administrators of Woodland.

36. The taller man indicated that they had a crisis on the third floor. He stated that there have been incidents with the residents, and the residents have all been discussing their right to leave.

37. He asked that we come up to the third floor with them and talk to the residents.

38. When we arrived on the third floor, there were several staff members around a woman who had on her coat and was waiting for the elevator.

39. One of the staff members said that the matter was under control, and they were taking the resident for a walk. However, the taller man who approached us downstairs insisted that Mr. Brower and I speak to her.

40. I identified myself to the woman and she declined to speak with me.

41. At that time, the Director of Nursing, Kimberly Williams (who I had originally met on February 18, 2022) began speaking to us about how we have incited the residents since coming to the facility. She said the residents are like Woodland's family and that Woodland understands what is best for them. I assured her that we conduct these kinds of activities all the time and do our best to avoid causing unnecessary disruption to anyone.

42. The taller man who had originally approached us downstairs suggested that we allow their staff into our interviews or interactions with the residents so they can ensure we are giving correct information.

43. At that time, we exited the third floor to allow the staff and residents space and to end the interaction.

44. We returned to the third floor about 15 minutes later. We did not interview anyone at that time, and instead, merely observed for approximately a half hour without further incident.

45. It will effectively impede our investigation of abuse and neglect if Disability Rights NJ staff are not permitted unaccompanied access to the facility and to the residents.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Dated: March 4, 2021

Gloria Jill Hoegel

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

DISABILITY RIGHTS NEW JERSEY	:	
	:	**Case No.** 2:22-cv-01240
	:	
Plaintiff,	:	**Judge:** Brian R. Martinotti
	:	
v.	:	**Magistrate Judge:** James B. Clark
	:	
ALLIANCE HC 11 d/b/a WOODLAND BEHAVIORAL AND NURSING CENTER	:	**Declaration of Gwen Orlowski in Support of Motion for Preliminary Injunction**
	:	
Defendant.	:	

I, Gwen Orlowski, of full age, in lieu of Affidavit, hereby state and declare as follows:

1. I am the Executive Director of Disability Rights New Jersey.

2. I make this Declaration in further support of the motion for preliminary injunction against Woodland Behavioral and Nursing Center ("Woodland").

3. Disability Rights New Jersey is the state-designated Protection and Advocacy system for the State of New Jersey.

4. As Executive Director at Disability Rights New Jersey, my job duties include overseeing staff, including staff responsible for monitoring facilities and places serving people with disabilities, and also investigating reports of abuse and neglect involving people with disabilities.

5. Disability Rights New Jersey temporarily suspended its in-person monitoring activities in March 2020 because of the COVID-19 pandemic and the risk that monitoring would transmit the virus to vulnerable persons with disabilities.

6. In April 2020, The New York Times ran a story indicating that a high percentage of residents at Woodland, then known as Andover II, had died from COVID-19 and bodies were being stored on site.[1]

7. Disability Rights New Jersey requested information from the Woodland, then doing business as Andover Subacute and Rehabilitation Center II over the course of Spring 2020. Woodland responded through counsel in a letter dated May 13, 2020. A true and accurate copy of the letter is attached hereto as **Exhibit A**.

8. Disability Rights New Jersey learned from Woodland's May 13, 2020 letter that Woodland houses a disproportionately high number of residents with serious mental illness and traumatic brain injury.

9. In May 2021, based on availability of the COVID-19 vaccine, Disability Rights NJ resumed in-person monitoring in a limited capacity.

10. Disability Rights New Jersey prioritized monitoring long term care facilities that purported to serve residents with mental health needs, behavioral needs, and other facilities that had received notoriety during the pandemic when in-person monitoring was suspended.

11. Because of ongoing COVID-19 precautions, Disability Rights New Jersey provided courtesy notice to all facilities chosen for monitoring, though our access authority does not require any notice.

12. Disability Rights New Jersey selected Woodland for monitoring based on the data we had gathered from the New Jersey Department of Health.

13. On July 12, 2021, Disability Rights New Jersey wrote to Woodland notifying the administrator of its intent to monitor and provided an explanation and references for our legal authority to do so. A true and accurate copy of the letter is attached hereto as **Exhibit B**.

[1] See https://www.nytimes.com/2020/04/15/nyregion/coronavirus-nj-andover-nursing-home-deaths.html

14. On July 26 and August 17, 2021, Disability Rights New Jersey staff conducted initial monitoring visits at Woodland at my direction. This monitoring activity raised concerns that residents that needed specialized services for serious mental illness and developmental disability were inappropriately placed at the facility. At my direction, staff began collecting Preadmission Screening and Resident Review (PASRR) information from the state suspecting there was an issue with the unnecessary placement of disabled residents in long term care facilities.

15. As monitoring activities continued, Disability Rights New Jersey became aware of additional reports of serious and acute health and safety violations. Specifically, we received a New Jersey Department of Health "Notice of Violations, Corrective Action, and State Monitoring" dated February 10, 2022.

16. Based on the detailed instances of abuse and neglect reported in the New Jersey Department of Health notice, I, as the director of Disability Rights NJ, in consultation with our Legal Director, Michael Bower, and other senior staff, determined there is probable cause to suspect that all residents at Woodland have been subject to ongoing abuse and neglect, and rights violations.

17. Specifically, the February 10, 2022 Notice indicates that residents are subject to widespread neglect and that the facility is severely understaffed compared to licensure requirements. The Department of Health surveyors also reported observing specific incidents of abuse by staff against residents. A true and accurate copy of the letter is attached hereto as **Exhibit C**.

18. I received a copy of the New Jersey Department of Health Notice on Sunday, February 13 2022 and shared it with my staff on Monday, February 14. I learned that it was distributed to all Woodland residents between February 10 and February 14, 2022.

19. The Department of Health notice documented numerous instances of verbal abuse of patients by staff. The report also documented numerous serious instances of neglect, including an instance where a patient was left soiled in feces for more than ten hours and another instance where staff failed to assist a resident who called for help due to a stuck catheter. The report also identified numerous instances in which

staff failed to provide any life saving emergency response, including an instance where staff failed to initiate CPR, call 911, or utilize a defibrillator after finding a 55 year old resident unresponsive. The report also identified serious deficiencies in COVID prevention and treatment protocols, unsecured storage of dangerous medications, and found that the facility failed to maintain sufficient levels of properly trained and qualified staff.

20. Based on the detailed instances of abuse and neglect reported in the New Jersey Department of Health notice, I determined there is probable cause to suspect that all residents at Woodland have been subject to ongoing abuse and neglect, and rights violations. I instructed Disability Rights New Jersey Director of Investigations and Monitoring Jill Hoegel to begin an investigation immediately.

21. Disability Rights NJ has been investigating the situation at Woodland since February 14, 2022, including by conducting site visits to monitor conditions and interview residents to understand concerns that need to be addressed.

22. On Sunday, February 20, 2022, I arrived at Woodland at approximately 9:40 am for the purpose of participating in an ongoing investigation of abuse and neglect Disability Rights New Jersey was conducting.

23. I accompanied two Disability Rights New Jersey colleagues, Elena Kravitz, Senior Advocate and Cory Bernstein, Staff Attorney, to the facility, and we proceeded inside to the lobby together to begin our work.

24. COVID protocols are set-up and reviewed by Woodland staff in the lobby, and I complied with all protocols including having my temperature taken, wearing Personal Protective Equipment (PPE), and providing proof of vaccination status. I was not given a COVID rapid test because I had been there several days earlier and tested negative for COVID.

25. I, along with Ms. Kravitz and Mr. Bernstein, attempted to enter the locked door that opens into the second floor nurses station, but an individual who identified himself as one of the owners of the facility, Mutty Scheinbaum, asked us to accompany him to his office, purportedly to meet members of his

senior staff. I introduced myself to Mr. Scheinbaum as the Executive Director of Disability Rights New Jersey and provided him with my business card, which includes my photograph.

26. On our way to Mr. Scheinbaum's office, I stopped and spoke with several residents, introducing myself and Disability Rights New Jersey. Mr. Scheinbaum continued his walk towards his office. Mr. Scheinbaum came back to me and insisted that I come directly to his office without speaking further with residents.

27. Thereafter, Mr. Scheinbaum essentially kept us trapped in his office for approximately ninety minutes, leaving us for periods of time, only saying he was looking for other staff or he was going to speak to his attorney. On one of the occasions that Mr. Scheinbaum left us in the office to speak to his attorney, we could hear him screaming in the hallway.

28. After Mr. Scheinbaum left us alone in his office for approximately twenty minutes, Ms. Kravitz, Mr. Bernstein, and I began leaving Mr. Scheinbaum's office, thinking he was not coming back. Mr. Scheinbaum then returned with a member of his staff he identified as Cindy Shiller, Infection Prevention Specialist. Mr. Scheinbaum asked if he could record our conversation, and I advised that he did not have my consent, as we just met, and I had no idea of his purpose for the meeting.

29. Mr. Scheinbaum challenged Disability Rights New Jersey's authority to access Woodland, even though we advised him that we had sent Woodland correspondence in July 2021, prior to our first in-person visit on July 26, 2021, which outlined our access authority. Furthermore, we conducted investigation and monitoring activities on several occasions thereafter with no incident. During our conversation, we repeatedly told him that our authority as the designated protection and advocacy agency was well-established and suggested that he consult with his attorney.

30. Mr. Scheinbaum continued to keep us confined to his office and at one point, threatened to call the police if we left his office.

31. After one purported conversation with his attorney (outside of the office), Mr. Scheinbaum told us his attorney advised that we did not have the authority to monitor, and instead, we only have limited

authority to investigate. Additionally, Mr. Scheinbaum informed us that Disability Rights New Jersey was being denied access to the facility because of active COVID outbreaks. In addition, Mr. Scheinbaum challenged that we were who we said we were, despite the fact that we had provided him business cards with photographs, the July 12, 2021 letter, were wearing photo identification, and we directed him to our website where our protection and advocacy authority is explained and there are photographs of staff present at Woodland that day.

32. In response to his position denying access based on an active COVID status, I called Disability Rights New Jersey's Legal Director, Michael Brower, who forwarded me a November 12, 2021 Centers for Medicare & Medicaid Nursing Home COVID-19 visitation memorandum. I showed Mr. Scheinbaum page seven of the memorandum, where it makes clear that nursing facilities must "allow immediate access to a resident by any representative of the protection and advocacy system" regardless of the public health emergency. A true and accurate copy of the memorandum is attached as **Exhibit D**.

33. Mr. Scheinbaum continued to deny Disability Rights New Jersey access to the facility and said "our boss" could call his attorney. I reminded him again that I was the Executive Director of Disability Rights New Jersey. He gave me his attorney's name, Peter Slocum, and Mr. Slocum's telephone number.

34. At approximately 11:15 am, I initiated a conference call with Mr. Brower and Mr. Slocum wherein I explained Disability Rights New Jersey's access authority, specifically unaccompanied access to any facility serving people with disabilities.

35. Mr. Slocum expressed understanding of our right to access the facility without accompaniment, expressed his belief that there had been a misunderstanding, and informed Mr. Brower and I that he would instruct his client, Woodland, not to interfere with our investigation

36. Upon re-entering the lobby, I asked Mr. Scheinbaum if he had spoken with his attorney and would allow us to enter the units, and he acquiesced but asked when we would be done. I told him I would let him know when I was done.

37. Woodland finally allowed Disability Rights New Jersey staff to enter the facility at 11:30 am, nearly two hours after arriving.

38. At approximately 1:15 pm, I went to Mr. Scheinbaum's office to let him know I was leaving but that my colleagues were still conducting the investigation. He was not there, so I left a message with a staff person in the next room.

39. I left the facility at approximately 1:20 pm on February 20, 2022.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Dated: March 4, 2022

Gwen Orlowski

EXHIBIT A

Lowenstein Sandler

Christopher Porrino
Partner

One Lowenstein Drive
Roseland, New Jersey 07068

T: 973.597.6314
F: 973.597.6315
E: cporrino@lowenstein.com

May 13, 2020

VIA EMAIL

Lycette Nelson, Esq.
Managing Attorney
Disability Rights New Jersey
210 South Broad Street
Trenton, New Jersey 08608
Email: lnelson@drnj.org

Re: Andover Subacute and Rehabilitation Center I and Andover Subacute and Rehabilitation Center II

Dear Ms. Nelson:

This law firm represents Andover Subacute and Rehabilitation Center I ("Andover Subacute I") and Andover Subacute and Rehabilitation Center II ("Andover Subacute II"). We are in receipt of the April 18, 2020 letter from Gwen Orlowski, Executive Director of Disability Rights New Jersey, requesting that Andover Subacute I and Andover Subacute II respond to certain information requests. Responses from each facility are as follows:

Andover Subacute and Rehabilitation Center I

1. The number of residents who have documented intellectual or developmental disabilities is 10.

2. The number of residents who have documented serious mental illness is 84.

3. The number of residents who have documented traumatic brain injury is 2.

4. The number of residents who have died from COVID-19 since March 1, 2020 who have documented intellectual or developmental disabilities, TBI, or serious mental illness is 9.

Andover Subacute and Rehabilitation Center II

1. The number of residents who have documented intellectual or developmental disabilities is 37.

2. The number of residents who have documented serious mental illness is 221.

3. The number of residents who have documented traumatic brain injury is 15.

4. The number of residents who have died from COVID-19 since March 1, 2020 who have documented intellectual or developmental disabilities, TBI, or serious mental illness is 41.

Please reach out to us if you have any questions about this information.

Sincerely,

/s/ Christopher Porrino

Christopher Porrino

EXHIBIT B

DISABILITYRIGHTS NEWJERSEY

210 South Broad Street, Third Floor
Trenton, New Jersey 08608
800.922.7233 | 609.633.7106 (TTY)
609.292.9742 | 609.777.0187 (FAX)
www.drnj.org

Gwen Orlowski, Executive Director

July 12, 2021

Mr. Isaac Greenberg, Administrator
Woodland Behavioral Health and Nursing Center
99 Mulford Road
Andover, New Jersey 07821

Via regular mail and fax: (973) 383-0359

RE: Disability Rights New Jersey Intent to Monitor

Dear Mr. Greenberg,

I am writing to notify you that Disability Rights New Jersey is initiating activities to monitor the rights of individuals living in the Woodland Behavioral Health and Nursing Center. This monitoring is intended to ensure that individuals with disabilities served in this setting are receiving necessary services, are not experiencing abuse or neglect, and are aware of their rights. We plan to conduct monitoring activities during the week of July 26, 2021.

Disability Rights NJ is federally mandated to provide protection and advocacy services to individuals with disabilities in the state of New Jersey. Disability Rights NJ provides free services to people who qualify under our federal mandates. The federal government established Protection and Advocacy programs to protect and advocate for the rights, safety and autonomy of people with disabilities, pursuant to the Developmental Disabilities Assistance and Bill of Rights ("DD") Act, 42 U.S.C. § 15041, *et seq*., the Protection and Advocacy for Individuals with Mental Illnesses ("PAIMI") Act, 42 U.S.C. § 10801, *et seq*., the Protection and Advocacy for Individual Rights ("PAIR") Act, 29 U.S.C. § 794e. In addition, CMS guidance issued September 17, 2020 (Ref: QSO-20-39-NH) provides clear guidance to facilities regarding the access authority of the P&A's in relation to COVID-19 and reiterates that our access remains intact.

However, in an attempt to help keep the spread of the COVID-19 virus minimized, Disability Rights NJ staff will follow the protocols and guidelines applicable to your facility staff. If you are utilizing any protocols other than the publicly available New Jersey Department of Health guidelines, please contact me to discuss.

Out of an abundance of caution, I ask that if any member of your staff who we interact with or interview tests positive for COVID-19 within 14 days of the visit, you contact me as soon as possible. In return, we will do the same. Please note we are not seeking the name of the individual, simply the diagnosis so we can engage in contact tracing.

In advance of our onsite activities, we are requesting the following public information. Please email (or alternatively, prepare for our staff onsite) to Jill Hoegel, Director of Investigations and Monitoring at jhoegel@drnj.org:

1. Current census information, including breakdown of facility residents who are identified as having 1) intellectual or developmental disability; 2) serious mental illness, and 3) traumatic brain injury (both children and adult breakdown)
2. Breakdown of census receiving any specialized rehabilitation services and eligibility criteria for those services
3. Current COVID screening and/or visitation policies
4. Current Certification/s and Site Visit Report/s

If you have any questions prior to our visit please feel free to contact me at (609) 292-9719 or at jhoegel@drnj.org.

Sincerely,

Jill Hoegel

Jill Hoegel
Director of Investigations and Monitoring
(609) 292-9719
jhoegel@drnj.org

EXHIBIT C

State of New Jersey
DEPARTMENT OF HEALTH
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PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

In Re Licensure Violations: Woodland Behavioral and Nursing Center (NJ Facility ID# NJ 61901)	:	NOTICE OF VIOLATIONS, CORRECTIVE ACTION, AND STATE MONITORING

TO: Menachem Spiegel, Administrator
Woodland Behavioral and Nursing Center
99 Mulford Road
P.O. Box 1279
Andover, New Jersey 07821-1279
mspiegel@woodlandbehavioral.com

The Health Care Facilities Planning Act (N.J.S.A. 26:2H-1 et seq.) (the Act) provides a statutory scheme designed to ensure that all health care facilities are of the highest quality. Pursuant to the Act and N.J.A.C. 8:43E-1.1 et seq., General Licensure Procedures and Standards Applicable to All Licensed Facilities, the Department's Commissioner is authorized to inspect all health care facilities and to enforce the Standards for Licensure of Long-Term Care Facilities set forth at N.J.A.C. 8:39-1.1 et seq.

Effective immediately, the Department of Health ("the Department") is issuing a Notice of Violations and Corrective Action to Woodland Behavioral Health and Nursing Center ("Woodland" or "the Facility"). In addition, the Department is appointing a state monitor to conduct a needs assessment and develop an analysis of the root causes of the current situation in the facility and provide a recommendation on what would be the most efficient and effective way to improve this facility so that it can safely care for residents into the future.

LICENSURE VIOLATIONS:

Staff from the Department's Health Facility Survey and Field Operations (HFS&FO) were on-site at Woodland Behavioral and Nursing Center (Facility) from January 3, 2022, through February 2, 2022. Based on observations, interviews, and review of pertinent Facility documentation the Facility failed to appropriately prevent abuse and neglect, with the deficiencies including:

1. Observations of Facility staff, including Certified Nurse Aides, revealed a phlebotomist verbally abused a resident on January 11, 2022, by cursing at him/her. Interviews with the Director of Nursing (DON) on January 21, 2022, revealed that she was aware of the allegation, and that the verbal abuse was witnessed by Facility staff, but there was no investigation of the abuse, and it was not reported to the New Jersey Department of Health (NJDOH) until the surveyor inquiry on January 21, 2022.

2. A Certified Nursing Aide (CNA) neglected a resident on January 11, 2022, by leaving him/her soiled in feces for ten hours from 11:00p.m. to 9:00/9:30a.m. the following morning despite the resident having a pressure ulcer wound to the sacrum. The resident reported that he/she informed the Staffing Coordinator that they no longer wanted the CNA because she made him/her "furious" and "scared." Interviews with the Staffing Coordinator revealed she was aware of the allegation of neglect and that the resident did not want care from the CNA anymore, but she failed to inform Facility administration or initiate an investigation into the allegation. Additionally, the Facility failed to investigate the allegation of neglect and never reported it to the NJDOH. The Facility never suspended the CNA pending the outcome of the investigation; the CNA continued to work over 36 shifts on 3 different units through January 31, 2022, after the allegation was made and prior to completion of any investigation. The CNA also continued to care for the resident on at least one additional shift after the neglect allegation.

3. A Licensed Practical Nurse (LPN) and a Quality Assurance Certified Nursing Aide (QA/CNA) neglected a resident after he/she called for assistance because his/her suprapubic catheter got stuck in a motorized wheelchair on January 16, 2022. The resident claimed it caused physical pain at the catheter site. The resident's pleas for help were ignored by the LPN and QA/CNA for over 40 minutes. An interview with the DON revealed she was aware of the incident, but she did not suspend the staff, investigate, or report the allegation of neglect to the NJDOH in accordance with the Facility's abuse policy even after being informed of the allegations of abuse and neglect on January 21, 2022. In addition, the Facility failed to suspend staff, initiate an investigation and report two other allegations of abuse to the NJDOH until January 27, 2022.

4. The surveyor witnessed verbal abuse from Facility staff towards a resident on January 26, 2022, when a CNA verbally abused the resident while in the room with the resident and in the presence of another CNA. The CNA pointed her finger at the resident, called the resident “manipulative,” stated that he/she had "sneaky eyes" and stated in front of the resident that she was going to quit her job because of him/her. Another CNA was present in the room when this occurred, but the CNA did not immediately report the verbal abuse to Facility management. The resident stated that this made them feel angry and he/she wanted to leave the Facility.

The Facility's failure to appropriately prevent abuse and neglect, initiate investigations into the allegations of abuse and neglect, and its failure to suspend identified staff until the outcome of the investigation was complete in accordance with its Abuse Policy, posed a likelihood of serious mental anguish to the specific residents and other residents.

The survey team identified an Immediate Jeopardy for Cardiopulmonary Resuscitation-CPR. The deficiencies include:

1. During a review of closed death records, the Survey team identified that the Facility failed to activate its life-saving emergency response by immediately initiating Cardiopulmonary Resuscitation (CPR) when two full code residents were found unresponsive without pulses or respirations. One resident was a full-code and the family requested aggressive life-saving treatment despite medical decline. The resident progress notes revealed that the resident was last seen on October 8, 2021, within their baseline, and was found without a heartbeat and respirations one and a half hours from last being observed by staff. The resident was pronounced dead without the Facility initiating CPR, calling 911, or accessing the AED (defibrillator). Survey interviewed the Nurse assigned who claimed to be CPR-certified, but he/she did not implement CPR because the resident was "visibly blue," had a "locked jaw," and the Nurse thought the resident’s physical signs meant the resident was “too far expired” and entered a state of irreversible death.

   The other 55-year old resident was found to be unresponsive without a pulse or respirations on New Year’s Day at 5:05 p.m., and was pronounced dead at 5:15 p.m., which was unexpected. The resident had last been seen one hour and thirty-five minutes prior and was within his/her baseline. According to documentation, the Facility never initiated CPR, called 911, or accessed the AED to provide life-saving measures. Furthermore, the resident had not been tested for COVID-19 since November 8, 2021, and there was no documented evidence that the resident had refused COVID-19 testing.

   Interviews with the Nurse assigned to this resident claimed they were certified in CPR, and that they initiated CPR that day, but did not document it. However,

there was no evidence of CPR being administered, or a 911 call made to initiate life-saving interventions, which is the standard of practice for emergency resuscitation.

2. Survey's interview with the DON on January 28, 2022, revealed that the Facility did not maintain or track the CPR certifications of Facility staff and that the nursing staff involved would have to provide their CPR certificates from home.

The Facility's failure to appropriately initiate CPR, appropriately activate an emergency response, including calling 911 when residents were full code and found to be unresponsive without a heart rate and respirations, and the Facility's failure to maintain tracking of valid CPR certifications to ensure all shifts had staff who were certified in CPR, placed all residents at risk for imminent death if found unresponsive without a pulse and without respirations.

The survey team identified another Immediate Jeopardy for deficiencies that include:

1. During closed death record reviews, Survey determined that the Facility failed to ensure an unvaccinated resident at risk for serious outcomes from COVID-19 received necessary treatment to avoid their COVID-19 condition worsening, including hospitalization and death. The resident tested positive for COVID-19 on October 15, 2021, and the Facility failed to ensure the resident received Monoclonal Antibodies therapy infusion (Regeneron) in accordance with a STAT (immediate) order obtained from the Advanced Practice Nurse (APN) on October 17, 2021. The reconstituted intravenous infusion Regeneron was delivered to the Facility on October 17, 2021, at 10:02 PM, but it was not administered within the 36 hours of reconstitution as required for viability. The resident never received the STAT dose of Regeneron and the resident developed severe symptoms of COVID-19. The resident required hospitalization on October 21, 2021, with Acute Hypoxemic Respiratory Failure with COVID-19. The resident died on November 11, 2021.

The Facility failed to communicate with the acute care hospital that the resident never received the monoclonal antibodies, despite the STAT order from the APN. The Hospital Admission Evaluation record dated October 21, 2021, erroneously reflected that the resident had received the Monoclonal Antibody Infusion prior to admission to the hospital. However, record reviews and interviews with Facility staff (LPN, RN, APN) indicated the resident never received the infusion in accordance with the order.

2. The Facility failed to have a written policy related to the emergency-use FDA authorization for administration of the monoclonal antibody therapy, or evidence of staff education for the administration of monoclonal antibodies therapy infusion. According to the FDA, the Facility should have included specific administration instructions including monitoring during and after the infusion, the need for a specialized intravenous filter tubing for the infusion, and post-infusion

instructions for flushing the line to ensure complete administration of the therapy dose.

3. A second unvaccinated resident tested positive for COVID-19 on October 19, 2021. A review of the resident's Progress Notes dated October 20, 2021, revealed that the Infectious Disease (ID) physician recommended the Monoclonal Antibody infusion, and the resident consented, but the Facility failed to order it for two days until October 22, 2021. The doctor ordered the Monoclonal Antibody infusion STAT, but the order for Regeneron was never received or delivered by the pharmacy. The facility failed to verify receipt of the medication. The resident was not sent to the hospital to get the IV line or render the monoclonal antibody infusion. The resident was hospitalized for COVID-19 related illness on October 25, 2021. The resident died on November 6, 2021.

   The Facility failed to identify that the residents never received the monoclonal antibodies infusions, and it failed to make the necessary corrective actions to prevent the failures from occurring again to any other residents scheduled to receive infusions.

   The Facility's failure to implement reasonable measures, including policies and staff education to ensure timely monoclonal antibody infusions to prevent serious outcomes and death for all other residents that are prescribed monoclonal antibody infusions for COVID-19, placed all residents at risk for serious harm or imminent death.

The survey team identified another deficiency for failure to keep the Facility free of accidents and/hazards and failing to provide supervision to keep the Facility free of accidents and hazards. The deficiency is based on the following findings:

1. On January 21, 2022, during a medication storage follow-up on 3-Central Behavior Unit, the surveyor observed that the easily accessible, unlocked nurses' station had an unlocked emergency medication kit (e-Kit). The surveyor observed multiple, high-risk medications accessible to any wandering or potentially suicidal residents on the unit. The medications that were accessible included two tubes of Glucose for emergency use; two tablets of Vitamin K of 5 mg each (medication that can lead to cardiac arrhythmia), Nitrostat sublingual tablets; four (4) bottles of 60 mL Kayexelate solution (used to lower potassium levels in the blood and can dangerously affect the heart); and, three (3) pre-filled syringes of Lovenox (anticoagulant). The 3-Central Nurses' station is located central to the Behavioral Unit, where 23 active wandering residents and 3 residents with a history of suicidal ideations reside. The survey revealed that the nurses' station on 3-Central Behavioral Unit was not always supervised or staffed. On January 21, 2022, a unit clerk was present at the nurses' station and had no knowledge about the e-Kit or that the e-Kit had been unlocked. Unsupervised access to an unlocked e-Kit containing high-risk medications

without a system in place for the accountability of ensuring its location and the integrity of its locking mechanism placed all the residents who wander with cognitive impairment, advanced psychiatric illness or suicidal ideations at a serious risk for harm, impairment or death if a resident consumed or self-injected the medications.

2. The Facility had no system in place for accountability of the Facility e-Kits, including the integrity of the locking mechanism. Further investigation revealed that the e-Kit had been unlocked for four (4) days since January 17, 2022, when it had to be accessed to administer emergency resuscitative medications for a resident in apparent cardiac arrest.

3. The Facility failed to follow its policy for the e-Kit use, including to return and replace it immediately after opening.

The survey team notified the Licensed Nursing Home Administrator (LNHA) of the failure to provide administration. The failure to provide administration began on December 12, 2021, when the Facility was identified to be non-compliant with the requirement to provide infection control and prevention and for the failure to implement its COVID-19 Outbreak Response Plan and the U.S. Centers for Disease Control and Prevention (CDC) guidelines for mitigating transmission of COVID-19 in nursing homes. The LNHA's lack of oversight to ensure that the Facility's outbreak response plan was implemented during an influx of new COVID-19 cases amongst residents and staff (102 new staff cases and 131 new resident cases within a two-week period of time from December 23, 2021 to January 1, 2022) placed all residents at risk for contracting COVID-19. This deficiency is based on the following findings:

1. The LNHA's failure to appropriately hire or train a qualified Infection Preventionist (IP) in accordance with the Executive Directive 20-026 (updated January 6, 2021), failure to replace the IP with a qualified designee while she was out on leave during the peak of new COVID-19 infections, and the failure to implement minimum infection control standards in accordance with the CDC guidelines and the Facility's outbreak response plan, placed all residents at risk for contracting COVID-19. Furthermore, the LNHA failed to ensure adequate staffing or necessary cohorting of staff to prevent spread and failed to document/record any minutes related to infection control meetings or communications held related to the Facility's COVID-19 outbreak.

2. Observations and interviews conducted on January 5, 2022 and January 6, 2022 by the survey team revealed that Facility staff were not wearing or not properly wearing the necessary personal protective equipment (PPE) while on the COVID-19 units (no use of eye protection, improperly worn gowns or no use of gowns). There were multiple wandering residents on the COVID units who were COVID-19 positive, and they were not wearing masks. Additionally, there were

no receptacles for discarding used PPE at the exits of the four (4) COVID-19 positive units.

3. Observations and interviews conducted on January 3, 2022 through January 6, 2022 by the survey team revealed a unit which contained residents designated on all three COVID-19 cohort zones, well residents, persons under investigation (PUI) residents and COVID-19 positive residents. This included 5 of 6 PUI residents on that unit who were unvaccinated and not placed on Transmission-Based Precautions or placed in the proper cohort. The Facility commingled well residents with PUI and COVID-19 positive residents. Staff were unaware that the residents were supposed to be placed on Transmission-Based Precautions. Staff (housekeeper, housekeeping manager and LPN) assigned to that unit had no knowledge of a well-to-ill rounding and staff would see the COVID-19 positive resident/resident area first before resuming services for the non-COVID residents on the same unit. Observations by the survey team revealed that the housekeeper who had just cleaned the COVID-19 positive area exited the area with the same contaminated gloves and without performing hand hygiene. The housekeeper attempted to enter a non-COVID-19 resident room by coming in direct contact with the resident's doorknob and a surveyor had to intervene. The housekeeping manager confirmed that housekeepers clean the COVID-19 positive areas first before resuming services elsewhere in the building.

4. The Facility's LNHA failed to ensure that contact tracing was conducted and failed to ensure that unvaccinated residents who should have been PUIs were quickly identified and placed on transmission-based precautions (TBP) with all the appropriate PPE in accordance with CDC guidelines. This occurred on January 3, 2022, for 11 residents who tested positive for COVID-19 on a single, non-COVID (Green Zone) cohort zone, who had not been previously identified as exposed to COVID-19. The Facility's LNHA did not ensure the implementation of transmission-based precautions for the remaining residents on the unit to mitigate the spread of COVID-19 when they could not clearly identify how those residents may have been exposed to COVID-19.

5. The LNHA confirmed that staff who cared for residents who tested positive for COVID-19 and residents considered PUI needed to wear personal protective equipment including gloves, gown, eye protection, and an appropriately worn N95 mask to prevent the spread of COVID-19. Staff were unaware of proper protocol of exposure and implementation of TBP to prevent the spread of infection.

6. Residents who have been exposed to COVID-19 have the potential to be COVID-19 positive and asymptomatic. Staff caring for these residents are unaware of these residents' exposure and could potentially further spread COVID-19 through not maintaining TBP. COVID-19 is known to be a highly infectious communicable disease that can lead to death. The lack of oversight to

ensure that the Facility's Outbreak Response Plan has been implemented during its COVID-19 outbreak and a system in place for identifying breaches in infection control and implementing corrective actions (Quality Assurance Performance Improvement plan) placed all the residents at risk for developing COVID-19. As of February 2, 2022, 14 resident of Woodlands who tested positive for COVID-19 during this outbreak have died.

The survey team identified another deficiency for the failure to implement a quality assurance and performance improvement plan. The deficiency is based on the following findings:

1. On January 21, 2022, during an investigation into the Facility's plan and practices, survey staff identified that the Facility had not formulated and implemented a QAPI plan to address any area related to infection prevention and control prior to and during their COVID-19 outbreak. The Facility had no system for identifying concerns related to infection prevention and control and there was no documented evidence of an identified area in need of sustaining or improvement, a measurable goal/benchmark, a written infection control implementation plan with audits, or a good faith effort of monitoring to evaluate for improvements related to infection control practices.

2. Interviews by survey staff with the Infection Preventionist who had been employed at the Facility since June 2021 revealed that she had not attended any QAPI Meetings and was not included or involved in the QAPI process, as is required. She was not aware of any designated staff either.

3. A review of Infection Control Meeting Minutes conducted on July 13, 2021 and October 26, 2021 revealed a brief report on employee health and the COVID-19 status of the Facility, but did not address a QAPI or any related infection control improvement efforts.

4. The LNHA did not have any documented evidence of meeting minutes for infection prevention and control prior to the onset of the COVID-19 outbreak that began in September 2021, and there was no evidence of a root-cause analysis/evaluation to determine possible causes for the significant increase of COVID-19 cases amongst residents, or of an effort to evaluate infection control measures or of reviewing other processes including COVID-19 testing. The Facility's LNHA and its Infection Preventionist were unable to provide any documentation to demonstrate a good faith attempt for any QAPI related to infection prevention and control.

5. Prior to the Facility's COVID-19 outbreak, there was no QAPI/written plan for infection prevention and control to monitor and evaluate the Facility's efforts or progress. Upon the start of the Facility's COVID-19 outbreak, and with the knowledge of a significant increase in COVID-19 cases, the Facility failed to

show evidence of an attempt to identify a root-cause for the rapid spread of COVID-19 amongst residents and staff and a means to further mitigate the spread of COVID-19. Without a system to self-identify possible infection control concerns, infections are likely to spread. As of February 2, 2022, the Facility had 14 deaths of residents who had tested positive for COVID-19 during this outbreak, and there was no QAPI for infection prevention and control in place prior to or during this outbreak until surveyor inquiry.

The survey team also identified a deficiency for the failure to provide infection prevention and control. The deficiency is based on the following:

1. The Facility failed to implement its outbreak response plan and the CDC guidelines regarding preventing the spread of COVID-19 in nursing homes. Furthermore, the Facility's Outbreak Response Plan did not address contact tracing. Residents who have been exposed to COVID-19 have the potential to be COVID-19 positive and asymptomatic. Staff caring for these residents are unaware of these residents' exposure and could potentially further spread COVID-19 through not maintaining TBP.

2. From December 23, 2021 through January 6, 2022, 102 Facility staff members tested positive for COVID-19 when the Facility and their Infection Preventionist (LPN/IP) stopped conducting contact tracing to identify residents exposed to COVID-19. The Facility's failure to identify residents exposed to COVID-19 and failure to place the unvaccinated residents on transmission-based precautions through the means of contact tracing to mitigate its transmission during their COVID-19 outbreak, placed all the residents in the Facility at risk of contracting COVID-19.

3. Observations and interviews conducted by the survey team on January 5, 2022 and January 6, 2022 revealed that Facility staff were not wearing or properly wearing the necessary PPE while on the COVID-19 units (no use of eye protection, improperly worn gowns or no use of gowns), and that there were multiple wandering residents who tested positive throughout the units who were not wearing appropriate PPE. Additionally, there were no receptacles for discarding used PPE upon at the exits of the 4 COVID-19 positive units.

4. Interviews with nursing staff by the survey team on a COVID-19 positive unit revealed that some of the staff float to various units/cohort zones, including taking on assignments for residents who were not positive for COVID-19.

5. Observations by the survey team of staff (CNA, housekeeper, Security Guard) revealed that they were improperly wearing an N95 respirator mask (surgical mask worn under the N95 mask), despite the claim to have been fit-tested for the mask.

6. Observations and interviews conducted on January 3, 2022 through January 6, 2022 by the survey team revealed a unit which contained residents designated on all three COVID-19 cohort zones, well residents, PUI residents and COVID-19 positive residents. This included 5 of 6 PUI residents on that unit who were unvaccinated and not placed on Transmission-Based Precautions or placed in the proper cohort. The Facility commingled well residents with PUI and COVID-19 positive residents. Staff were unaware that the residents were supposed to be placed on Transmission-Based Precautions. Staff (housekeeper, housekeeping manager and LPN) assigned to that unit had no knowledge of a well-to-ill rounding and staff would see the COVID-19 positive resident/resident area first before resuming services for the non-COVID residents on the same unit. Observations by the survey team revealed that the housekeeper who had just cleaned the COVID-19 positive area exited the area with the same contaminated gloves and without performing hand hygiene. The housekeeper attempted to enter a non-COVID-19 resident room by coming in direct contact with the resident's doorknob and a surveyor had to intervene. The housekeeping manager confirmed that housekeepers clean the COVID-19 positive areas first before resuming services elsewhere in the building.

7. Furthermore, the Facility's designated, full-time Infection Preventionist/LPN did not meet the State-mandated qualifications to act as the Facility's IP, in accordance with Executive Directive 20-026, updated January 6, 2021.

8. In addition, there was no documented evidence of monitoring for signs and symptoms of COVID-19 for residents that were PUI or positive for COVID-19, including for residents leading up to hospitalization and expiration.

9. The Facility failed to perform contact tracing, failed to identify PUI residents, failed to implement TBP including appropriate PPE, failed to use N95 masks, goggles, TBP signs to indicate the residents exposed to the staff that tested positive and to provide the necessary PPE bins on all units. Specifically, this occurred on January 3, 2022, when 11 residents who tested positive for COVID-19 on a single, non-COVID (Green Zone) Cohort when they had not been previously identified as exposed to COVID-19. The Facility did not implement transmission-based precautions for the remaining residents on the unit to mitigate the spread of COVID-19 when it could not clearly identify how those residents may have been exposed to COVID-19.

10. The LNHA confirmed that staff who cared for residents who tested positive for COVID-19 and residents considered PUI needed to wear personnel protective equipment including gloves, gowns, eye protection, and an appropriately worn N95 mask to prevent the spread of COVID-19. Staff were unaware of proper protocol of exposure and implementation of TBP to prevent the spread of infection.

The survey team identified another violation for the failure to provide COVID-19 testing of residents and staff. The deficiency is based on the following findings:

1. During a review of COVID-19 testing for residents and staff, the survey team identified that the Facility failed to consistently perform bi-weekly COVID-19 testing for vaccinated and unvaccinated staff and residents during their COVID-19 outbreak when contact tracing could not be implemented, and in accordance with the Facility's Outbreak Response Plan, the Facility's Testing Policy and Procedure, and CDC guidance to mitigate the spread of the COVID-19 virus.

2. The Facility failed to provide sufficient and consistent evidence of tracking COVID-19 testing for residents and staff which was likely to delay identification of residents and staff who could have been positive for the COVID-19 virus.

3. The Facility failed to keep an accurate record of staff who were partially vaccinated and unvaccinated for COVID-19 to ensure testing was done for the required individuals. Specific dates the Facility was unable to provide evidence of testing or results of COVID-19 testing for any staff included: November 12, 2021 through December 6, 2021 and December 29, 2021 through January 10, 2022, and January 13, 2022 through January 26, 2022.

4. Two residents that had expired had no evidence of COVID-19 testing in accordance with required time frames; one resident who did not have the booster and received their second dose of the COVID-19 vaccine on June 3, 2021 had not been tested since August 5, 2021 and expired on October 8, 2021; and another resident who did not have the booster and received their 2nd dose of the vaccine on February 16, 2021 had not been tested for COVID-19 since November 8, 2021 and expired on January 1, 2022. There was no documented evidence that either of the residents had refused COVID-19 testing. An interview with an unvaccinated CNA revealed that the Facility had stopped testing for COVID-19 for a period of time in November 2021, but she could not explain why this was the case.

5. Interviews with the Facility's Infection Preventionist indicated that the Facility was not appropriately tracking staff and residents who were tested for COVID-19. The Infection Preventionist stated that she was unable to tell the survey team which residents and staff members were tested for COVID-19 upon review of the information provided by the Facility. The Infection Preventionist further stated that she was unaware of a staff member working at the Facility that would be able to speak to COVID-19 testing for residents and staff. No other information was provided by the Licensed Nursing Home Administrator.

6. The Facility's failure to ensure that COVID-19 testing was performed in accordance with CMS requirements and CDC guidelines for vaccinated and unvaccinated staff and residents in a timely manner delayed the identification of

COVID-19 positive residents and staff, which impacted the ability to promptly cohort residents and prevent the further spread of COVID-19. As of February 2, 2022, the Facility had 14 deaths of residents who had tested positive for COVID-19 since the onset of its most recent COVID-19 outbreak.

The survey team identified a state violation based on the following findings:

1. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 7 of 14 evening shifts and deficient in total staff for residents on 10 of 14 overnight shifts as follows:

   a. 12/19/21 had 37 CNAs for 458 residents on the day shift, required 58 CNAs.

   b. 12/19/21 had 41 total staff for 458 residents on the evening shift, required 46 total staff.

   c. 12/19/21 had 25 total staff for 458 residents on the overnight shift, required 33 total staff.

   d. 12/20/21 had 43 CNAs for 458 residents on the day shift, required 58 CNAs.

   e. 12/21/21 had 48 CNAs for 458 residents on the day shift, required 58 CNAs.

   f. 12/22/21 had 43 CNAs for 458 residents on the day shift, required 58 CNAs.

   g. 12/23/21 had 41 CNAs for 463 residents on the day shift, required 58 CNAs.

   h. 12/24/21 had 37 CNAs for 463 residents on the day shift, required 58 CNAs.

   i. 12/24/21 had 39 total staff for 463 residents on the evening shift, required 47 total staff.

   j. 12/24/21 had 27 total staff for 463 residents on the overnight shift, required 34 total staff.

   k. 12/25/21 had 39 CNAs for 462 residents on the day shift, required 58 CNAs.

l. 12/25/21 had 41 total staff for 462 residents on the evening shift, required 47 total staff.

m. 12/25/21 had 25 total staff for 462 residents on the overnight shift, required 33 total staff.

n. 12/26/21 had 23 CNAs for 461 residents on the day shift, required 58 CNAs.

o. 12/26/21 had 38 total staff for 461 residents on the evening shift, required 47 total staff.

p. 12/26/21 had 23 total staff for 461 residents on the overnight shift, required 33 total staff.

q. 12/27/21 had 32 CNAs for 460 residents on the day shift, required 58 CNAs.

r. 12/27/21 had 43 total staff for 460 residents on the evening shift, required 46 total staff.

s. 12/27/21 had 21 total staff for 460 residents on the overnight shift, required 33 total staff.

t. 12/28/21 had 32 CNAs for 460 residents on the day shift, required 58 CNAs.

u. 12/28/21 had 24 total staff for 460 residents on the overnight shift, required 33 total staff.

v. 12/29/21 had 34 CNAs for 458 residents on the day shift, required 58 CNAs.

w. 12/29/21 had 30 total staff for 458 residents on the overnight shift, required 33 total staff.

x. 12/30/21 had 29 CNAs for 457 residents on the day shift, required 58 CNAs.

y. 12/30/21 had 25 total staff on the overnight shift, required 33 total staff.

z. 12/31/21 had 28 CNAs for 455 residents on the day shift, required 57 CNAs.

aa. 12/31/21 had 36 total staff for 455 residents on the evening shift, required 46 total staff.

bb. 12/31/21 had 22 total staff on the overnight shift, required 33 total staff.

cc. 01/01/22 had 31 CNAs for 453 residents on the day shift, required 57 CNAs.

dd. 01/01/22 had 37 total staff for 453 residents on the evening shift, required 46 total staff.

ee. 01/01/22 had 19 total staff for 453 residents on the overnight shift, required 33 total staff.

This letter reflects Federal deficiencies, and a State Licensure report will also be issued. You will receive a complete inspection report detailing all deficiencies.

CORRECTIVE ACTION :

The above-referenced violations pertain to the care of residents and to hazardous and unsafe conditions existing in the Facility. In accordance with N.J.S.A. 26:2H-14 and N.J.A.C. 8:43E-3.8, the Department hereby notifies Woodland that it shall have 72 hours in which to correct the violations. If the violations are not corrected within 72 hours and continue to pose an immediate threat to the health, safety or welfare of the public or the residents of the Facility, then the Department will issue a notice of summary suspension of Woodland's license, which will provide a time period to effect an orderly transfer of residents, and order immediate correction of any violations as a prerequisite to reinstatement of the license.

The Facility shall:

1. Submit an acceptable plan of correction within ten days of receipt of the final statement of deficiencies and comply with the plan of correction;

2. Comply with the Directed Plans of Correction and Curtailment of Admissions, as set forth below;

3. Fully cooperate with the state monitor, as set out below; and,

4. Within 72 hours, correct the violations outlined above pertaining to the care of residents or to the hazardous or unsafe conditions of the physical structure that pose an immediate threat to the health, safety, and welfare of the public or the residents of the facility.

STATE MONITORING:

The Department will select a management consulting firm with expertise in nursing home administration, finance and clinical operations (the "Monitor'). The Monitor shall be engaged at the Department's expense and shall complete the following tasks, at a minimum:

1. Conduct a general assessment of operations, including contracts and leases, and infrastructure of the facility. The assessment does **not** need to include a physical plant/life safety code assessment. The infrastructure assessment will include identifying if the current layout and design of the facility meets the needs of the residents into the future;
2. Report on the delivery of all services, including which services are contracted and the relationship between the contractors and the owners of the facility, inclusive of financial arrangements;
3. Conduct an analysis of the care needs of the residents and write an evaluation of whether these needs can be met by the facility's current operations plan;
4. Develop a closure plan for the facility and develop a plan for safe and effective care of the residents in the event of a change of ownership or in the event the Department summarily suspends or revokes the facility's license based upon the facility's failure to correct the violations (to include discharge planning that complies with State and federal regulatory requirements);
5. Develop an analysis of the root causes of the current situation in the facility and provide a recommendation on what would be the most efficient and effective way to improve this facility so that it can safely care for residents into the future; and,
6. Provide weekly updates to the Department including recommendations made to the facility and the facility's response to the recommendations.

In carrying out these responsibilities, the monitor shall: i) have full access to any and all records and information at Woodland in order to gain an understanding of the prior and current level of care provided, as well as the financial decisions of Woodland, ii) have full access to the senior management team and staff to determine, among other things, how strategic and resident care decisions are made; iii) have full access to brief the facility's owners and senior management as a group or individually, and iv) report to the Commissioner of the Department of Health to facilitate the regulatory relationship.

The appointed monitor shall provide all of its reports, findings, projections, operational and strategic plans to the Commissioner on or before the 90th day from the appointment.

CURTAILMENT OF ADMISSIONS AND DIRECTED PLAN OF CORRECTION:

On January 11, 2022, the Department issued an order curtailing all admissions to the Facility, excluding readmissions. In addition, the Department issued a Directed Plan of Correction requiring the Facility to retain an Administrative Consultant and to submit a plan detailing the steps it would take to meet state staffing requirements. On January 14, 2022, the Department issued an Amended Directed Plan of Corrections requiring the Facility to retain a Registered Nurse Consultant and Certified Infection Control Practitioner Consultant. The Curtailment, Directed Plan of Correction and Amended Directed Plan of Correction shall remain in place until the Facility is otherwise notified in writing by a representative of the Department.

STAFFING:

Staffing at the Facility must meet the needs of the residents in accordance with state law, including N.J.S.A. 30:13-18.

RIGHT TO HEARING:

In the event the Department issues the Facility a summary suspension, the Facility will have a right to a hearing consistent with N.J.S.A. 26:2H-14.

NOTIFICATION:

The facility shall notify residents, family members and guardians by providing them with a copy of this Notice of Violations, Corrective Action and State Monitoring within 72 hours of receipt. The facility shall maintain a record of such notifications which shall be available for inspection by the Department and Monitor.

Department staff will monitor compliance with this notice to determine whether corrective measures are implemented by Woodland. Failure to comply with these and any other applicable requirements, as set forth in pertinent rules and regulations, may result in the imposition of penalties. The Department also reserves the right to pursue all other remedies available by law.

Thank you for your attention to this important matter and for your anticipated cooperation. Should you have any questions concerning this matter, please contact Lisa King, Office of Program Compliance at (609) 376-7751.

Sincerely,

Lisa King, Regulatory Officer

Division of Certificate of Need and Licensing
Office of Program Compliance

LK:GR:JLM:MJ:WCK:jb

DATE: February 10, 2022
FACSIMILE (201) 967-7336
E-MAIL (mspiegel@woodlandbehavioral.com)
REGULAR AND CERTIFIED MAIL
RETURN RECEIPT REQUESTED
Control # 21031

EXHIBIT D

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: QSO-20-39-NH

DATE: **September 17, 2020** ***REVISED 11/12/2021***

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Nursing Home Visitation - COVID-19 *(REVISED)*

Memorandum Summary

- CMS is committed to continuing to take critical steps to ensure America's healthcare facilities are prepared to respond to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- **Visitation Guidance:** CMS is issuing new guidance for visitation in nursing homes during the COVID-19 PHE, including the impact of COVID-19 vaccination.
- ***Visitation is now allowed for all residents at all times.***

Background

Nursing homes have been severely impacted by COVID-19, with outbreaks causing high rates of infection, morbidity, and mortality.[1] The vulnerable nature of the nursing home population combined with the inherent risks of congregate living in a healthcare setting have required aggressive efforts to limit COVID-19 exposure and to prevent the spread of COVID-19 within nursing homes.

In March 2020, CMS issued memorandum QSO-20-14-NH providing guidance to facilities on restricting visitation of all visitors and non-essential healthcare personnel, except for certain compassionate care situations, such as an end-of-life situation. In May 2020, CMS released Nursing Home Reopening Recommendations, which provided additional guidance on visitation for nursing homes as their states and local communities progress through the phases of reopening.

While CMS guidance has focused on protecting nursing home residents from COVID-19, we recognize that physical separation from family and other loved ones has taken a physical and emotional toll on residents and their loved ones. Residents may feel socially isolated, leading to increased risk for depression, anxiety, and expressions of distress. Residents living with cognitive impairment or other disabilities may find visitor restrictions and other ongoing changes related to

[1] Information on outbreaks and deaths in nursing homes may be found at https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg.

COVID-19 confusing or upsetting. CMS understands that nursing home residents derive value from the physical, emotional, and spiritual support they receive through visitation from family and friends. In light of this, CMS is revising the guidance regarding visitation in nursing homes during the COVID-19 PHE. The information contained in this memorandum supersedes and replaces previously issued guidance and recommendations regarding visitation.

Since the release of QSO memorandum 20-39-NH on September 17, 2020, COVID-19 vaccines have received *full approval and* Emergency Use Authorization from the Food and Drug Administration. Millions of vaccinations have since been administered to nursing home residents and staff, and these vaccines have been shown to help prevent symptomatic SARS-CoV-2 infection (i.e., COVID-19). *In addition, CMS requires nursing homes to educate residents and staff on the risks and benefits of the vaccines, offer to administer the vaccine, and report resident and staff vaccination data to CDC's National Healthcare Safety Network. CMS now posts this information on the CMS COVID-19 Nursing Home Data website along with other COVID-19 data, such as the weekly number of COVID-19 cases and deaths.* **Therefore, CMS, in conjunction with the Centers for Disease Control and Prevention (CDC), is updating its visitation guidance accordingly, but emphasizing the importance of maintaining infection prevention practices.**

We note that the reason for visitation restrictions during the COVID-19 PHE were to mitigate the opportunity for visitors to introduce COVID-19 into the nursing home. Per 42 CFR § 483.10(f)(4), a resident has the right to receive visitors of his or her choosing at the time of his or her choosing, and in a manner that does not impose on the rights of another resident, such as a clinical or safety restriction (see 42 CFR § 483.10(f)(4)(v)). In other words, while all residents have a right to visitation, fully open and unrestricted visitation posed a clinical health and safety risk to other residents during this PHE, and therefore, it was reasonable to place limits on visitation. However, current nursing home COVID-19 data shows approximately 86% of residents and 74% of staff are fully vaccinated, and the number of new COVID-19 cases each week has been dramatically reduced. For example, the average number of national resident COVID-19 weekly cases in January 2021 was approximately 20,000 per week, whereas the average number in September 2021 was approximately 5100 per week (approximately an 80% reduction), demonstrating the effectiveness of the vaccines.

We note that staff vaccination rates remain significantly lower than resident vaccination rates. Therefore, we remain concerned about the transmission of the virus from unvaccinated staff to residents and are taking additional measures, such as establishing a staff vaccination requirement, to mitigate the spread of COVID-19 and protect residents. On November 4, 2021, CMS issued a regulation *requiring that all nursing home staff be vaccinated against COVID-19 as a requirement for participating in the Medicare and Medicaid programs. This requirement also applies to nearly all Medicare and Medicaid-certified providers and suppliers. CMS will continue to monitor vaccination and infection rates, including the effects of COVID-19 variants on nursing home residents, which have recently caused the number of cases to slightly increase. However, at this time, continued restrictions on this vital resident's right are no longer necessary.*

We acknowledge that there are still concerns associated with visitation, such as visitation with an unvaccinated resident while the nursing home's county COVID-19 level of community transmission[2]

[2] *Level of Community Transmission: This metric ** uses two indicators for categorization (1. Total number of new cases per 100,000 persons within the last 7 days and 2. Percentage of positive diagnostic and screening nucleic acid*

is substantial or high. However, adherence to the core principles of COVID-19 infection prevention mitigates these concerns. Furthermore, we remind stakeholders that, per 42 CFR § 483.10(f)(2), the resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. We further note that residents may deny or withdraw consent for a visit at any time, per 42 CFR § 483.10(f)(4)(ii) and (iii). Therefore, if a visitor, resident, or their representative is aware of the risks associated with visitation, and the visit occurs in a manner that does not place other residents at risk (e.g., in the resident's room), the resident must be allowed to receive visitors as he/she chooses.

Guidance

Visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, *and* outdoors. Regardless of how visits are conducted, certain core principles and best practices reduce the risk of COVID-19 transmission:

Core Principles of COVID-19 Infection Prevention

- *Visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or currently meet the criteria for quarantine, should not enter the facility. Facilities should screen all who enter for these visitation exclusions.*
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose) and *physical* distancing at least six feet between people, in accordance with CDC guidance
- Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting high-frequency touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care)
- Resident and staff testing conducted as required at 42 CFR § 483.80(h) (see QSO-20- 38-NH)

These core principles are consistent with the Centers for Disease Control and Prevention (CDC) guidance for nursing homes, and should be **adhered to at all times**. Additionally, visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. The risk of transmission can be further reduced through the use of physical barriers (e.g., clear Plexiglass dividers, curtains). Also, nursing homes should enable visits to be conducted with an adequate degree of privacy. Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the below guidance.

Outdoor Visitation

amplification tests (NAAT) during the last 7 days), which can be found on the CDC COVID-19 Integrated County View site at https://covid.cdc.gov/covid-data-tracker/#county-view.

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred when the resident and*/or* visitor are *not* fully vaccinated[3] against COVID-19. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. However, weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) or an individual resident's health status (e.g., medical condition(s), COVID-19 status, quarantine status) may hinder outdoor visits. When conducting outdoor visitation, all appropriate infection control and prevention practices should be followed.

Indoor Visitation

Facilities must allow indoor visitation at all times and for all residents as permitted under the regulations. While previously acceptable during the PHE, facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits.

Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents. Facilities should ensure that physical distancing can still be maintained during peak times of visitation (e.g., lunch time, after business hours, etc.). Also, facilities should avoid large gatherings (e.g., parties, events) where large numbers of visitors are in the same space at the same time and physical distancing cannot be maintained. During indoor visitation, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. *Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission.*

If a resident's roommate is unvaccinated or immunocompromised (regardless of vaccination status), visits should not be conducted in the resident's room, if possible. For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of infection prevention.

If the nursing home's county COVID-19 community level of transmission is substantial to high, all residents and visitors, regardless of vaccination status, should wear face coverings or masks and physically distance, at all times. In areas of low to moderate transmission, the safest practice is for residents and visitors to wear face coverings or masks and physically distance, particularly if either of them is at increased risk for severe disease or are unvaccinated. If the resident and all their visitor(s) are fully vaccinated and the resident is not moderately or severely immunocompromised, they may choose not to wear face coverings or masks and to have physical contact. Visitors should wear face coverings or masks when around other residents or healthcare personnel, regardless of vaccination status. Additional information on levels of community transmission is available on the CDC's COVID-19 Integrated County View webpage.

While not recommended, residents who are on transmission-based precautions (TBP) or quarantine can still receive visitors. In these cases, visits should occur in the resident's room and the resident

[3] Fully vaccinated *refers to the CDC definition. The current definition can be found on CDC's website: "Interim Public Health Recommendations for Fully Vaccinated People."*

should wear a well-fitting facemask (if tolerated). Before visiting residents, who are on TBP or quarantine, visitors should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors should adhere to the core principles of infection prevention. Facilities may offer well-fitting facemasks or other appropriate PPE, if available; however, facilities are not required to provide PPE for visitors.

NOTE: CMS and CDC continue to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection. This continues to be the safest way to prevent the spread of COVID-19, particularly if either party has not been fully vaccinated. However, we acknowledge the toll that separation and isolation has taken. We also acknowledge that there is no substitute for physical contact, such as the warm embrace between a resident and their loved one. Therefore, if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor in accordance with the CDC's *"Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic." Unvaccinated residents may also choose to have physical touch based on their preferences and needs, such as with support persons for individuals with disabilities and visitors participating in certain religious practices, including in end-of-life situations. In these situations, unvaccinated residents (or their representative) and their visitors should be advised of the risks of physical contact prior to the visit.* Visitors should *also* physically distance from other residents and staff in the facility.

Indoor Visitation during an Outbreak *Investigation*

An outbreak *investigation is initiated* when a new nursing home onset of COVID-19 occurs (i.e., a new COVID-19 case among residents or staff). To swiftly detect cases, we remind facilities to adhere to CMS regulations and guidance for COVID-19 testing, including routine *unvaccinated* staff testing, testing of individuals with symptoms, and outbreak testing.

When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing *in accordance with CMS QSO 20-38-NH REVISED and CDC guidelines.*

While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility. Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If residents or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits, regardless of vaccination status, and visits should ideally occur in the resident's room. Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation.

Visitor Testing and Vaccination

While not required, we encourage facilities in *counties with substantial* or high *levels of community transmission* to offer testing to visitors, if feasible. *If facilities do not offer testing, they should* encourage visitors to be tested on their own *before* coming to the facility (e.g., within 2–3 days).

CMS strongly encourages all visitors to become vaccinated and facilities should educate and also encourage visitors to become vaccinated. Visitor testing and vaccination can help prevent the spread of COVID-19 and facilities *may ask about a visitors' vaccination status, however,* ***visitors***

are **not required to be tested or vaccinated** (or show proof of such) as a condition of visitation. *If the visitor declines to disclose their vaccination status, the visitor should wear a face covering or mask at all times.* This also applies to representatives of the Office of the State Long-Term Care Ombudsman and protection and advocacy systems, as described below.

Compassionate Care Visits

Compassionate care visits are allowed at all times. Previously during the PHE, there were some scenarios where residents should only have compassionate care visits. However, visitation is now allowed at all times for all residents, in accordance with CMS regulations. Therefore, we believe there are few scenarios when visitation should be limited only to compassionate care visits. In the event a scenario arises that would limit visitation for a resident (e.g., a resident is severely immunocompromised and the number of visitors the resident is exposed to needs to be kept to a minimum), compassionate care visits would still be allowed at all times. CMS expects these scenarios to be rare events.

Required Visitation

Facilities shall not restrict visitation without a reasonable clinical or safety cause, consistent with 42 CFR § 483.10(f)(4)(v). *In previous nursing home visitation guidance during the PHE, CMS outlined some scenarios related to COVID-19 that would constitute a clinical or safety reason for limited visitation. However, there are no longer scenarios related to COVID-19 where visitation should be limited, except for certain situations when the visit is limited to being conducted in the resident's room or the rare event that visitation is limited to compassionate care. Therefore, a* nursing home **must** facilitate in-person visitation consistent with the applicable CMS regulations, which can be done by applying the guidance stated above. Failure to facilitate visitation, per 42 CFR § 483.10(f)(4), *which states "The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident," would constitute a potential violation* and the facility would be subject to citation and enforcement actions.

As stated above, we acknowledge that there are still risks associated with visitation and COVID-19. However, the risks are reduced by adhering to the core principles of COVID-19 infection prevention. Furthermore, we remind facilities and all stakeholders that, per 42 CFR §483.10(f)(2), residents have the right to make choices about aspects of his or her life in the facility that are significant to the resident. Visitors, residents, or their representative should be made aware of the potential risk of visiting and necessary precautions related to COVID-19 in order to visit the resident. However, if a visitor, resident, or their representative is aware of the risks associated with visitation, and the visit occurs in a manner that does not place other residents at risk (e.g., in the resident's room), the resident must be allowed to receive visitors as he/she chooses.

Access to the Long-Term Care Ombudsman

As stated in previous CMS guidance QSO-20-28-NH (revised), regulations at 42 CFR § 483.10(f)(4)(i)(C) require that a Medicare and Medicaid-certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident. *If an ombudsman is planning to visit a resident who is in TBP or quarantine, or an unvaccinated resident in a nursing home in a county where the level of community transmission is*

substantial or high in the past 7 days, the resident and ombudsman should be made aware of the potential risk of visiting, and the visit should take place in the resident's room. We note that representatives of the Office of the Ombudsman should adhere to the core principles of COVID-19 infection prevention as described above. *If the resident or the Ombudsman program requests alternative communication in lieu of an in-person visit,* facilities must, at a minimum, facilitate alternative resident communication with the Ombudsman *program*, such as by phone or through use of other technology. Nursing homes are also required under 42 CFR § 483.10(h)(3)(ii) to allow the Ombudsman to examine the resident's medical, social, and administrative records as otherwise authorized by State law.

Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs

42 CFR § 483.10(f)(4)(i)(E) and (F) requires the facility to allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000). P&A programs authorized under the DD Act protect the rights of individuals with developmental and other disabilities and are authorized to "investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported to the system or if there is probable cause to believe the incidents occurred." 42 U.S.C. § 15043(a)(2)(B). Under its federal authorities, representatives of P&A programs are permitted access to all facility residents, which includes "the opportunity to meet and communicate privately with such individuals regularly, both formally and informally, by telephone, mail and in person." 42 CFR § 51.42(c); 45 CFR § 1326.27.

If the P&A is planning to visit a resident who is in TBP or quarantine, or an unvaccinated resident in a county where the level of community transmission is substantial or high in the past 7 days, the resident and P&A representative should be made aware of the potential risk of visiting and the visit should take place in the resident's room.

Additionally, each facility must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act *of 1973, 29 U.S.C. § 794 (Section 504)* and the Americans with Disabilities Act *of 1990, 42 U.S.C. §§ 12101 et seq.* (ADA).

For example, *if communicating with individuals who are deaf or hard of hearing, it is recommended to use a clear mask or mask with a clear panel. Face coverings should not be placed on anyone who has trouble breathing or is unable to wear a mask due to a disability, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.*

In addition, if a resident requires assistance to ensure effective communication (e.g., a qualified interpreter or someone to facilitate communication) and the assistance is not available by onsite staff or effective communication cannot be provided without such entry (e.g., video remote interpreting), the facility must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions. This would not preclude nursing homes from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the core principles of COVID-19 infection prevention. Any questions about or issues related to enforcement or oversight of the non-CMS requirements and citations referenced above under this section subject heading should be referred to the HHS Office for Civil Rights *(Toll-free: 800-368-*

1019) (TDD toll-free: 800-537-7697), the Administration for Community Living *(202-401-4634)*, or other appropriate oversight agency.

Entry of Healthcare Workers and Other Providers of Services

All healthcare workers must be permitted to come into the facility as long as they are not subject to a *work exclusion* or showing signs or symptoms of COVID-19. *In addition to health care workers, personnel educating and assisting in resident transitions to the community should be permitted entry consistent with this guidance.* We note that EMS personnel do not need to be screened, so they can attend to an emergency without delay. We remind facilities that all staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements.

Communal Activities, Dining *and Resident Outings*

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission. *The safest approach is for everyone, regardless of vaccination status, to wear a face covering or mask while in communal areas of the facility. For more information, see the Implement Source Control section of the CDC guidance "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic."*

Facilities must permit residents to leave the facility as they choose. Should a resident choose to leave, the facility should remind the resident and any individual accompanying the resident to follow all recommended infection prevention practices including wearing a face covering or mask, physical distancing, and hand hygiene and to encourage those around them to do the same.

Upon the resident's return, nursing homes should take the following actions:

- *Screen residents upon return for signs or symptoms of COVID-19.*
    - *If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, test the resident for COVID-19, regardless of vaccination status. Place the resident on quarantine if the resident has not been fully vaccinated.*
    - *If the resident develops signs or symptoms of COVID-19 after the outing, test the resident for COVID-19 and place the resident on Transmission-Based Precautions, regardless of vaccination status.*
- *A nursing home may also opt to test unvaccinated residents without signs or symptoms if they leave the nursing home frequently or for a prolonged length of time, such as over 24 hours.*
- *Facilities might consider quarantining unvaccinated residents who leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended infection prevention measures.*
- *Monitor residents for signs and symptoms of COVID-19 daily.*

Residents who leave the facility for 24 hours or longer should generally be managed as a new admission or readmission, as recommended by the CDC's "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes." Please note that there are exceptions to quarantine, including for fully vaccinated residents.

Survey Considerations

State survey agencies and CMS are ultimately responsible for ensuring surveyors are compliant with the applicable expectations. Therefore, LTC facilities are not permitted to restrict access to surveyors based on vaccination status, nor ask a surveyor for proof of his or her vaccination status as a condition of entry. If facilities have questions about the process a state is using to ensure surveyors can enter a facility safely, those questions should be addressed to the State Survey Agency. Surveyors should not enter a facility if they *have a positive viral test for COVID-19,* signs or symptoms of COVID-19, *or currently meet the criteria for quarantine*. Surveyors should also adhere to the core principles of COVID-19 infection prevention and adhere to any COVID-19 infection prevention requirements set by *federal and* state *agencies (including Executive Orders).*

- For concerns related to resident communication with and access to persons and services inside and outside the facility, surveyors should investigate for non-compliance at 42 CFR § 483.10(b), F550.
- For concerns related to a facility limiting visitors, surveyors should investigate for non-compliance at 42 CFR § 483.10(f)(4), F563.
- For concerns related to ombudsman access to the resident and the resident's medical record, surveyors should investigate for non-compliance at 42 CFR §§ 483.10(f)(4)(i)(C), F562 and 483.10(h)(3)(ii), F583.
- For concerns related to lack of adherence to infection control practices, including practices for residents and staff based on COVID-19 vaccination status, surveyors should investigate for non-compliance at 42 CFR § 483.80(a), F880.

Contact: Questions related to this memorandum may be submitted to: DNH_TriageTeam@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers, and the State/CMS Locations within 30 days of this memorandum.

/s/
David R. Wright

cc: Survey Operations Group

February 02, 2022

Nursing Home Visitation
Frequently Asked Questions (FAQs)

CMS is providing clarification to recent guidance for visitation (see CMS memorandum QSO-20-39- NH REVISED 11/12/2021). While CMS cannot address every aspect of visitation that may occur, we provide additional details about certain scenarios below. However, the bottom line is visitation must be permitted at all times with very limited and rare exceptions, in accordance with residents' rights. In short, nursing homes should enable visitation following these three key points:

- Adhere to the core principles of infection prevention, especially wearing a mask, performing hand hygiene, and practicing physical distancing;
- Don't have large gatherings where physical distancing cannot be maintained; and
- Work with your state or local health department when an outbreak occurs.

States may instruct nursing homes to take additional measures to make visitation safer, while ensuring visitation can still occur. This includes requiring that, during visits, residents and visitors wear masks that are well-fitting, and preferably those with better protection, such as surgical masksor KN95. States should work with CMS on specific actions related to additional measures they are considering.

1. What is the best way for residents, visitors, and staff to protect themselves from the Omicron variant?

A: The most effective tool to protect anyone from the COVID-19 Omicron variant (or any version of COVID-19) is to become fully vaccinated AND receive booster shots per CDC recommendations.Also, we urge all residents, staff, and visitors to follow the guidelines for preventing COVID-19 from spreading, including wearing a well-fitting mask (preferably those with better protection, such as surgical masks or KN95) at all times while in a nursing home, practicing physical distancing, and performing hand hygiene by using an alcohol-based hand rub or soap and water. Residents do not have to wear a mask while eating or drinking, or in their rooms alone or with their roommate.

2. How should nursing homes address visitation when they expect a high volume of visitors, such as over the holidays?

A: In general, visitation should be allowed for all residents at all times. However, as stated in CMS memorandum QSO-20-39-NH REVISED 11/12/2021, "facilities should ensure that physical distancing can still be maintained during peak times of visitation," and "facilities should avoid large gatherings (e.g., parties, events)." This means that facilities, residents, and visitors should refrain from having large gatherings where physical distancing cannot be maintained in the facility. In other words, if physical distancing between other residents cannot be maintained, the facility may restructure the visitation policy, such as asking visitors to schedule their visit at staggered time-slots throughout the day, and/or limiting the number of visitors in the facility or aresident's room at any time. Note: While these may be strategies used during the holidays or

when a high volume of visitors is expected (especially in light of the uncertain impact of the Omicron variant in facilities), we expect these strategies to only be used when physical distancing cannot be maintained. Also, there is no limit on length of visits, in general, as long as physical distancing can be maintained and the visit poses no risk to or infringes upon other residents' rights. If physical distancing cannot be maintained or infringes on the rights and safety of others, the facility must demonstrate that good faith efforts were made to facilitate visitation.

3. Can residents have close contact with their visitor(s) during a visit and visit without a mask?

A: Visitors, regardless of vaccination status, must wear masks and physically distance themselves from other residents and staff when in a communal area in the facility. Separately, while we strongly recommend that visitors wear masks when visiting residents in a private setting, such as a resident's room when the roommate isn't present, they may choose not to. Also, while not recommended, if a resident (or responsible party) is aware of the risks of close contact and/or not wearing a mask during a visit, and they choose to not wear a mask and choose to engage in close contact, the facility cannot deny the resident their right to choose, as long as the residents' choice does not put other residents at risk. This would occur only while not in a communal area. Prior to visiting, visitors should also be made aware of the risks of engaging in close contact with the resident and not wearing a mask during their visit. For additional information see the CDC website Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes.

4. Can visits occur in a resident's room if they have a roommate?

A: Yes. Ideally an in-room visit would be conducted when the roommate is not present, howeverif that is not an option and as long as physical distancing can be maintained, then a visit may be conducted in the resident's room with their roommate present. If physical distancing cannot be maintained, the visit should occur in a different area of the facility, or the visit should occur at a time when the roommate is not in the room, or the visitors should be asked to limit the number of visitors that are in the room at one time. Also, visitors and residents should adhere to the principles of infection control, including wearing a mask and performing frequent hand hygiene.

5. Can a visitor share a meal with or feed the resident they are visiting?

A: Visitors may eat with a resident if the resident (or representative) and the visitor are aware of the risks and adhere to the core principles of infection prevention. Eating in a separate area is preferred, however if that is not possible, then the meal could occur in a common area as long as the visitor, regardless of their vaccination status, is physically distanced from other residents and wears a mask, except while eating or drinking. If the visitor is unable to physically distance from other residents, they should not share a meal with the resident in a common area. Visitors, regardless of vaccination status, must wear masks and physically distance from other residents and staff when in a communal area in the facility.

6. How should nursing homes work with their state or local health department when there is a COVID-19 outbreak?

A: Prior to the COVID-19 Public Health Emergency (PHE), there were occasions when a local or state health department advised a nursing home to pause visitation and new admissions due to a large outbreak of an infectious disease. Consultation with state health departments on how to address outbreaks should still occur. In fact, we remind nursing homes that they are still expected to contact their health department when any of the following occur, per CDC guidelines:

- ≥ 1 residents or staff with suspected or confirmed SARS-CoV-2 infection
- Resident with severe respiratory infection resulting in hospitalization or death, or
- ≥ 3 residents or staff with acute illness compatible with COVID-19 with onset within a 72-hour period.

While residents have the right to receive visitors at all times and make choices about aspects of their life in the facility that are significant to them, there may be times when the scope and severity of an outbreak warrants the health department to intervene with the facility's operations. We expect these situations to be extremely rare and only occur after the facility has been working with the health department to manage and prevent escalation of the outbreak. Wealso expect that if the outbreak is severe enough to warrant pausing visitation, it would also warrant a pause on accepting new admissions (as long as there is adequate alternative access to care for hospital discharges). For example, in a nursing homes where, despite collaborating with the health department over several days, there continues to be uncontrolled transmission impacting a large number of residents (e.g., more than 30% of residents became infected*), and the health department advised the facility to pause visitation and new admissions temporarily. Inthis situation, the nursing home would not be out of compliance with CMS' requirements.

* CMS does not define a specific threshold for what constitutes a large outbreak and this could vary basedon facility size or structure. However, we emphasize that any visitation limits should be rare and applied when there are many cases in multiple areas of the facility.

Nursing facilities should continue to consult with state and local health departments when outbreaks occur to determine when modifications to visitation policy would be appropriate. Facilities should document their discussions with the health department, and the actions they took to attempt to control the transmission of COVID-19.

7. Should the facility pause communal activities and dining during an outbreak investigation?

A: If the facility is using a contact tracing approach for an outbreak investigation, those residents who are identified as potentially being a close contact of the individual who tested positive for COVID-19, are considered to have had close contact and should not participate in communal dining or activities. Residents who have not received a COVID-19 vaccine and have had close contact with someone with COVID-19 infection should be placed in quarantine for 14 days after the close contact, even if viral testing is negative. In general, fully vaccinated residents and residents who had COVID-19 in the last 90 days do not need to be quarantined or restricted to their room and should wear masks when leaving their room.

When using a broad-based approach for an outbreak investigation, residents who have not received a COVID-19 vaccine should generally be restricted to their rooms, even if testing is negative, and should not participate in communal dining or group activities for 14 days. In general, fully vaccinated residents and residents who had COVID-19 in the last 90 days do not need to be restricted to their rooms unless they develop symptoms of COVID-19, are diagnosedwith COVID-19 infection, or the facility is directed to do so by the jurisdiction's public health authority.

8. Is a resident (not on transmission-based precautions or quarantine) who is unable or unwilling to wear a mask allowed to attend communal dining and activities?

A: A resident who is unable to wear a mask due to a disability or medical condition may attend communal activities, however they should physically distance from others. If possible, facilities should educate the resident on the core principles of infection prevention, such as hand hygiene, physical distancing, cough etiquette, etc. and staff should provide frequent reminders to adhere to infection prevention principles.

A resident who is unable to wear a mask and whom staff cannot prevent having close contactwith others should not attend communal activities. To help residents prevent having close contact, such as in the case of a memory care unit, the staff should limit the size of group activities. They should also encourage frequent hand hygiene, assist with maintaining physicaldistancing as much as possible, and frequently cleaning high-touch surfaces.
If a resident refuses to wear a mask and physically distance from others, the facility should educate the resident on the importance of masking and physical distancing, document the education in the resident's medical record, and the resident should not participate in communal activities.

9. How can a long-term care provider coordinate an onsite clinic to provide COVID-19 vaccine and boosters for staff and residents?

A: Many LTC providers have already identified strategies and partnerships to obtain and administer COVID-19 vaccines for residents and staff, including: working with established LTC partners and retail pharmacy partners or coordinating with state and local health departments. You may request vaccination support from a pharmacy partner enrolled in the Federal Retail Pharmacy Program. See Connecting Long-Term Care Settings with Federal Pharmacy Partners forlinks and contact information. If you are having difficulties arranging COVID-19 vaccination for your residents and staff, contact your state or local health department's immunization program for assistance. If the state or jurisdictional immunization program is unable to connect your LTC setting with a vaccine provider, CDC is available as a safety net support (Contact CDC INFO at 800-232-4636 for additional support).

10. With COVID-19 cases spiking due to the Omicron variant, should facilities continue to permit visitation?

A: Yes. While CMS is concerned about the rise of COVID-19 cases due to the Omicron variant, we're also concerned about the effects of isolation and separation of residents from their loved ones. Earlier in the pandemic we issued guidance for certain limits to visitation, but we've learned a few key things since then. Isolation and limited visitation can be traumatic for residents, resulting in physical and psychosocial decline. So, we know it can lead to worse outcomes for people in nursing homes. Furthermore, we know visitation can occur in a manner that doesn't place other residents at increased risk for COVID-19 by adhering to the practices for infection prevention, such as physical distancing, masking, and frequent hand hygiene. There are also a variety of ways that visitation can be structured to reduce the risk of COVID-19 spreading. So, CMS believes it is critical for residents to receive visits from their friends, family, and loved ones ina manner that does not impose on the rights of another resident. Lastly, as indicated above, facilities should consult with their state or local public health officials, and questions about visitation should be addressed on a case by case basis.

11. Why can a resident choose to have a visit even when COVID-19 cases are increasing?

A: It is important to note that federal regulations explicitly state that residents have the right to make choices about significant aspects of their life in the facility and the right to receive visitors, as long as it doesn't infringe on the rights of other residents (42 CFR 483.10(f)(2) and (4), respectively). In this case, as long as a visit doesn't increase the risk of COVID-19 for other residents (i.e., by using the guidance for conducting safe visits), the resident still has the right to choose to have a visitor. Therefore, if the resident is aware of the risks of the visit, and the visit is conducted in a manner that doesn't increase the risk of COVID-19 transmission for other residents,the visit must still be permitted in accordance with the requirements.

12. Are there any suggestions for how to conduct visits that reduce the risk of COVID-19 transmission? For example, should facilities have different policies for vaccinated and unvaccinated visitors?

A: While we strongly encourage everyone to get vaccinated, *the facility must permit visitation* regardless of the visitor's vaccination status (*if the visitor(s) does not report COVID-19 symptoms or meet the criteria for quarantine)*. There are ways facilities can and should take extra precautions, such as hosting the visit outdoors, if possible; creating dedicated visitation space indoors; permitting in-room visits when the resident's roommate is not present; and the resident and visitor should wear a well-fitting mask (preferably those with better protection, such as surgical masks or KN95), perform frequent hand-hygiene, and practice physical distancing. Some other recommendations include:

- Offering visitors surgical masks or KN95 masks.
- Restricting the visitor's movement in the facility to only the location of the visit.
- Not conducting visits in common areas (except those areas dedicated for visitation).
- Increasing air-flow and *improving ventilation and air quality*.

- Cleaning and sanitizing the visitation area after each visit.
- Providing reminders in common areas (e.g., signage) to maintain physical distancing, perform hand-hygiene, and wear well-fitting masks.

13. Are there best practices for improving air quality to reduce risks during visitation?

A: *Yes, a facility may consider a number of options related to air quality such as:*

- *Adding ultraviolet germicidal irradiation (UVGI) to the heating ventilation and air conditioning system (HVAC).*
- *To avoid having multiple groups of people or multiple visitors for a resident within small rooms or spaces, designate special visitation areas that are outdoors when practical or in designated large-volume spaces with open windows and/or enhanced ventilation.*
- *Adding portable room air cleaners with high-efficiency particulate air (HEPA, H-13 or -14) filters to communal areas.*
- *Ensure proper maintenance of HVAC system to ensure maximum outdoor air intake.*

For additional information on air cleaning, disinfecting, and UVGI, see CDC's Ventilation FAQs or the American Society of Heating, Refrigerating and Air-Conditioning Engineers site on Filtration and Disinfection.

14. What are ways a facility can improve and or manage air flow during visitation?

A: *A facility may consider implementing the following:*

- *The use of a portable fan placed close to an open window could enable ventilation. A portable fan facing towards the window (i.e. facing outside) serves to pull the room and exhaust air to the outside; a fan facing towards the interior of the room (i.e. facing inside) serves to pull in the outdoor air and push it inside the room. Direct the fan discharge towards an unoccupied corner and wall spaces or up above the occupied zone.*
- *Activate resident restroom exhaust fans whenever visitors are present.*
- *Consider opening windows, even slightly, if practical and will not introduce other hazards.*
- *The use of ceiling fans at low velocity and potentially in the reverse-flow direction (so that air is pulled up toward the ceiling), especially when windows are closed.*
- *Avoid the use of the high-speed settings for any fan.*

For additional information on improving air quality, optimizing air flow and use of barriers, see the Centers for Disease Control and Prevention (CDC) site on Ventilation in Buildings.

15. *Is there funding available for environmental changes which reduce transmission of COVID-19?*

A: *Yes, a facility may request the use of Civil Money Penalty (CMP) Reinvestment funds to purchase portable fans and portable room air cleaners with HEPA filters to increase or improve air quality. A maximum use of $3,000 per facility including shipping costs may be requested.*

16. *Can a state require facilities to test visitors as a condition of entering the facility?*

A: *States can require visitors to be tested prior to entry if the facility is able to provide a rapid antigen test (i.e., the visitor is not responsible for obtaining a test). If the facility cannot provide the rapid antigen test, then the visit must occur without a test being performed if the visitor(s) does not report COVID-19 symptoms or meet the criteria for quarantine.*

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

DISABILITY RIGHTS NEW JERSEY	:	
	:	**Case No.** 2:22-cv-01240
Plaintiff,	:	**Judge:** Brian R. Martinotti
v.	:	**Magistrate Judge:** James B. Clark
ALLIANCE HC 11 LLC d/b/a WOODLAND BEHAVIORAL AND NURSING CENTER	:	**Declaration of Michael R. Brower in Support of Motion for Preliminary Injunction**
Defendant.	:	

I, Michael R. Brower, of full age, in lieu of Affidavit, hereby state and declare as follows:

1. I am the Legal Director of Disability Rights New Jersey.

2. I make this Declaration in further support of the motion for preliminary injunction.

3. Disability Rights New Jersey is the state-designated Protection and Advocacy system for the State of New Jersey.

4. As Legal Director of Disability Rights New Jersey, my job duties include providing legal advice and support, including to the team responsible for monitoring facilities and places serving people with disabilities, and also investigating reports of abuse and neglect involving people with disabilities.

5. Disability Rights New Jersey temporarily suspended its in-person monitoring activities in March 2020 because of the COVID-19 pandemic and the risk that monitoring would transmit the virus to vulnerable persons with disabilities.

6. In April 2020, The New York Times ran a story indicating that a high percentage of residents at Woodland, then known as Andover II, had died from COVID-19 and bodies were being stored on site.[1]

7. Disability Rights New Jersey requested information from the Department of Health over the course of 2020 and learned that Woodland housed a disproportionately high number of residents with serious mental illness and traumatic brain injury.

8. In May 2021, based on availability of the COVID-19 vaccine, Disability Rights NJ resumed in-person monitoring in a limited capacity.

9. Disability Rights New Jersey prioritized monitoring long term care facilities that purported to serve residents with mental health needs, behavioral needs, and other facilities that had received notoriety during the pandemic when in-person monitoring was suspended.

10. Because of ongoing COVID-19 precautions, Disability Rights New Jersey provided courtesy notice to all facilities chosen for monitoring, though our access authority does not require any notice.

11. Disability Rights New Jersey selected Woodland for monitoring based on the data we had gathered indicating that Woodland housed a disproportionately high number of residents with serious mental illness and traumatic brain injury.

12. On July 12, 2021, Disability Rights New Jersey wrote to Woodland notifying the administrator of its intent to monitor and provided an explanation and references for our legal authority to do so. *See* Declaration of Gwen Orlowski ("Orlowski Decl."), Exhibit A

13. On July 26 and August 17, 2021, Disability Rights New Jersey staff conducted initial monitoring visits at Woodland. This monitoring activity raised concerns that residents that needed

[1] See https://www.nytimes.com/2020/04/15/nyregion/coronavirus-nj-andover-nursing-home-deaths.html

specialized services for serious mental illness and developmental disability were inappropriately placed at the facility. We began collecting Preadmission Screening and Resident Review (PASRR) information from the state suspecting there was an issue with the unnecessary placement of disabled residents in long term care facilities.

14. As monitoring activities continued, Disability Rights New Jersey became aware of additional reports of serious and acute health and safety violations. These are contained in a New Jersey Department of Health issued "Notice of Violations, Corrective Action, and State Monitoring" dated February 10, 2022. *See* Orlowski Decl., Exhibit C.

15. Based on the detailed instances of abuse and neglect reported in the New Jersey Department of Health notice, Disability Rights New Jersey determined there is probable cause to suspect that all residents at Woodland have been subject to ongoing abuse, neglect, and rights violations.

16. Specifically, the February 10, 2022 Notice indicates that residents are subject to widespread neglect, and that the facility is severely understaffed compared to licensure requirements. The Department of Health surveyors also reported observing specific incidents of abuse by staff against residents. *See* Orlowski Decl., Exhibit C.

17. The Department of Health notice documented numerous instances of verbal abuse of patients by staff. The report also documented numerous serious instances of neglect, including an instance where a patient was left soiled in feces for more than ten hours and another instance where staff failed to assist a resident who called for help due to a stuck catheter. The report also identified numerous instances in which staff failed to provide any life saving emergency response, including an instance where staff failed to initiate CPR, call 911, or utilize a defibrillator after finding a 55 year old resident unresponsive. The report also identified serious deficiencies in COVID prevention and treatment protocols, unsecured storage of dangerous medications, and found that the facility failed to maintain sufficient levels of properly trained and qualified staff.

18. Disability Rights NJ has been investigating the situation at Woodland since February 14, 2020, including conducting site visits to monitor conditions and interview residents to understand concerns that need to be addressed.

19. On Sunday, February 20, 2022, at 10:30 a.m. I received text messages and phone calls from a team of Disability Rights New Jersey staff conducting an investigation at Woodland.)

20. That team consisted of Executive Director Gwen Orlowski, Esq., Senior Staff Advocate Elena Kravitz, and Staff Attorney Cory Bernstein, Esq.

21. Gwen Orlowski told me that Woodland administrators had challenged Disability Rights New Jersey's access authority, confined the team to an administrative office, and threatened to call the police if they left the office to continue their investigation.

22. At approximately 11:14 a.m., I participated in a conference call with Gwen Orlowski and Peter Slocum, Esq. of the law firm Lowenstein Sandler, LLP, who stated he was Woodland's attorney.

23. During our conference call, Gwen Orlowski explained our statutory and regulatory right to unaccompanied access to Woodland facilities and residents.

24. Mr. Slocum expressed understanding of our right to access the facility without accompaniment, expressed his belief that there had been a misunderstanding, and informed Gwen Orlowski and I that he would instruct his client, Woodland, not to interfere with our investigation.

25. The team was allowed to resume its investigation activity after nearly two hours of interruption by Woodland administrators.

26. At approximately 10:20 a.m. on Wednesday February 23, 2022, I arrived at Woodland to continue the ongoing Disability Rights New Jersey investigation into alleged abuse, neglect, and rights violations at Woodland.

27. I accompanied Disability Rights New Jersey's Director of Investigations and Monitoring, Jill Hoegel and Senior Staff Advocate Elena Kravitz.

28. From approximately 10:20 a.m. to 12:30 p.m., I observed conditions in the facility and interviewed residents as part of the investigation.

29. At approximately 12:30 p.m., I was interviewing a resident on the second floor.

30. Two men named Joey and Michael, who identified themselves as part of the ownership and administration of Woodland, approached me during that interview requesting my attention.

31. They stated that Disability Rights New Jersey was giving Woodland residents advice about their rights, causing them to become agitated and to try to leave the facility.

32. Joey and Michael asked me to accompany them to the third floor to intervene in an ongoing behavioral crisis and to explain to residents that they could not leave the facility.

33. I declined to intervene in the alleged crisis but accompanied the men to the third floor to observe the situation. I asked my colleague Jill Hoegel to accompany me.

34. Upon arriving on the third floor, we were confronted by Joey, Michael, and a director of nursing who did not provide her name. They stated that Disability Rights New Jersey's investigation had caused disruption to the residents and caused the residents to want to promptly leave the facility.

35. I informed Joey, Michael, and the director of nursing that we were only gathering information as part of our investigation and that we did not provide any advice to any resident about their right to leave the facility.

36. The Woodland staff present asked us to include Woodland staff in any Disability Rights New Jersey interaction with residents and to stop interacting with them unaccompanied because Woodland staff were the equivalent of residents' family and knew how to interact with them.

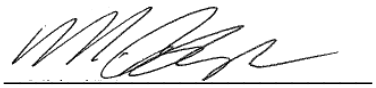
37. I declined to commit to limiting our investigation method, but for the remainder of the site visit on February 23, Disability Rights staff did not conduct further resident interviews to avoid further confrontation.

38. Woodland's insistence that Disability Rights New Jersey be accompanied when speaking with residents, its ongoing practice of confronting, and repeated interrupting Disability Rights New Jersey staff is

stymieing its ability to conduct its investigation. Disability Rights New Jersey needs unaccompanied access to collect candid information from residents on the care they are receiving, violations of their rights, and whether or not they are subject to ongoing abuse or neglect.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Dated: March 4, 2022



Michael R. Brower, Esq.

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

DISABILITY RIGHTS NEW JERSEY	:	
	:	**Case No.** 2:22-cv-01240
Plaintiff,	:	**Judge:** Brian R. Martinotti
v.	:	**Magistrate Judge:** James B. Clark
ALLIANCE HC 11 LLC d/b/a WOODLAND BEHAVIORAL AND NURSING CENTER	:	**Declaration of Elena Kravitz in Support of Motion for Preliminary Injunction**
Defendant.	:	

I, Elena Kravitz, of full age, in lieu of Affidavit, hereby state and declare as follows:

1. I am a Senior Advocate Investigator at Disability Rights New Jersey.

2. I make this Declaration in further support of the motion for preliminary injunction against Woodland Behavioral and Nursing Center (Woodland).

3. Disability Rights New Jersey is the state-designated Protection and Advocacy system for the State of New Jersey.

4. As a Senior Advocate Investigator at Disability Rights New Jersey, my job duties include investigating reports of abuse and neglect involving people with disabilities.

5. On Friday February 18, 2022, I arrived at Woodland at approximately 9:30am for the purpose of conducting an ongoing investigation of abuse and neglect Disability Rights New Jersey is conducting.

6. I was accompanied by my Disability Rights New Jersey colleagues Jill Hoegel, Director of Investigations and Monitoring, and Marie Ciallella, another Senior Advocate Investigator.

7. I entered the facility and began carrying out my investigation after checking in at the front desk. I introduced myself to residents and observed conditions in the facility from my arrival until approximately 1:45 p.m.

8. At 1:45 p.m., I observed Ms. Hoegel with a resident who approached the nursing desk on the third floor and requested her inhaler. A Woodland staff named Allison was staffing the desk. Allison stated she was not able to assist the resident. Allison became visibly bothered by the interaction with the resident.

9. Woodland staff began congregating at the nursing desk, and I overheard them mocking residents while they were present. I told the staff that mocking residents was inappropriate.

10. Allison screamed at us that the resident who needed an inhaler did not need it and pursued us down the hallway as we made our way toward the elevator.

11. A Woodland security guard arrived and stopped her from pursuing us, and Allison screamed at him "don't f****** do that to me again."

12. The other Woodlands staff who had congregated around the nursing station shouted to us "why don't you get the f*** out of here?" and "why are you trying to scare the residents?"

13. Thereafter, we summoned the elevator and departed the building to avoid further confrontation with a clearly angered staff.

14. On Sunday, February 20, 2022, I arrived at Woodland at approximately 9:40am to continue the ongoing investigation of abuse and neglect into Woodland.

15. I met with two Disability Rights New Jersey colleagues, Gwen Orlowski, Executive Director, and Cory Bernstein, Staff Attorney, who arrived at Woodland after me. We proceeded inside to the lobby together to begin our work.

16. I complied with all Woodland COVID protocols including having my temperature taken, wearing Personal Protective Equipment, and providing proof of vaccination status. I was not given a COVID rapid test because I had been there several days earlier and tested negative for COVID.

17. Thereafter, I along with Ms. Orlowski and Mr. Bernstein, attempted to enter the locked door that opens into the second-floor nurses station, but an individual who identified himself as one of the owners of the facility, Chaim Scheinbaum, intercepted us. He asked us to accompany him to the administrative office, purportedly to meet members of his senior staff. I introduced myself and provided him with my business card.

18. Thereafter, Mr. Scheinbaum kept us in his office, leaving us for periods of time, saying he was looking for members of his staff or that he was going to speak to his attorney. On one of the occasions that he left us in the office to speak to his attorney, we could hear him screaming in the hallway. We felt as if we were trapped in Mr. Scheinbuam's office.

19. After Mr. Scheinbaum left us alone in his office for approximately twenty minutes, we were going to leave his office, as we believed he was not returning. However, Mr. Scheinbaum returned with a member of his staff he identified as Cindy Shiller, Infection Prevention Specialist. Mr. Scheinbaum asked if he could record our conversation, and I said I was not comfortable with a recording, having just met Mr. Shiller and having no idea what the purpose of this impromptu meeting was.

20. Mr. Scheinbaum proceeded to challenge Disability Rights New Jersey's access authority, even though we advised him that we sent Woodland a letter dated July 12, 2021, prior to our first in-person visit. The letter outlined our authority to visit Woodland. Previously, I personally conducted investigation and monitoring activity at this facility in June 2021 with no incident. On several occasions, we told him that our authority as the designated protection and advocacy agency was well-established and suggested that he consult with his attorney.

21. Mr. Scheinbaum continued to keep us confined to his office, threatening to call the police at one point if we left his office.

22. After one purported conversation with his attorney (outside of the office), he told us his attorney advised that we did not have the authority to monitor and only limited authority to investigate. In addition, he informed me that he denied Disability Rights NJ access to the facility because of active COVID outbreaks. In addition, he challenged that we were not who we said we were, despite him being given business cards with photographs, us producing the July 7, 2021 letter, us wearing photo IDs, and us directing him to our website where our protection and advocacy authority is explained, and there is a roster of current staff.

23. I overheard Ms. Orlowski calling Disability Rights New Jersey's Legal Director Michael Brower, who forwarded her a November 12, 2021 Centers for Medicare and Medicaid Services (CMS) Nursing Home COVID-19 visitation memorandum. She showed Mr. Scheinbaum page seven, where it explains that nursing facilities must "allow immediate access to a resident by any representative of the protection and advocacy system" regardless of the public health emergency.

24. Mr. Scheinbaum continued to deny Disability Rights New Jersey access to the facility and said "our boss" could call his attorney.

25. At this point, I left the building and waited in the parking lot for the outcome of the conversation between Ms. Orlowski and Woodland's attorney, Mr. Slocum.

26. Ms. Orlowski texted me at approximately 11:30 am and asked me to re-enter the building to continue the investigation.

27. For the remainder of the day, Mr. Scheinbaum followed us as we moved through the building. He maintained a line-of-sight surveillance until we left.

28. I left the facility at approximately 3:00 pm.

29. On Tuesday March 1, 2022, I arrived at Woodland at approximately 10:19 am to continue the investigation of abuse and neglect Disability Rights New Jersey was conducting at Woodland. I was accompanied by Ms. Ciallella.

30. I began my investigation by interviewing residents and observing conditions at the facility.

31. At approximately 12:00 pm, I took photographs of the shower rooms on the north wing of the second floor. The shower facilities were completely unoccupied. I proceeded to the east wing to continue the investigation.

32. Mr. Scheinbaum intercepted us and falsely accused us of photographing residents. He was angry and again stated that our presence was disrupting the facility's operation and upsetting staff.

33. An additional administrator named Michael expressed anger that Ms. Ciallella and I had not notified him of our visit when we arrived. He loudly stated that our failure to announce our visit to administration was unprofessional.

34. Mr. Scheinbaum, Michael, and a third administrator, who did not provide his name, pursued us into the east wing of the second floor and shouted complaints about us being there.

35. Mr. Scheinbaum and Michael approached me very closely, within arm's length, in a posture of physical aggression. All three administrators were leaning into my face with body language that indicated he might strike me. I told them that I was not comfortable with their physical posture and proximity, then they backed up.

36. Michael invited us to the administrative office to discuss the conflict and resolve their concerns. We accompanied him to the office in an effort of de-escalation. When we arrived at the office, there was a conference table with two women already seated. Realizing that this would be a meeting with five people and confrontation, we asked to have a private discussion. He led us to another public room with staff already present.

37. At approximately 1:45pm, we decided to leave the building to contact our supervisor, Jill Hoegel.

38. We returned to the building at about 2:15 pm. For the remainder of the day, Mr. Scheinbaum maintained line of sight surveillance.

39. We left the facility for the day at about 3:00pm.

40. On Wednesday March 2, 2022 I arrived at Woodland at approximately 8:30am to continue Disability Rights New Jersey's investigation into Woodland.

41. While I was talking with a resident about her medication regimen, I witnessed a second resident accuse the in-service nurse of giving her the wrong dose of medication.

42. The in-service nurse turned to me and yelled "This is all your fault! They were never like this before you came here. Everything is because of you. I can't do this anymore!".

43. The in-service nurse stopped distributing medication and left the floor, indicating that she would not dispense medication while the investigation continued as she walked away.

44. I left the facility at approximately 2:30 or 3:00 pm.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Dated: March 05, 2022

Elena Kravitz

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

DISABILITY RIGHTS NEW JERSEY,	:	
	:	**Case No.**
Plaintiff,	:	**Judge:**
v.	:	**Magistrate Judge:**
ALLIANCE HC 11 LLC d/b/a WOODLAND BEHAVIORAL AND NURSING CENTER 99 Mulford Road Andover, New Jersey 07821	:	
Defendant.	:	

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

I. INTRODUCTION

1. This action seeks to enjoin Alliance HC 11 LLC, d/b/a Woodland Behavioral and Nursing Center ("Woodland"), from continuing to violate federal laws that grant Plaintiff Disability Rights New Jersey ("Disability Rights NJ") reasonable unaccompanied access to residents and records for the purpose of fulfilling its mandate as the protection and advocacy system for people with disabilities in New Jersey.

2. Due to Defendants' continuing violation of federal law, Plaintiff Disability Rights NJ seeks declaratory and preliminary and permanent injunctive relief to enjoin Defendant from denying reasonable unaccompanied access to individuals with disabilities who reside at Woodland.

3. Disability Rights NJ files suit and seeks relief as described after making repeated efforts to resolve this matter with the Defendants.

4. Plaintiff Disability Rights New Jersey also seeks attorneys' fees and costs, and any other available relief.

5. Each paragraph of this Complaint incorporates all others without specific restatement.

II. JURISDICTION AND VENUE

6. Jurisdiction is vested in this Court as this case raises a question of general federal law, 28 U.S.C. § 1331.

7. Plaintiff's cause of action arises under the Protection and Advocacy for Individuals with Mental Illness Act of 1986 ("PAIMI Act"), 42 U.S.C. § 10801 *et seq.*; the Developmental Disabilities Assistance and Bill of Rights Act of 2000 ("PADD Act"), 42 U.S.C. § 15041 *et seq.*; and the Protection and Advocacy for Individual Rights Act ("PAIR Act"), 29 U.S.C. § 794e. Costs may be awarded pursuant to Fed. R. Civ. P. 54.

8. Venue is proper in this Court under 28 U.S.C. § 1391(b). Defendant is located in this district, and the events and omissions complained of occurred in this district.

III. PARTIES

9. Plaintiff Disability Rights NJ is a non-profit corporation duly incorporated in the state of New Jersey. Disability Rights New Jersey is the designated protection and advocacy system for the State of New Jersey.

10. Plaintiff Disability Rights NJ files this Complaint in its own name to redress injuries to itself in fulfilling its mandate to protect and advocate for the rights of people with disabilities in New Jersey.

11. Plaintiff Disability Rights NJ's office is located in Trenton, New Jersey.

12. Congress established the protection and advocacy ("P&A") system in 1975 to protect and advocate for the rights of persons with developmental disabilities, and reauthorized the system in the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (the "PADD Act"). 42 U.S.C. § 15041 *et seq.* Congress provided P&A systems with the authority to investigate incidents of abuse and neglect against individuals with developmental disabilities and pursue legal, administrative, and other remedies on their behalf. 42 U.S.C. § 15043(a).

13. Congress thereafter expanded the scope of the P&A system to provide protection and advocacy services to all persons with disabilities. The Protection and

Advocacy for Individuals with Mental Illness Act of 1986 (the "PAIMI Act") provides for the protection of rights of individuals with mental illness, 42 U.S.C. § 10801 *et seq.*; and the Protection and Advocacy of Individual Rights Program (the "PAIR Act") was created to protect the rights of all other individuals with disabilities who are not covered under the PADD and PAIMI Acts. 29 U.S.C. § 794e *et seq.*

14. Pursuant to these laws, Plaintiff Disability Rights NJ has a federal mandate to protect and advocate for the rights of persons with disabilities in New Jersey, including people with disabilities who are institutionalized in facilities such as Woodland.

15. Among other activities, Plaintiff Disability Rights NJ travels throughout the state to investigate allegations of abuse and neglect in facilities.

16. Defendant Woodland, is a limited liability corporation created under and governed by the laws of the State of New Jersey.

17. Defendant Woodland operates a skilled nursing facility that is licensed by the New Jersey Department of Health that is located at 99 Mulford Road, Andover, New Jersey 07821.

18. Hundreds of people with disabilities are served by Defendant's licensed residential facility.

19. Upon information and belief, many of the residents who reside at Defendant's facility are under guardianship.

20. Individuals with physical or mental impairments that substantially limit one or more major life activities of such individuals are institutionalized at Defendant Woodland.

21. Individuals who are institutionalized at Woodland receive skilled nursing services.

22. Defendant Woodland is a facility as defined in 42 U.S.C. § 10802(3) and 42 C.F.R. § 51.2.

23. Defendant is also a location, as provided in 42 U.S.C. § 15043(a)(2)(H), and a service provider, as provided in 42 C.F.R. § 1326.27(c), because services, supports, and other assistance are provided there to individuals with disabilities.

IV. STATEMENT OF FACTS

24. In April 2020, The New York Times published a story indicating that a high percentage of residents at Woodland, then known as Andover II, had died from COVID-19 and bodies were being stored on site. *See After Anonymous Tip, 17 Bodies Found at Nursing Home Hit by Virus*, N.Y. Times, Apr. 15, 2020, *available at* https://www.nytimes.com/2020/04/15/nyregion/coronavirus-nj-andover-nursing-home-deaths.html

25. Disability Rights NJ requested information from nursing facilities over the course of 2020 and learned that Woodland housed a disproportionately high number of residents with serious mental illness and traumatic brain injury.

26. On or around July 12, 2021, Disability Rights NJ wrote to Woodland, notified the administrator of its intent to monitor, and provided an explanation and references for Disability Rights NJ's legal authority to do so.

27. On July 26 and August 17, 2021, Disability Rights NJ staff conducted initial monitoring visits at Woodland. This monitoring activity raised concerns that residents that needed specialized services for serious mental illness and developmental disability were inappropriately placed at the facility.

28. Disability Rights NJ began collecting Preadmission Screening and Resident Review (PASRR) information from the state suspecting there was an issue with the unnecessary placement of disabled residents in long term care facilities.

29. As monitoring activities continued, Disability Rights NJ became aware of additional reports of serious and acute health and safety violations.

30. The New Jersey Department of Health issued a "Notice of Violations, Corrective Action, and State Monitoring" dated February 10, 2022 to Woodland.

31. The Department of Health notice documented numerous instances of verbal abuse of patients by staff. The report also documented numerous serious instances of neglect, including an instance where a patient was left soiled in feces for more than ten hours and another instance where staff failed to assist a resident who called for help due to a stuck catheter. The report also identified numerous instances in which staff failed to provide any life saving emergency response, including an

instance where staff failed to initiate CPR, call 911, or utilize a defibrillator after finding a 55 year old resident unresponsive. The report also identified serious deficiencies in COVID prevention and treatment protocols, unsecured storage of dangerous medications, and that the facility failed to maintain sufficient levels of properly trained and qualified staff.

32. Based on the detailed instances of abuse and neglect reported in the New Jersey Department of Health notice, Disability Rights NJ determined there was probable cause to suspect that all residents at Woodland have been subject to ongoing abuse, neglect, and rights violations.

33. Plaintiff Disability Rights New Jersey provided Defendant Woodland with information regarding its federal and state access authority to "unaccompanied access to residents at all times necessary to conduct a full investigation of an incident of abuse or neglect."

34. Plaintiff Disability Rights NJ's authority to speak confidentially with individuals with disabilities is an important oversight component for facilities like Woodland.

35. Initially, Defendant Woodland agreed to allow Disability Rights NJ access to the facility, but later Woodland administrators and staff attempted to limit Disability Rights NJ's access to the facility and interfered with their ability to speak confidentially with individuals with disabilities at the facility.

36. On February 18, 2022, Disability Rights NJ Director of Investigations and Monitoring Gloria Jill Hoegel , Disability Rights NJ Senior Advocate Elena Kravitz, and Disability Rights NJ Staff Advocate Mary Ciallela visited the Woodland facility as part of Disability Rights NJ's investigation.

37. During the visit, Disability Rights NJ staff witnessed an instance of staff verbal abuse of a resident who sought assistance. Woodland staff dismissed the resident's concerns as attention seeking. The same staff member confronted the Disability Rights NJ monitoring team as they were leaving the facility, addressing Disability Rights NJ staff with a raised voice while claiming that their presence was upsetting people and falsely claiming that members of the Disability Rights NJ monitoring team were telling staff to "sharpen up their resumes".

38. On February 20, 2022, a Disability Rights NJ team which included Executive Director Gwen Orlowski, made another in person visit to the facility.

39. The team was met at the door by an individual who identified himself as "Mutty" Scheinbaum, who stated that he was one of the owners of the facility. The Disability Rights NJ team introduced themselves, provided photo identification, and explained the purpose and authority for the visit.

40. Mr. Scheinbaum delayed the Disability Rights NJ investigative team for two hours. Mr. Scheinbaum insisted that the team go directly to his office without speaking to residents. Mr. Scheinbaum indicated that the team needed to stay in his

office while he spoke with staff and his attorney. After twenty minutes waiting in the office, Mr. Scheinbaum returned as the team was attempting to leave.

41. Mr. Scheinbaum challenged Disability Rights NJ's access authority, even though the team had previously visited the facility and had provided written correspondence to Woodland informing the facility of Disability Rights NJ's access authority. Mr. Scheinbaum demanded that the Disability Rights NJ team remain confined to his office and threatened to call the police if they left. Mr. Scheinbaum told Disability Rights NJ's team that his attorney advised him that Disability Rights NJ's team did not have authority to monitor, and that Disability Rights NJ's authority to investigate was limited. Mr. Scheinbaum claimed that he could deny access authority due to COVID, and he claimed that the Disability Rights NJ team was not who they said they were, despite the fact that they each presented personal identification.

42. During the course of this confrontation, Disability Rights NJ's Legal Director Michael Brower provided November 2021 regulatory guidance from the Centers for Medicare & Medicaid which stated that nursing home facilities must provide "immediate access" by any representative of the protection and advocacy system regardless of the COVID public health emergency.

43. Despite this, Mr. Scheinbaum continued to deny access to the facility and demanded that Disability Rights NJ speak to his attorney, Peter Slocum. Disability

Rights NJ staff communicated with Mr. Slocum via telephone and provided him with legal authority on Disability Rights New Jersey's access authority. At the conclusion of the discussion, Mr. Slocum acknowledged Disability Rights NJ's access rights and stated that he would instruct his client not to interfere further with the investigation. Mr. Scheinbaum then allowed the Disability Rights NJ team to begin their work, two hours after they had arrived at the facility, but followed within sight of the team throughout the visit.

44. On February 23, 2022, a Disability Rights NJ team which included Legal Director Michael Brower and Elena Kravitz made another in person visit to the facility. As the Disability Rights NJ team was conducting interviews with residents, they were approached by two men who identified themselves as Joey and Michael, who stated that they were owners and administrators at the facility. Joey and Michael asked Disability Rights NJ staff to go to the third floor of the facility and to intervene in what they described as a behavioral crisis, and to explain to residents that they were not allowed to leave the facility. Disability Rights NJ declined to do so, but accompanied Joey and Michael to the third floor to observe the situation. On the third floor, Joey and Michael were joined by a member of the nursing staff who told Disability Rights NJ that their presence was disruptive to residents because it made them want to leave the facility. Woodland staff claimed that Woodland staff were "like family" to the residents and knew how to interact with them. Woodland staff

demanded that Disability Rights NJ agree not to engage in any further interactions or interviews with residents without Woodland staff present.

45. On March 1, 2022, a Disability Rights NJ team which included Elena Kravitz made another in person visit to the facility. As part of the visit, Ms. Kravitz interviewed residents and then took photographs of an unoccupied shower facility. Soon after, Ms. Kravitz was confronted by Mr. Scheinbaum, who raised his voice in anger and falsely accused Disability Rights NJ staff of photographing residents, upsetting staff, and disrupting the facility. Mr. Scheinbaum and a second administrator who identified himself as "Michael" physically intimidated Ms. Kravitz by yelling at her and leaning towards her as though they were going to physically strike her. Michael then insisted that Disability Rights NJ staff accompany him to the facility's administrative office, where other administrators were also present. Ms. Kravitz left the building to contact her supervisor, Ms. Hoegel. When she returned to the facility a few minutes later to complete the visit, Mr. Scheinbaum continued to keep Disability Rights NJ staff within line of sight surveillance.

46. On March 2, 2022, a Disability Rights NJ team which included Elena Kravitz made another in person visit to the facility. As Ms. Kravitz was communicating with a resident, she overheard a second resident complain that a nurse had given her the wrong dose of medication. The nurse then confronted Ms. Kravitz and yelled "This is all your fault! They were never like this before you came here.

Everything is because of you. I can't do this anymore!" The nurse then refused to dispense medication while Disability Rights NJ staff were present.

47. Woodland has engaged in a pattern and practice of impeding Disability Rights NJ's access to the facility and to residents.

48. Woodland's attempts to bar Disability Rights NJ staff from speaking with residents confidentially and privately and its ongoing practice of confronting and interrupting Disability Rights NJ staff has stymied the ability of Disability Rights NJ to collect candid information from residents on the care they are receiving, violations of their rights, and whether or not they are subject to ongoing abuse or neglect.

49. The conduct has interfered with and impeded Disability Rights NJ's ability to investigate abuse and neglect of residents with disabilities at the facility.

50. At all times, Plaintiff Disability Rights New Jersey cooperatively provided Woodland with information about the purpose and reasonableness of Plaintiff Disability Rights NJ's investigative activities, the federal laws regarding Plaintiff Disability Rights NJ's authority to have reasonable unaccompanied access to observe and speak with individuals at the facility.

V. LEGAL CLAIMS

A. First Claim for Relief: Based on Violation of the PAIMI Act and Implementing Regulations

51. As the designated protection and advocacy system for individuals with disabilities in New Jersey, Plaintiff Disability Rights NJ has access to facilities in New Jersey providing care or treatment to individuals with mental illness. 42 U.S.C. § 10805(a)(3).

52. Plaintiff Disability Rights NJ is charged to investigate instances of abuse and neglect of individuals with mental illness. 42 C.F.R. § 51.42(b).

53. Plaintiff Disability Rights NJ is authorized to have reasonable unaccompanied access to public and private facilities and programs in the State, which render care or treatment for individuals with mental illness, and to all areas of the facility which are used by residents or are accessible to residents. 42 C.F.R. § 51.42(b).

54. The P&A system shall have reasonable unaccompanied access to residents at all times necessary to conduct a full investigation of an incident of abuse or neglect. Residents include adults or minors who have legal guardians or conservators. 42 C.F.R. § 51.42(b) and (d).

55. Unaccompanied access to residents includes the opportunity to meet and communicate privately with individuals regularly, both formally and informally, by telephone, mail and in person. 42 C.F.R. § 51.42(d).

56. The P&A system also has: access to the records of any of the following individuals with mental illness:

a) An individual who is a client of the P&A system if authorized by that individual or the legal guardian, conservator or other legal representative.

b) An individual, including an individual who has died or whose whereabouts is unknown to whom all of the following conditions apply:

1) The individual, due to his or her mental or physical condition, is unable to authorize the P&A system to have access.

2) The individual does not have a legal guardian, conservator or other legal representative, or the individual's guardian is the State or one of its political subdivisions; and

3) A complaint or report has been received and the P&A system has determined that there is probable cause to believe that the individual has been or may be subject to abuse or neglect.

c) An individual who has a legal guardian, conservator, or other legal representative, with respect to whom a complaint or report has been received by the P&A system and with respect to whom the P&A system has determined that there is probable cause to believe that the health or safety of the individual is in serious and immediate jeopardy, whenever all of the following conditions exists:

4) The P&A system has made a good faith effort to contact the representative upon prompt receipt of the representative's name and address;

5) The P&A system has made a good faith effort to offer assistance to the representative to resolve the situation; and

6) The representative has failed or refused to act on behalf of the individual. 42 C.F.R. § 51.41(b)

57. Plaintiff Disability Rights NJ became aware of incidents of abuse and neglect of residents at Woodland arising out of the New Jersey Department of Health February 2022 report. Such incidents provide Disability Rights NJ with probable

cause to believe that abuse and neglect has occurred or is occurring at Woodland. The additional access is necessary to conduct a full investigation of abuse and neglect.

58. Disability Rights NJ requested access to Woodland, but Woodland has significantly limited requested access. Further, given the risk of abuse and neglect, Disability Rights NJ has probable cause to believe that the health and safety of the residents at Woodland are in serious and immediate jeopardy.

59. Defendant Woodland has interfered with Plaintiff Disability Rights NJ's attempts to conduct site visits and interview residents at the facility.

60. Defendants' refusal to provide Plaintiff Disability Rights NJ with reasonable unaccompanied access to the facility, residents, and records violates the PAIMI Act and its implementing regulations.

61. Defendants' violation of the PAIMI Act and its implementing regulations frustrates and interferes with Plaintiff Disability Rights NJ's federal mandate to protect people with disabilities in New Jersey; to provide legal advocacy for people with disabilities; to conduct an investigation of the facility, and to determine whether corrective action should be taken.

62. Defendants' violation of the PAIMI Act and its implementing regulations frustrates the rights of individuals institutionalized at Woodland to have access to a meaningful and effective protection and advocacy system.

63. Pursuant to 42 U.S.C. § 10805(a)(1)(B), Plaintiff Disability Rights NJ is authorized to pursue administrative, legal, and other appropriate remedies to ensure the protection of individuals with mental illness who are receiving care or treatment in New Jersey

64. Plaintiff Disability Rights NJ is entitled to relief under 42 U.S.C. § 10805(a)(3) and 42 C.F.R. § 51.41(c).

B. Second Claim for Relief: Based on the Violation of the PADD Act, Implementing Regulations, and 42 U.S.C. § 1983

65. Plaintiff Disability Rights NJ is authorized to have access at reasonable times to any individual with a developmental disability in a location in which services, supports, and other assistance are provided to such an individual. 42 U.S.C. § 15043(a)(2)(H).

66. Plaintiff Disability Rights NJ is authorized to have unaccompanied access to individuals with developmental disabilities at all times necessary to conduct a full investigation of an incident of abuse and neglect. 45 C.F.R. § 1326.27(b).

67. Access to individuals with developmental disabilities includes the opportunity to meet and communicate privately with individuals regularly, both formally and informally, by telephone, mail, and in person. 45 C.F.R. § 1326.27(d).

68. A P&A system shall have reasonable unaccompanied access to public and private service providers, programs in the State, and to all areas of the service provider's premises that are used by individuals with developmental disabilities or are

accessible to them. Such access shall be provided without advance notice and made available immediately upon request. This authority shall include the opportunity to interview any individual with developmental disability, employee, or other persons, including the person thought to be the victim of such abuse, who might be reasonably believed by the system to have knowledge of the incident under investigation. 45 C.F.R. § 1326.27(b).

69. The P&A system also has access to the records of individuals with developmental disabilities under the following circumstances:

a) (1) If authorized by an individual who is a client of the system, or who has requested assistance from the system, or by such individual's legal guardian, conservator or other legal representative.

b) (2) In the case of an individual to whom all of the following conditions apply:

1) (i) The individual, due to his or her mental or physical condition, is unable to authorize the system to have access;

2) (ii) The individual does not have a legal guardian, conservator or other legal representative, or the individual's guardian is the State (or one of its political subdivisions); and

3) (iii) The individual has been the subject of a complaint to the P&A system, or the P&A system has probable cause (which can be the result of monitoring or other activities including media reports and newspaper articles) to believe that such individual has been subject to abuse and neglect.

c) (3) In the case of an individual, who has a legal guardian, conservator, or other legal representative, about whom a complaint has been received by the system or, as a result of monitoring or other activities, the system has determined that there is probable cause to believe that the individual with developmental disability has been subject to abuse or neglect, whenever the following conditions exist:

1) (i) The P&A system has made a good faith effort to contact the legal guardian, conservator, or other legal representative upon prompt receipt (within the timelines set forth in paragraph (c) of this section) of the contact information (which is required to include but not limited to name, address, telephone numbers, and email address) of the legal guardian, conservator, or other legal representative;

2) (ii) The system has offered assistance to the legal guardian, conservator, or other legal representative to resolve the situation; and

3) (iii) The legal guardian, conservator, or other legal representative has failed or refused to provide consent on behalf of the individual.

4) (4) If the P&A determines there is probable cause to believe that the health or safety of an individual is in serious and immediate jeopardy, no consent from another party is needed. 45 C.F.R. § 1326.25

70. Plaintiff Disability Rights NJ became aware of serious incidents of abuse and neglect at Woodland arising out of the New Jersey Department of Health February 2022 report. Such incidents provide Disability Rights NJ with probable cause to believe that abuse and neglect has occurred or is occurring at Woodland. The additional information requested is necessary to conduct a full investigation of abuse and neglect.

71. Disability Rights NJ has probable cause to believe that the health and safety of individuals with disabilities at Woodland are in serious and immediate jeopardy.

72. Defendant Woodland refused Disability Rights NJ's attempts to conduct site visits and interview residents at the facility.

73. Defendants' refusal to allow Plaintiff Disability Rights NJ reasonable unaccompanied access to the facility, residents, and records at Woodland violates the PADD Act and its implementing regulations.

74. Defendants' violation of the PADD Act and its implementing regulations frustrates and interferes with Plaintiff Disability Rights NJ's federal mandate to protect people with disabilities in New Jersey; provide legal advocacy for people with disabilities; determine whether an investigation by Plaintiff Disability Rights NJ should be conducted; and determine whether corrective action should be taken.

75. Defendants' violation of the PADD Act and its implementing regulations frustrates the rights of individuals with disabilities institutionalized at Woodland to have access to a meaningful and effective protection and advocacy system.

76. Pursuant to 42 U.S.C. § 15043(a)(2)(A)(i), Plaintiff Disability Rights NJ is authorized to pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of such individuals

within New Jersey who are or who may be eligible for treatment, services, or habilitation.

77. Plaintiff Disability Rights NJ is entitled to relief under 42 U.S.C. § 15043(a)(2)(H), and 45 C.F.R. § 1326.27(d).

C. Third Claim for Relief: Based on Violation of the PAIR Act, Implementing Regulations, and 42 U.S.C. § 1983

78. The PAIR Act provides Plaintiff Disability Rights NJ with the authority to serve individuals with disabilities who are not otherwise eligible for protection and advocacy services under either the PADD Act or PAIMI Act. 29 U.S.C. § 794e(a)(1).

79. The PAIR Act incorporates the same general authorities of access as are found in the PADD Act. 29 U.S.C. § 794e(f)(2).

80. Plaintiff Disability Rights NJ is authorized to have access at reasonable times to any individual with a disability in a location in which services, supports, and other assistance are provided to such an individual. 42 U.S.C. § 15043(a)(2)(H).

81. Plaintiff Disability Rights NJ is authorized to have unaccompanied access to individuals with a disability including, but not limited to, the opportunity to meet and communicate privately with individuals regularly, both formally and informally, by telephone, mail, and in person. 45 C.F.R. § 1326.27(d).

82. A P&A system shall have reasonable unaccompanied access to public and private service providers, programs in the State, and to all areas of the service provider's premises that are used by individuals with developmental disabilities or are

accessible to them. Such access shall be provided without advance notice and made available immediately upon request. This authority shall include the opportunity to interview any individual with developmental disability, employee, or other persons, including the person thought to be the victim of such abuse, who might be reasonably believed by the system to have knowledge of the incident under investigation. 45 C.F.R. § 1326.27(b).

83. The P&A system also has access to the records of individuals with developmental disabilities under the following circumstances:

> **a)** (1) If authorized by an individual who is a client of the system, or who has requested assistance from the system, or by such individual's legal guardian, conservator or other legal representative.
>
> **b)** (2) In the case of an individual to whom all of the following conditions apply:
>
> 1) (i) The individual, due to his or her mental or physical condition, is unable to authorize the system to have access;
>
> 2) (ii) The individual does not have a legal guardian, conservator or other legal representative, or the individual's guardian is the State (or one of its political subdivisions); and
>
> 3) (iii) The individual has been the subject of a complaint to the P&A system, or the P&A system has probable cause (which can be the result of monitoring or other activities including media reports and newspaper articles) to believe that such individual has been subject to abuse and neglect.
>
> **c)** (3) In the case of an individual, who has a legal guardian, conservator, or other legal representative, about whom a complaint has been received by the

system or, as a result of monitoring or other activities, the system has determined that there is probable cause to believe that the individual with developmental disability has been subject to abuse or neglect, whenever the following conditions exist:

1) (i) The P&A system has made a good faith effort to contact the legal guardian, conservator, or other legal representative upon prompt receipt (within the timelines set forth in paragraph (c) of this section) of the contact information (which is required to include but not limited to name, address, telephone numbers, and email address) of the legal guardian, conservator, or other legal representative;

2) (ii) The system has offered assistance to the legal guardian, conservator, or other legal representative to resolve the situation; and

3) (iii) The legal guardian, conservator, or other legal representative has failed or refused to provide consent on behalf of the individual.

d) (4) If the P&A determines there is probable cause to believe that the health or safety of an individual is in serious and immediate jeopardy, no consent from another party is needed. 45 C.F.R. § 1326.25

84. Plaintiff Disability Rights NJ became aware of serious instances of abuse and neglect at Woodland arising out of the New Jersey Department of Health February 2022 report. Such incidents provide Disability Rights NJ with probable cause to believe that abuse and neglect has occurred or is occurring at Woodland. Access to the facility is necessary to conduct a full investigation of abuse and neglect.

85. Given the serious nature of the reports of abuse and neglect, Disability Rights NJy has probable cause to believe that the health and safety of the youth at Woodland are in serious and immediate jeopardy.

86. Defendant Woodland interfered with Plaintiff Disability Rights NJ's attempts to conduct site visits and interview residents at the facility.

87. Defendants' refusal to allow Plaintiff Disability Rights NJ reasonable unaccompanied access to the facility violates the PAIR Act and its implementing regulations.

88. Defendants' violation of the PAIR Act and its implementing regulations frustrates and interferes with Plaintiff Disability Rights NJ's federal mandate to protect people with disabilities in New Jersey; provide legal advocacy for people with disabilities; to conduct an investigation by Plaintiff Disability Rights NJ; and to determine whether corrective action should be taken.

89. Defendants' violation of the PAIR Act and its implementing regulations frustrates the rights of individuals institutionalized at Woodland to have access to a meaningful and effective protection and advocacy system.

90. Pursuant to 29 U.S.C. § 794e(f)(3), Plaintiff Disability Rights NJ is authorized to pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of such individuals

within New Jersey who are or who may be eligible for treatment, services, or habilitation.

91. Plaintiff Disability Rights NJ is entitled to relief under 29 U.S.C. § 794e(f)(2).

VI. NECESSITY FOR INJUNCTIVE RELIEF

92. Defendant has acted and continues to act in violation of the law as explained above. Plaintiff Disability Rights NJ and the individuals it is mandated to serve do not have an adequate remedy at law and will be irreparably harmed if Defendants are permitted to continue blocking Plaintiff Disability Rights NJ's access to investigate incidents of abuse and neglect at Woodland.

VII. PRAYER FOR RELIEF

WHEREFORE, Plaintiff Disability Rights NJ requests the following relief:

A. a declaratory judgment that Defendant has violated Plaintiff Disability Rights NJ's rights under the PAIMI Act, PADD Act, and PAIR Act.

B. an injunction ordering Defendant to provide Plaintiff Disability Rights NJ with reasonable unaccompanied access to speak privately with individuals with disabilities at Woodland pursuant to its federal and state authority;

C. an injunction ordering Defendant to provide Plaintiff Disability Rights NJ with reasonable unaccompanied access to the facility at Woodland pursuant to its federal and state authority;

D. an award of costs pursuant to Fed. R. Civ. Proc. 54;

E. an award of reasonable attorney fees pursuant to 42 U.S.C. § 1988.

and

F. any other relief that the Court deems appropriate.

Respectfully submitted,

/s/ Javier L. Merino
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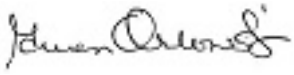
Counsel for Plaintiff Disability Rights of New Jersey

Verification

I, Gwen Orlowski, after being duly cautioned and sworn, verify, pursuant to 28 U.S.C. § 1746, under penalty of perjury that the foregoing is true and correct, that the allegations contained in the foregoing complaint and true and accurate to the best of my recollection.

Dated: March 7, 2022



Gwen Orlowski

JS 44 (Rev. 04/21)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

DISABILITY RIGHTS NEW JERSEY

(b) County of Residence of First Listed Plaintiff Mercer
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Javier L. Merino, Esq.Andrew R. Wolf, Esq.
The Dann Law Firm, PC 1520 U.S. Highway 130, Suite 101
North Brunswick, NJ 08902 Telephone: (216) 373-0539

DEFENDANTS

ALLIANCE HC 11 LLC d/b/a
WOODLAND BEHAVIORAL AND NURSING CENTER

County of Residence of First Listed Defendant
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☑ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

INTELLECTUAL PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☑ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

V. ORIGIN *(Place an "X" in One Box Only)*

☑ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
42 U.S.C. § 10801, 42 U.S.C. § 15041, 29 U.S.C. § 794e

Brief description of cause:
Voilations of Protection and Advocacy for Individuals with Mental Illness Act of 1986, Developmental Disabilities Assistance and Bill of Rights Act of 2000

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☑ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
03/07/2022

SIGNATURE OF ATTORNEY OF RECORD
/s/ Javier Merino

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) **Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) **County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) **Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. **Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

III. **Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. **Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. **Origin.** Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.

VI. **Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service.

VII. **Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. **Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

AO 440 (Rev. 12/09) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of New Jersey

DISABILITY RIGHTS NEW JERSEY

Plaintiff

v.

ALLIANCE HC 11 LLC d/b/a
WOODLAND BEHAVIORAL AND NURSING CENTER

Defendant

Civil Action No.

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* ALLIANCE HC 11 LLC d/b/a
WOODLAND BEHAVIORAL
AND NURSING CENTER
99 Mulford Road
Andover, New Jersey 07821

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Javier L. Merino, Esq.
Andrew R. Wolf, Esq.
The Dann Law Firm, PC
1520 U.S. Highway 130, Suite 101
North Brunswick, NJ 08902

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No.

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

.

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

Print Save As... Reset

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

DISABILITY RIGHTS NEW JERSEY **210 South Broad Street** **3rd Floor** **Trenton New Jersey 08608** **Plaintiff,** **v.** **ALLIANCE HC 11 LLC d/b/a WOODLAND BEHAVIORAL AND NURSING CENTER** **99 Mulford Road** **Andover, New Jersey 07821** **Defendant.**	:	**Case No. 2:22-cv-01240** **Judge: Brian R. Martinotti** **Magistrate Judge: James B. Clark** **PROPOSED ORDER GRANTING MOTION FOR PRELIMINARY INJUNCTION**

THIS MATTER having been opened to the Court by Plaintiff Disability Rights New Jersey (Plaintiff or Disability Rights NJ), and by their undersigned attorneys, upon motion for an order granting preliminary injunction, based on the facts set forth in the Declarations of Gloria Jill Hoegel, Gwen Orlowski, Esq., Michael R. Brower, Esq., and Elena Kravitz, and the accompanying Memorandum of Law; and

IT APPEARING TO THE COURT THAT

1. Plaintiff is likely to succeed on the merits of its action; and
2. Plaintiff is currently sustaining and is at risk in the future of sustaining immediate and irreparable injury, including its inability to meet its federal statutory mandate to protect and advocate for the rights of individuals with disabilities at Woodland; and
3. The injuries suffered and to be suffered outweigh any harm that the relief will inflict upon the Defendant; and
4. The relief sought serves the public interest; and
5. The injuries being sustained by Plaintiff and which may be sustained in the future are irreparable because this Court has found that the injury and risk of injury is of the nature of a protection and advocacy's agency inability to meet its federal statutory mandate to protect and advocate for the rights of disabled people, such that there will be no adequate remedy in damages; and
6. Plaintiff has been and is unable to access and speak confidentially with the individuals at Woodland, and the residents at Woodland are at high risk of dangerous and life-threatening conditions, despite many and repeated requests to the Defendant; and
7. The resident population of Woodland remains at risk of continued physical injury and death due to the present conditions at Woodland, and will remain

at risk as they will not be aware of Disability Rights NJ's services or have an opportunity to request assistance; and

8. The submission by Plaintiffs with respect to this motion, including the Declarations of Declarations of Gloria Jill Hoegel, Gwen Orlowski, Esq., Michael R. Brower, Esq., and Elena Kravitz, as well as the allegations made in Plaintiff Verified Complaint, have sufficiently demonstrated that the balance of the equities favors Plaintiff; and it is therefore

ORDERED that, pursuant to Rule 65(b) of the Federal Rules of Civil Procedure, until the Court rules otherwise, Defendant Alliance HC 11 LLC d/b/a Woodland Nursing Home and Behavioral Center (Defendant), its officers, agents, servants, employees, and all those in privity or acting in concert with Defendant, be and hereby are preliminarily enjoined from directly or indirectly violating Plaintiff's rights under the Protection and Advocacy for Individuals with Mental Illness Act, the Protection and Advocacy for the Developmentally Disabled Act, and the Protection and Advocacy of Individual Rights Act, and Defendant is temporarily ordered to:

1. Provide Plaintiff Disability Rights NJ with reasonable unaccompanied access to speak privately with individuals with disabilities and to access their records at Woodland pursuant to its federal authority; and

2. Provide Plaintiff Disability Rights NJ with reasonable unaccompanied access to the facility at Woodland; and it is further

ORDERED that for all of the foregoing reasons, the Court, for good cause shown, directs that Woodland shall appear and show cause before this Court, Martin Luther King Building & United States Courthouse, Newark, New Jersey, in Courtroom ___, on the _____ day of _____, 2022 at _____ a.m / p.m., or as soon thereafter as counsel can be heard, as to why an Order pursuant to Federal Rule of Civil Procedure 65 and Local Civil Rule 65.1 the temporary relief entered above should not be made permanent.

ORDERED that Plaintiffs shall serve a copy of this Order, the Declarations of Gloria Jill Hoegel, Gwen Orlowski, Esq., Michael R. Brower, Esq., and Elena Kravitz, and the accompanying Memorandum of Law, on counsel for Defendant by ECF, personal service, e-mail (if agreed upon in advance), Federal Express, or certified mail – return receipt requested, any of which shall be deemed sufficient service upon the Defendant, within ___ days of the date hereof; and it is further

ORDERED that Plaintiff must file with the Court, their proof of service on the Defendant no later than ___ days before the return date; and it is further

ORDERED that Defendant, if they oppose Plaintiff's application for preliminary relief, shall serve by ECF, personal service, e-mail (if agreed upon in

advance), Federal Express, or certified mail – return receipt requested, and file a written response by _____, 2022; and it is further

ORDERED that Plaintiff shall serve by ECF, personal service, e-mail (if agreed upon in advance), Federal Express, or certified mail – return receipt requested, and file a reply thereto or other submission before by _____, 2022; and it is further

ORDERED that if Defendant does not file and serve opposition to this application, the application will be decided on the papers on the return date, and relief may be granted by default, provided that Plaintiff files a proof of service and proposed form of Order at least ___ days prior to the return date; and it is further

ORDERED that if Plaintiff has not already done so, a proposed form of Order addressing the relief sought on the return date must be submitted to the Court no later than ___ days before the return date.

_____
HON. BRIAN R. MARTINOTTI, U.S.D.J.