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# P U B L I C  H E A R I N G

before

## ASSEMBLY SENIOR CITIZENS COMMITTEE

The closing of senior citizens' residences,
specifically the River Vale Manor

November 17, 1986
Northvale Senior Center
Northvale, New Jersey

**MEMBERS OF COMMITTEE PRESENT:**

Assemblyman John E. Rooney, Chairman
Assemblyman Robert W. Singer, Vice Chairman

**ALSO PRESENT:**

Norma Svedosh
Office of Legislative Services
Aide, Assembly Senior Citizens Committee

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Hearing Recorded and Transcribed by
Office of Legislative Services
Public Information Office
Hearing Unit
State House Annex
CN 068
Trenton, New Jersey 08625

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JOHN E. ROONEY
rman
T W. SINGER
Chairman
DOLORES COOPER
WALTER M.D. KERN, JR.
JEFFREY W. MORAN
JOHN PAUL DOYLE
THOMAS PATERNITI

New Jersey State Legislature
ASSEMBLY SENIOR CITIZENS COMMITTEE
STATE HOUSE ANNEX, CN-068
TRENTON, NEW JERSEY 08625
TELEPHONE: (609) 292-1646

# NOTICE OF A PUBLIC HEARING

THE ASSEMBLY SENIOR CITIZENS COMMITTEE ANNOUNCES A PUBLIC HEARING ON THE CLOSING OF SENIOR CITIZENS' RESIDENCES, SPECIFICALLY THE RIVER VALE MANOR.

MONDAY, NOVEMBER 17, 1986
BEGINNING AT 6:00 PM
NORTHVALE SENIOR CENTER
116 PARIS AVENUE
NORTHVALE, NEW JERSEY

The Assembly Senior Citizens Committee will hold a public hearing on Monday, November 17, 1986 at 6:00 p.m. in the Northvale Senior Center, 116 Paris Ave, Northvale, New Jersey. The purpose of the hearing is to discuss the closing of senior citizens' residences, and specifically the River Vale Manor residence.

Address any questions and requests to testify to Norma Svedosh (609-292-1646), State House Annex, Trenton, New Jersey 08625. Persons wishing to testify are asked to submit ten copies of their testimony on the day of the hearing. The chairman may find it necessary to limit the number of witnesses or the time available for each witness.

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mjz: 1-39

**ASSEMBLYMAN JOHN E. ROONEY (Chairman):** I think we are going to get started. Hopefully, some of the other members of the Committee will come in later. I think the important people are here now, so we will get started.

Good evening. I want to welcome you to this public hearing before the Assembly Senior Citizens Committee. Our purpose is to discuss what procedures should be followed in the closing of a senior citizens' residence, and to determine if these procedures were utilized in the closing of the River Vale Manor. River Vale Manor, which was a residential health care facility, unexpectantly and without warning, ceased operation on August 13, 1986. This sudden closing caused many difficulties and concerns for the 18 residents who were residing at the facility. Many of the residents were elderly, and the sudden change in their living arrangements was traumatic and stressful to them, and to their families.

It is because of that problem that we are investigating here tonight the events leading to that closing. We will also discuss the closing of senior citizens' residences in general. The key reason for the hearing is to determine the involvement of State, county, and local agencies in the closing of the facility, and whether or not the actions taken by these agencies may have been a contributing factor leading to the closing. The importance of the situation is very clear, when it is realized there is a critical need for senior citizen housing in the State of New Jersey. The senior citizens in this State are in need of housing options that offer them a range of services from total nursing care to minimal group home care. It is essential that the variety of housing and care options remain available to our seniors.

The seriousness of the closing of the River Vale Manor is heightened by the fact that, it is estimated that there is currently a waiting list of 1300 people who are in need of beds and health care facilities. Therefore, it must be realized

that the loss of one bed, in reality creates the need for two new beds due to the long waiting list that now exists. Due to the critical housing situation, it is imperative that steps be taken, or legislation enacted, to prevent any future closing of residential health care facilities and other senior housing which is desperately needed.

We have invited many members of State, county, and local governments here tonight, and you will be hearing their testimony. What we are doing is transcribing this as a record. It will be given to us in a finished form, and then we will have that at our option to look at to determine that there was nothing that could be done, that maybe there was something that could be done, or that some corrections could be made. So, this is what we are here for tonight.

For the record, I would like to thank Virginia Glessner (phonetic spelling), who is the Director of the Northvale James McGuire Senior Center, for allowing us the use of this facility; also, for the coffee, cake, and donuts here; and also for their hospitality.

For those of you who are not aware of it, this happens to be the Borough of Northvale -- those of you who have come up from Trenton and parts south. I am still Mayor of Northvale up until the end of December. I did not run for reelection this year due to my commitment to being in the Legislature. You are in my hometown, and I welcome you as the Mayor of Northvale, also.

We have a request from Frank Power to be on first. The reason for that is that he has his two young ones with him tonight, and he wants to get them home early. Frank is from the Bergen County Office on Aging, and we will let him start off.

I believe most of the people who are speaking tonight have prepared texts. If you have any extra copies, I believe the press is also interested in those. If you have one copy,

we do have a copy machine, and copies can be made after the hearing. So, thank you very much. At this time, I will turn it over to Frank.

**F R A N K  P O W E R:** Is this on? (referring to microphone)

ASSEMBLYMAN ROONEY: You are being taped, Frank. That is not an amplifier. It is for the tape.

MR. POWER: I will speak loudly, then. My name is Frank Power. I work at the Bergen County Office on Aging. I am one of the planners at the office, and specialize in housing matters.

The closing of the River Vale Manor first came to our attention through Mr. Tim Mauer (phonetic spelling), who also is the Chairperson of our Housing Committee, and runs a boarding home. Early in August, he got a number of calls from distraught residents of the River Vale Manor seeking space in his facility. He called us, and that is how we became involved.

Rather than go through the details of what we did, which was principally to seek information and to find out if there were others -- and we learned that there were -- who were looking into this matter, according to their jurisdiction, we have this testimony, which I will read:

The Bergen County Office on Aging welcomes the opportunity to present its opinion to the Assembly Senior Citizens Committee regarding the closing of senior citizens' residences, specifically the River Vale Manor.

We, as well as all senior citizen advocates, should resolve that traumatic and summary closures of senior citizen residences must not be permitted. State agencies and those responsible for monitoring senior citizens' boarding facilities must not let the sudden closing of senior facilities happen. The closing of the River Vale Manor on August 16, 1986 brought mental and emotional anguish and physical hardship to its residents. It allowed no time or opportunity for consideration of options and choices. It was an unnecessary event that

denied the residents dignity and freedom. The sudden closing could have, and should have been prevented by legal injunction up to 30 days for the time and effort necessary to make reasonable and appropriate relocation.

The Office on Aging received, on November 7, 1986, the report of the State Ombudsman on the closing of the River Vale Manor. It was received by way of a copy of a letter to Commissioner Coye regarding its recommendations pursuant to its investigation.

We heartily second the four recommendations in the letter and report. In particular, we urge that facilities should be kept open by injunction, if necessary, for the full 30 days after proper notice is given to the residents. Ih this way, the needs and desires of the residents can be met, and orderly and appropriate relocations can be achieved. To do less is to trample the dignity, freedom, and individual rights of the residents.

We wish to commend the personnel of the Bergen County Board of Social Services who worked effectively to place the River Vale residents in alternate housing that very day. We note, however, that it was most fortuitous that it was even possible in one day. Normally, vacancies are extremely limited in Bergen County facilities.

Finally, we stress that older adults should never be treated as minors and left uninformed concerning major changes that chiefly affect their lives. Older adults have borne plenty of hardship to have lived so long. When it is necessary, they can adapt to necessary changes when given sufficient time and appropriate assistance. No one, especially the frail elderly, should ever, without warning, have to move from their place of residence in one day. No one, including the owner of the former River Vale Manor, who believes or acts so that seniors do not have the right and dignity to at least 30 days notice, should be allowed to operate a licensed boarding home in New Jersey.

ASSEMBLYMAN ROONEY: Thank you, Frank. I would normally at this time ask for questions from the Committee, but I am the Committee, as it stands. I think there is a question here about it being 60 days notice required. I think that is going to have to come from the Ombudsman's office -- that the State law requires 60 days notice -- but we will get into that with Jack D'Ambrosio.

MR. POWER: That can be clarified. I thought it was 30 days notice to the residents.

ASSEMBLYMAN ROONEY: There will be testimony from the Bergen County Board of Social Services as to the events of that day, also.

MR. POWER: Yes, I anticipated that.

ASSEMBLYMAN ROONEY: Is there anything else at this time, Frank?

MR. POWER: No.

ASSEMBLYMAN ROONEY: Okay, thank you. Thank you very much for your testimony.

I believe the one item that is probably the most encompassing item regarding this whole matter is going to be the Ombudsman's report. As a matter of fact, the Ombudsman's office was involved immediately on that day. They got into the situation, and have done an excellent job of investigation. I believe the only piece of material that is still-- The one piece of the puzzle that hasn't been put in, is the report from the owner of the River Vale Manor. She has been out of the country -- unavailable. I believe there was a subpoena for her appearance at the Ombudsman's office. So, I just mention that. But that is the only part of the report that isn't complete.

At this time, I am going to introduce Mr. Thomas J. McNiff. He represents Mr. D'Ambrosio, Ombudsman for the Institutionalized Elderly of the State of New Jersey Mr. McNiff?

**T H O M A S J. M c N I F F:** Here are some copies of my testimony.

MS. SVEDOSH (Committee Aide): Thank you.

MR. McNIFF: Mr. Rooney, and members of the staff: My name is Thomas McNiff. I am Supervisor of Investigations for the New Jersey State Office of the Ombudsman for the Institutionalized Elderly. Mr. Jack D'Ambrosio, who is the Ombudsman, is currently out of the State, and he has asked me to appear before you to explain the involvement of the Ombudsman's office with regard to the closing of River Vale Manor, a residential health care facility licensed by the New Jersey State Department of Health.

First, I would like to explain that the Ombudsman's office is not a regulatory office. It has no power to levy fines, curtail admissions, close a facility, or otherwise impose sanctions on a facility. Neither does the Ombudsman's office make placements, as other agencies already have that responsibility. The Ombudsman's office is an advocacy type office, which responds to complaints and/or information indicating that elderly residents living in facilities which are identified by statute, are receiving less than adequate care or are not being treated with respect and dignity.

With regard to River Vale Manor, this office, late in the morning of Saturday, August 16, 1986, received information from the answering service which provides coverage of our 24-hour hot line, that River Vale Manor was that date ceasing operations, and all residents had to be relocated. A nurse field representative of this office on duty then made a number of phone calls during the day, and was able to determine that the Department of Health was aware of the situation, that the Bergen County Bureau of Social Services was aware and was responding, and that all of the residents would be relocated before the day was completed.

On Monday, August 18, 1986, Mr. D'Ambrosio requested that an inquiry be conducted to gather all facts concerning the closing. He was concerned with the manner in which the residents had to be uprooted and relocated with such short notice. Additionally, there was information that the facility lacked food, giving rise to the possibility that the closing, approximately two weeks prior to the scheduled closing date, may have been premeditated. The purpose of the investigation was not, and still is not, to cast blame. Rather, the inquiry was to gather facts concerning the closing, determine whether existing regulations were adequate, and, if not, make recommendations for the implementation of new laws/regulations to avoid a recurrence.

As a result of the inquiry conducted by the Ombudsman's office, it could not be determined that the closing of River Vale Manor was premeditated. Rather, the closing seems to have been precipitated by the unexpected departure on Friday evening, August 15, 1986, of the one full-time employee, who according to information developed, worked seven days per week, 24 hours per day, affording supervision at the facility. It was also determined that there was a sufficient supply of food at the facility to feed residents for the remainder of the month.

At the same time, however, inquiry by the Ombudsman's office was unable to uncover any information indicating that the operator of River Vale Manor made any attempt to keep the facility open, subsequent to her learning the morning of August 16, 1986 that her one known full-time employee had left the previous evening. All evidence seems to indicate that a decision was made by the operator that morning to close the facility, and move all residents out that day. It is the belief of the Ombudsman's office that such a decision, if true, callously disregarded the concerns and welfare of the residents. Temporary help could have been obtained, as

evidenced by the actions of the Bergen County Social Services, which that same day, was able to obtain the services of both a nurse and an aide from an agency.

Inquiry by the Ombudsman's office was also able to determine that all residents were relocated on August 16, 1986, either to family or to locations providing a similar level of care. One resident, placed in a facility in one of the shore counties, was unhappy with his placement, because it removed him from familiar surroundings. That resident has since been relocated in an another RHCF in Bergen County. Another resident, who later expressed dissatisfaction with his placement, has also been relocated to a location more to his liking.

During the inquiry, it was determined that the operator of River Vale Manor appeared to have broken several regulations relating to the closing of a facility and relocation of residents. This information was provided to the Department of Health by letter -- October 31, 1986 -- with a request that regulatory action be taken by the Department. It was also ascertained that five residents of the facility, who were relocated on August 16, 1986, believed that money was still owed to them by the operator. However, these residents are uncertain as to amounts, as they kept no records.

The Ombudsman's office has made every possible effort to secure the cooperation of the operator of River Vale Manor, to obtain her account relating to the closing of River Vale Manor, and to determine whether or not funds are owed some residents. On one occasion, the operator spoke briefly via telephone to a representative from this office, but when pressed for specifics, refused to continue the conversation. This office was then referred by her husband to an attorney, who he said represented the operator. The attorney, after several contacts, advised our office that he was unable to reach his client. A subpoena was then issued. A delay date

was sought by the attorney and was granted. Finally, the attorney, on the date of the appearance, advised that the operator could not appear because of illness. A copy of a doctor's certificate to the illness of the operator was received by the Ombudsman's office on November 14, 1986; however, records of the facility promised by the attorney have yet to be received.

Court proceedings have been initiated requiring the operator to appear in court tomorrow -- November 18 -- to show cause why terms of the subpoena should not be enforced.

Generally speaking, current regulations, as the Ombudsman sees them, do provide some protection to prevent what happened at River Vale Manor on August 16, 1986. These regulations require that the Department of Health be given 60 days notice prior to an RHCF discontinuing operations or substantially reducing its operations, and it is also required that residents be given 30 days advance notice of proposed relocation. In the instance of the closing of River Vale, these regulations were not followed. The Ombudsman's office does recommend that the existing regulations be made stronger by requiring that the 30-day notification to residents/families be made by certified mail, and that a caveat be added to the regulations specifically stating it is the responsibility of the operator to maintain services for the residents until the scheduled date of closing.

I have attached a copy of the Ombudsman's October 31, 1986 letter to the Department of Health to written copies of my testimony, which I presented to you prior to my speaking. I believe you will find that letter goes into greater detail concerning the results of the inquiry conducted by this office than my presentation here this evening.

Should there be any questions, I would be pleased to make an effort to answer them.

ASSEMBLYMAN ROONEY: It is a lengthy letter from the Ombudsman's office, but I believe that is why we are here tonight. Perhaps, Mr. McNiff, you could give us some highlights, or synopsize the Ombudsman's letter for the record, and for the audience who is here tonight. Could you go through that for us?

MR. McNIFF: Okay. The statement I just made sort of summarizes it, but I can go into greater detail. The first indication the Ombudsman's office had that the facility was closing was the receipt of a letter of August 6, which was addressed to the Governor and a number of other State officials. It was dated July 27, 1986, and indicated that the facility was intending to close. The reason given for the closing was: "Continued operation of the facility compromises life safety and well-being of our residents and facility interest due to the long delay inherent in coordination of the financing and architectural plans of the necessary life safety improvements."

The letter says (paraphrased): It is my understanding that on approximaely August 7, the facility was visited by representatives of the Department of Health and the Bergen County Social Services, and they found that the facility had not abided by the 30-day notice to residents. The facility was therefore cited.

On the morning of August 16, the operator of the facility, or a resident on the premises, telephoned a number of agencies, including the River Vale Police Department, the Bergen County Social Services, and the Ombudsman's office, advising that she was closing that day because her employees had left. A nurse representative made a number of phone calls, including contact with the Bergen County Bureau of Social Services, and ascertained that they were aware of the situation, and were attempting to assist the operator in making placements.

A representative of our office did not appear personally at the scene that day, because it was not felt necessary since placements were being made. We were also in contact with the State Department of Health. They advised us that they were aware of the situation, and that they were in contact with the Bergen County Social Services.

With regard to information about the lack of food, we could not definitely determine where that information came from, but we believe the phone call was made early that morning by one of the residents to the River Vale Police Department. The statement was made that there was no food. Actually, what I think it really was, was that the food had not yet been prepared, and had not been served. We gained access to the facility about three days after the closing, and the freezers in the basement and in the kitchen seemed to be well-stocked, as was the pantry. According to the cook on duty, whom we interviewed, it was her belief that there was sufficient food to feed the residents until the end of the month.

At the time of the closing, there were 18 residents there, and they were all relocated. Three of them went to a facility that the operator of River Vale Manor operates in the State of New York. Of the other 15 residents, 11 went to RHCFs in the State of New Jersey, and I believe four went to family members. Most of them who left at that time left their clothing and all of their personal possessions behind. Several days later, the operator opened the facility, so that the families and/or residents could reclaim some of their property.

We have talked to as many people as we could who had knowledge of the situation, including former employees. Of the 15 residents who were relocated in New Jersey, we spoke to 11 residents and/or family members. Generally speaking, the comments from the residents and families were that the services provided prior to the closing were satisfactory. There were no big complaints about the care being afforded prior to that date.

I did go into detail regarding the refusal, or the reluctance of the operator of River Vale Manor to make herself available to our office for questioning. Hopefully, that matter should be resolved in court tomorrow.

ASSEMBLYMAN ROONEY: Okay. Mr. McNiff, one of the other things you mentioned in your testimony that came through loud and clear was that there was one full-time employee there on the premises -- Mr. Deloraya, or something like that. I believe he is a Phillippine national who lived there on the premises. He was the one who supposedly sparked this whole situation. He disappeared the night before the closing. It seems he was the only full-time employee, someone who was there not only full-time, but 24 hours a day, seven days a week. That was his function there.

One of the things I would like to hear-- What we are suggesting is tightening up regulations on the 60-day notice and the 30-day notice. But, what about the requirement to have people there on staff? If this is allowed to continue, that someone could have a person there for 24 hours a day, seven days a week-- I would think that this would be part of the licensing requirement -- that you have staff available. We should lay down the rules, and say what type of staff should be available, and who should be there, as a minimal amount of care. Something like this shouldn't happen again.

This is what disturbs me. This is almost like slave labor, when you have one person there 24 hours a day, seven days a week. That concerns me. That factor of it concerns me. You mentioned the licensing. I would think that is more pertinent.

MR. McNIFF: Well, the matter concerns Mr. D'Ambrosio, too, and it is a matter we are still looking into. That is one of the reasons we are subpoenaing records, to find out, first of all, what was her exact census, and how many employees she had. Now, the Department of Health regulations require that a

facility having 24 or more, has to have 24-hour awake supervision. River Vale Manor was licensed for 26 beds.

ASSEMBLYMAN ROONEY: Right.

MR. McNIFF: If that was true, it should have had 24-hour awake supervision. However, in speaking to the Department of Health, nurses who did the investigating said that if the facility had less than 24 occupied beds, they did not consider it as needing 24-hour awake coverage.

As far as the Ombudsman's office is concerned, the statute is not worded that way. It says that if a facility has a license for 26, it needs 24-hour coverage. It does not address the fact of whether it has 10, 15, or 20 residents. So, we are looking into that.

ASSEMBLYMAN ROONEY: I think your report could be amended then to include that information for our Committee, that the licensing of 24 beds-- I have gotten correspondence from Mrs. Such. It was rambling correspondence. We have some copies. It was patched together.

MR. McNIFF: I think I have seen it.

ASSEMBLYMAN ROONEY: Yeah, I think you have. I turned it over to Jack D'Ambrosio. She claims she had 24 beds, but only 18 were filled at that time. So, I don't know, with a 26 license-- She was under the impression she was licensed for 24 beds. Now, again, that is a question we are going to have to resolve.

MR. McNIFF: Another reason we didn't address it, Mr. Rooney, is because in talking to the residents, it really was not clear as to whether or not there were part-time employees coming in. There were a couple of other names mentioned to us as people who did work at the facility. However, we were unable to locate them. The reason we held off on it was, we were waiting to see what her records show as far as disbursements to employees go, and will try to ascertain it that way.

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ASSEMBLYMAN ROONEY: And we're still looking for Pat, right? (referring to Mr. Deloraya)

MR. McNIFF: Oh, no, we located him in the State of Washington.

ASSEMBLYMAN ROONEY: In the State of Washington?

MR. McNIFF: And we interviewed him.

ASSEMBLYMAN ROONEY: That is about as far away as he could get.

MR. McNIFF: We interviewed him in detail.

ASSEMBLYMAN ROONEY: Okay, very good. Let me introduce my Vice Chairman, who came up all the way from Lakewood, New Jersey.

ASSEMBLYMAN SINGER: I left yesterday.

ASSEMBLYMAN ROONEY: Now you know how it is for me to get to Trenton. Bob Singer, I really appreciate your coming tonight.

ASSEMBLYMAN SINGER: Thank you. Excuse me for being a little bit late, John. Again we ran into a lot of traffic.

There are just two points I want to share with you. Number one is, I have a big problem with the certificate of need process that goes with the Department of Health for any of these residential care facilities, namely because I am Mayor of a town that has many of these residential care facilities within it, and I understand some of the problems. Too many times, the Department of Health certifies them and that's it. Then they walk away from the problem. I think that is something we are going to have to address at some later date.

Also, my concern is, recently in the State Assembly, we passed a bill about dog pounds; that if an owner is arrested, we immediately go in there to protect the rights of the dogs, and make sure that they are fed and taken care of. I would think that in the same case here, why doesn't the State step right in immediately and, not push people right out, but operate the facility until things can be analyzed and they can

look and see what the best interests of the people are? These are the forgotten people of the State too many times. I think if we worry about dogs, which is a wonderful cause-- But I am more concerned about people. I think that is the kind of thing we have to look at, also.

MR. McNIFF: Department of Health regs do say that anyone convicted of a felony cannot operate a health care facility. If she was convicted -- and I am not aware that she has been convicted of anything as yet-- I don't know whether the Department of Health could act on that at all.

ASSEMBLYMAN ROONEY: I understand that she was there, and she was trying to place those people that day. Most of the placement was done by her. I have to give here that much, because I know that from personal experience, that she was there. She had tried to place some people prior to that. She did place them in her own facilities elsewhere, so she's not all bad.

I think we are getting off the track here. What we are trying to do is find out how we can prevent this from happening again; not how we can blame someone for something, but how we can prevent it from happening again, by giving some rules and regulations, and some legislation, if necessary, enabling you to do your job and all of the departments to do their jobs properly.

One of the things I have seen -- and this is probably another example -- is that the Department of Health may not belong in this. Maybe it should be in the Office on Aging, because Aging comes under the Department of Community Affairs, and Community Affairs regulates housing in the State of New Jersey. So, I think perhaps this may be a very good case for having the Office on Aging doing some of this, in conjunction with DCA. It's a possibility.

ASSEMBLYMAN SINGER: You know, John, where my concern comes into this is, we house the largest residential care

facility in the State of New Jersey in my town. It has 246 beds. If tomorrow the owner closed its doors-- You're not going to be able to place 246 beds like you did 18. There has to be authority for the State to step in and operate that facility until things can be done. Maybe we have to find out who is going to take that responsibility. Someone has to be able to step in and do that.

ASSEMBLYMAN ROONEY: Absolutely. I think that is our purpose here tonight.

MR. McNIFF: I agree with you.

ASSEMBLYMAN ROONEY: Thank you very much, Mr. McNiff. We appreciate your testimony.

MR. McNIFF: Thank you.

ASSEMBLYMAN ROONEY: Anything you might add after Mrs. Such comes forward-- We would appreciate hearing that. We would appreciate anything there.

I am going to take this in the order on the witness list. Linda MacLellan, Administrative Supervisor, Bergen County Board of Social Services?

**L I N D A M a c L E L L A N:** Assemblyman Rooney, Assemblyman Singer, and staff: Simply put, the purpose of the Rooming and Boarding House Act of 1979 is to help to ensure that residents are being cared for appropriate to their level of need; that complaints of abuse, neglect, or exploitation made by, or on behalf of residents, are handled expeditiously; that the two Departments in the State that are mandated to be responsible for boarding homes and residential health care facilities -- that is, the New Jersey Department of Community Affairs and the New Jersey Department of Health -- will ensure that all facilities in the State meet strict licensing requirements, and that the 21 county Boards of Social Services will provide social services to those residents who need, or request them; that those services are appropriate and available.

The Bergen County Board of Social Services realizes the limitations of this law. We also recognize that no law can prevent an owner from closing a facility. However, the Bergen County Board of Social Services agrees with Jack D'Ambrosio, the Ombudsman for the Institutionalized Elderly, in his recent letter to Molly Coye, Commissioner of the New Jersey State Department of Health, where he made the recommendation that the Department of Health, the agent of the State which licenses residential health care facilities, give consideration to new legislation, or changes in their existing regulations, in three areas:

1) When a facility intends to close, notification of such action has to be given to both the Department of Health and residents and families by certified mail.

2) When the notice is given, it is the responsibility of the facility owner to ensure that personnel is there and services and supplies are available to maintain the operation of the facility.

3) That the Department of Health circulate to all of the facilities and appropriate agencies, a telephone number at which a representative of the Department of Health can be reached during off-hours.

ASSEMBLYMAN ROONEY: Good suggestions. I appreciate your input. Any questions from the Committee?

ASSEMBLYMAN SINGER: Do you mean from south of the border? (laughter)

ASSEMBLYMAN ROONEY: Thank you very much. Barbara Parkoff, from the staff of Division on Aging? Is Barbara here? (no response) Did she get lost somewhere between here and Trenton? Okay, Mary Bentivegna, from the staff of Division on Aging? (no response) I guess it is too far from Trenton to come up.

Is there anyone else here who hasn't signed in, who has testimony to give at the present time? (no response)

ASSEMBLYMAN SINGER: John, I would just share one thought with you, as an aside to this, that people here might be interested in. I was with Commissioner Altman and Commissioner Coye about two weeks ago. As I said, my town houses 95% of the residential care facilities in our county. And, having many of the problems with that which many of the towns share, we have some grave concerns.

There is a recent bill placed by Senator Lynch, which is going to involve itself with the siting of residential care facilities within municipalities. It is going to be worked on, I'm sure, and we will be doing so in the Assembly. But it is important for all of us to take a look at how the siting of these facilities are determined. Again, I have some grave concerns with the way the Department of Health handles things. For example, they just approved a residential care facility in our town, and they never physically went out and looked at the site. They have never been to the site. It is on a major highway. It is a former hotel which is probably 65 or 70 years old. To the best of our ability, from our Inspection Department, we do not know how it will ever conform to the modern codes, yet this is not a concern in getting that certificate of need.

I have asked them to reconsider their whole process of how a certificate of need is granted for these facilities, and to make an on-site visit. Also, the fact is that during that process, at no point, is the local municipality or the county asked for their input, which again I think is a wrong thing. Unfortunately, because of the low paying funds per resident in these care facilities, it is not economically sound for people to build new facilities. So we see the conversion of former boarding houses, hotels, and things of that sort. Unfortunately, because the shore areas -- whether it be Asbury Park, Lakewood, or Atlantic City -- have these old hotels, they are perfect areas for them to be relocated.

I think we do a disservice to these people the way it has been handled. I think we are going to have to reevaluate what the costs are, and make it at least to the point that new facilities should be built. We don't want to fight new facilities. We realize we all have a responsibility. But also the fact is, I have some big problems when we convert former hotels to these types of facilities.

The last point I would like to make is, the Department of Human Services, under Commissioner Altman, is also lacking in responsibility in one sense. They place these people in municipalities, but do not give you the backup services needed. This is an expensive entity. These people need services seven days a week. Too many times, we find in our town, that come Friday, they are locked in the facility, and that is what happens for the entire weekend. It's wrong; it's not justified. I think certainly we are going to have to take a hard look at that.

I just wanted to share those comments with you, Mr. Chairman.

ASSEMBLYMAN ROONEY: I appreciate that. One disappointment I have, is that the Department of Health did not come forward to speak on this, because a lot of the involvement here hinges on the Department of Health's reaction to this, or inaction, on the particular matter.

There is a letter here dated October 8. I might as well read it into the record, because it is from the Department of Health. It is the only correspondence we have. It is from Paul Langevin, Assistant Commissioner, Division of Health Facilities Evaluation. It says:

"In response to your request, please find attached a brief history of recent events at River Vale prepared by the Division of Health Facilities Evaluation. You had expressed some concern regarding the Department of Health forcing premature closure of the home, and thus not allowing ample time

for the residents and their families to find alternative arrangements.

"As you can see from the summary, this was not the case. While we were monitoring the facility to assure that no hazardous conditions arose during the phase-out period, at no time did we even intend to accelerate the closure process. We always try to effect an orderly and well-planned closing, to minimize the effect of the move on the residents.

"I hope that this documentation clarifies the circumstance surrounding the closure at River Vale. If you have any questions, please feel free to contact me." And there is a phone number.

Some of the surveillance: "River Vale Manor RHCF, 11/1/84, Annual Operational Survey: Time records did not accurately state employee duty hours." That is one of the questions we have. "The facility was cited for noncompliance regarding physical environment maintenance. This was evidenced by 13 areas cited throughout the facility. Health maintenance and monitoring policies and procedures were not available.

"January 14, 1985: Complaint from Ombudsman regarding insufficient amounts of food and nutritionally inadequate meals.

"February 4, 1985: Complaint, investigation, and reinspection survey. Not all food items on the week's menu were available. Menus were not posted; therefore, residents could not request substitutions. There is a 14-1/2-hour span between the evening meal and breakfast. Evening snacks were not available.

"March 15, 1985: Surveillance visit. Physical environment deficiencies continue. Span is still 14-1/2 hours. Special meeting with Bergen County Welfare Office regarding resident problems.

"April 1, 1985: No deficiencies.

"April 18, 1985: Interdepartmental meeting regarding dietary deficiencies.

"May 29, 1985: Surveillance visit. Menus recorded included inadequate portions.

"June 4, 1985: Food problems resolved following hiring of management consultant team.

"August 1, 1985: Complaint investigation regarding destruction of residents' personal property. Resolved with Bergen County Social Services.

"November 18, 1985: Operational annual survey. Resident inebriated; verbally abusive to other patients. Patient information not in register. Current medical certifications for three residents not available. Physical environment maintenance not in compliance; evidenced in eight areas. Cleaning schedule for kitchen and food area was not available.

"January 6, 1986: Reinspection. Physical environment maintenance not in compliance in four areas. Health maintenace and monitoring assessments were not complete.

"June 12, 1986: Complaint investigation. Two fire escape beams rotting. Second floor emergency light not functioning.

"July 7, 1986: Revisit. Items not corrected.

"July 14, 1986: Fine warning issued based on 7/7/86 revisit, and giving the facility until 8/15/86 to submit architectural plans to the Department of Community Affairs for sprinkler system, or be subject to a fine." At this point -- 7/14/86 -- I just want to insert that this is July now, one month before the closing. Sprinkler systems, probably, in a building of that magnitude, are in the neighborhood of $100,000 or so.

"August 7, 1986: Joint visit with Bergen County Board of Social Services. There were three deficiencies in housekeeping maintenance; one emergency light that was lit, but very dim; painting needed; wallpaper pealing in one area. Additional deficiencies given to failure to provide 30-day

notice of closing of the facility to the guests. Operator reported the facility would be closing at 8:30, and residents had not been notified as of 8/7/86.

"August 16, 1986: Operator called Bergen County Board of Social Services and stated that someone had pirated her staff." The staff was one person at this time. "The Board of Social Services found 18 guests at the facility without staff or food." This is again a misinterpretation. The food was there. "Residents were relocated on 8/16/86 by the Bergen County Board of Social Services, and the operator closed the facility as of that date."

So, there is a lot of misinformation that has been passed back and forth. We are trying to determine what happened, why it happened, and how to prevent it, and that is the purpose of this hearing. And it has brought us pretty much full circle. I would have preferred the Department of Health be directly involved here, because a lot of this information comes from their records. I am disappointed that they didn't come. We didn't hear that until today. A lot of it hinges on them. They shall hear from us. You can be sure of that. They were a major player -- as it is called -- in the events of that day in that particular month, and I definitely want to find out what the real story was.

Again, we are concerned -- the Assembly Senior Citizens Committee -- with housing of all types. One of the most critical needs in the State of New Jersey is housing, not only for our seniors, but for all of our residents. We have a big problem on affordable housing of any type. Seniors are probably more vulnerable to that situation, I think. The waiting lists for nursing beds, or even for this type of a facility, are immense. I think the total is what, 55,000 looking for beds in all areas of senior citizen housing? Is that what it looks like now? (no response) We had some numbers on that from one of our Committee meetings on housing

for seniors. That is a staggering number. We can't afford to lose any of them.

Are there any comments from my Vice Chairman?

ASSEMBLYMAN SINGER: No, sir.

ASSEMBLYMAN ROONEY: Are there any comments from the public at large, or would anyone else like to be heard? All right, from this side? (in response to affirmative answer from audience) May we have your name?

**N A O M I F I S H M A N (speaking from audience):** My name is Naomi Fishman. I am a Supervisor at Bergen County Board of Social Services, and I was there that day--

ASSEMBLYMAN ROONEY: Right.

MS. FISHMAN: --the day that River Vale closed. What I am bringing up is the general-- You said something about the Office on Aging taking something over, rather than the Department of Health, etc. You must remember that many of the RHCFs not only have elderly, but many from the deinstitutionalization. They are connected with a mental health center. They go to day programs, or they are monitored through them. So many of the RHCFs throughout the State have these people primarily as their clientele. So, you have more than just an elderly population. You have a population that has been deinstitutionalized, and they have many problems.

ASSEMBLYMAN ROONEY: We're having a hard time recording your comments.

MS. FISHMAN: All I am trying to say is that many of the residents of RHCFs are deinstitutionalized patients from mental hospitals. They are not necessarily the elderly.

ASSEMBLYMAN ROONEY: Okay, I appreciate your comment.

Why don't you come up to the microphone. It would be a little bit easier. (addressed to next person wishing to speak)

**M A R C E L L A S T U D E N T:** My name is Marcela Student. I am a resident of Northvale. Assemblyman, my question first

is-- It is kind of a twofold thing. First of all, there is a 30-day notice, as you have said. Since it is so difficult to place people, don't you think 30 days is kind of short? I feel maybe they should get 60 days, and perhaps the State 90 days, since availability is such a problem.

ASSEMBLYMAN ROONEY: Well, the 60 days is on a closing; they are required to give 60 days on a closing. On a transfer, they have to give the resident 30 days notice. If they were transfering a resident from one facility to another, there would be a 30-day notice requirement to that resident that they had already found someplace -- that would say they had already found someplace, and, "You have 30 days, and we will place you within that 30 days."

MS. STUDENT: In a case like this, where they weren't able to find anyplace, don't you think 30 days was kind of short? I mean, for covering incidents like this--

ASSEMBLYMAN ROONEY: Well, this wasn't even 30 days. This was only about 12 days.

MS. STUDENT: I don't think they even got two weeks.

ASSEMBLYMAN ROONEY: Twelve days was what it came to.

MS. STUDENT: And then the other part is, when you have a situation like this, I feel the State should have -- or the county -- the power to more or less seize that building and take care of those people.

ASSEMBLYMAN ROONEY: That is what we are looking at. The State should step in. We are trying to determine which agency.

MS. STUDENT: That is just what I would like to recommend to the Committee. That is my personal feeling. Thank you very much.

ASSEMBLYMAN ROONEY: Thank you very much, Ms. Student. There is a familiar face right over here, I think. Would you like to come up, young lady? May we have your name and who you represent?

**M A R T H A  R O O N E Y:** My name is Martha Rooney. I happen to be related to the Assemblyman. I also happen to be the daughter of one of the residents who was at River Vale Manor. He was there for approximately 10 years.

ASSEMBLYMAN ROONEY: Nine.

MS. ROONEY: Seven years? It was an extremely long period of time. First of all, I would like to set the record straight on one thing. There were many part-time employees. They had kitchen help; they also had cleaning people. There were, at any given time, approximately three people living on site, one of them being Pat, the gentleman who has since moved to Washington State.

The staff itself were very caring of all of the people there. In particular, I will give you one very small example. My father dislikes Italian food. On the day they served Italian food -- which was once a week -- they always made sure there was something for him, rather than the food he disliked. When he wasn't well enough to get to the table, they always provided his meals in his room. So, there was this caring attitude by the people working there.

The day in question that the house itself closed-- I think at this point it has been determined that the timing was completely inadequate, because we, as family members of someone living there, received notice on August 2 that they were closing on August 30. Unfortunately, we happened to be going away the following day for a week, so I was not able to start making arrangements right away. As soon as we got back, I did start making inquiries in the area for similar facilities, and found that there was nothing available.

During that week that we were away, there were quite a few beds open, and some people did make arrangements. One of them went into the facility mentioned that is owned by Mr. Mauer in Park Ridge or Montvale. I am not even sure at this point.



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The number of beds available in this area is inadequate. After I realized there was going to be a problem, I started investigating them. Some of the facilities are extremely nice; extremely expensive. The ones that were in my father's price range-- Some are deplorable. I did not think that River Vale Manor was a particularly nice facility, but it was conveniently located. I was in and out of it many times during the week. Every two weeks I stopped by, and I always stopped by at different times, so there was no such thing as going in at a given time when things were being very well cared for. I was there almost around the clock.

The homes still within Bergen County-- There are some which are deplorable, and they should be investigated. If anyone is interested, I can give you some names of places that should be looked into.

I am trying to think of some of the other points I wanted to make. The day the place closed, I can't tell you the turmoil I found when I arrived shortly before 11 a.m. We got a phone call about nine o'clock, stating that they were going to close the doors that day at noontime. I immediately got over there, and I found people in tears, completely confused, because there were many childlike people living there, in addition to people of my father's caliber. He is slightly invalided, but very sharp as far as his mind goes.

The woman, Mrs. Such, took no consideration of anyone there that day. She just literally told people where they were going to go, and then physically helped to pack them and move them out by cab. Family members were notified, "Come get your family member." One gentleman made at least 20 trips back and forth, just loading his mother's belongings into a car. Unfortunately, there were only four family members who actually came and took people out. The rest of the people just wandered around. They did not know what was happening. There was one gentleman there who was in his 90s, and he was extremely

childlike. He was just placed in a cab. He had no idea of where he was going, why he was going, or what was happening. Most of the residents seemed to take just about all of their belongings.

There were also questions about deposits, because everyone had to put one month's deposit. I don't think most people were even aware of the fact that they had deposits going. There was one incident that I found particularly distressing, because I am a member of the Board of the Community Center for Mental Health, and there were three clients of the Mental Health Center who had been placed at River Vale Manor. One of the members was taken by her family. The other two were sent to Lakewood. When I was told -- or when I overheard them and found out that these people were going to be sent down to Lakewood, I informed the woman from Bergen County, "Do not move them from this area. They are undergoing treatment, and it is extremely difficult for clients to be taken away from the things they know." There seemed to be no regard about this. I gave them the name of the psychiatrist on staff, who has always been extremely responsive. They do have a crisis center through the Mental Health Center. They could perhaps have placed these patients in the area so they could continue treatment. It was not done, and I was very distressed about this.

I made my views known to more than one person that day. I don't understand why a staff was not brought in. It would have been easier on all of the people there. I found it very traumatic for my father, for my family, and for everyone I saw there, and I stayed from before 11 a.m. until approximately six o'clock that day. I can't tell you how upsetting it was for me to watch what happened.

I know there were other points I was going to make, but I am getting a little upset even talking about it. So, if there are any questions anyone would like to ask me, I would be happy to answer them.

ASSEMBLYMAN ROONEY: Thank you, Ms. Rooney. I think Social Services is going to have some questions for you. Ms. MacLellan, could you please come up to the microphone, because we won't be able to get you on the record otherwise.

One of the things I want to stress right now is, I know Social Services has a letter from me, which was a confidential letter, by the way. No one else got any copies. There were some questions back and forth as to what happened. There was a time lag, which shouldn't have been. This was, I think, one of the critical items. From nine o'clock in the morning, when we were notified, I don't think that Social Services got there until after three. This was a major problem, because that is when a lot of this turmoil occurred.

MS. ROONEY: The turmoil took place prior to three.

ASSEMBLYMAN ROONEY: That's what I'm saying. Between nine a.m. and three p.m. was when the turmoil occurred, because there was no direction there. What probably should have happened -- and this is going to be a lesson for all of us; we will learn from this-- It has to happen immediately. Someone has to get in there, whether it is local officials -- local health officials, local social services-- They have to get in quickly and take charge immediately. That is part of the thing we are trying to find out, isn't it?

We are not looking to assess any blame. I said that before. We want to see how we can prevent it in the future, so we will all know how we can do a better job. I just wanted to make that clear, Linda.

MS. MacLELLAN: I have a synopsis of the events of the day from our perspective, with our time frames, which we can verify, which I will get into later. I just wanted to make a comment on Ms. Rooney's comment that we did not seem to have any regard for the two individuals who we knew had been receiving treatment at the Community Center for Mental Health.

That afternoon, Ms. Fishman and I, placed several calls to the emergency number of the Community Center for Mental Health, trying to seek placement at one of their transitional residences for the two people who were still at River Vale Manor, who had been receiving services at the center. At your suggestion, Ms. Rooney, we asked specifically to speak with the doctor who is the psychiatrist at that center. All of those calls were returned by an emergency worker from Community Mental Health. He was very sympathetic; he was very understanding. But he was unable to negotiate placement for us. Otherwise, we certainly would have placed those two individuals at a transitional residence. Had we known that places were available, we would not have had to send them out of the county to Lakewood.

As far as the time frames go, our first call was at approximately nine o'clock. At that point, the caller stated that there wasn't any food; that the residents had not been served breakfast, and there were no employees available to care for the residents. But you have to understand that we pay for, we purchase -- we are one of the few counties that do this-- The County Board of Social Services purchases a 24-hour, toll-free hot line to accept reports of abuse, neglect, and exploitation. The service is part of what we call our "Outer Intervention Project," which is a pilot program -- State-funded -- to provide protective services to vulnerable individuals. The responsibility for the hot line is shared between us and another agency in the county, which is the Protective Services Program for the Frail Elderly, which is funded through the Bergen County Office on Aging.

On that day, Protective Services for the Frail Elderly was on primary duty, and we were the backup. I happened to be the backup person. The first call came at nine o'clock on that day. Protective Services for the Frail Elderly was the person receiving the call. They contacted me, and then we called

River Vale Manor. We found out that the owner was on her way to River Vale Manor. We did not know if she-- If she was already there, we were not informed of that.

MS. ROONEY: She wasn't.

MS. MacLELLAN: She wasn't there?

MS. ROONEY: She got there about a quarter to eleven.

MS. MacLELLAN: Yeah, a quarter to eleven was when I received another call saying that the owner was closing the facility that day. That was my first indication that the facility was being closed.

I called her immediately. I called Mr. Such immediately. She had told me that her employees had walked off the job, and that she was closing. I told her that I thought that she should try to get temporary help from a temporary agency, such as a nursing service, or whatever, to keep the place open. I offered her help in that area. She was adamant about her decision to close.

At that point, she gave me a list of about 12 people who she said needed placement. It was a Saturday. I did not have the record for River Vale Manor right in front of me. I did not know exactly, and I couldn't remember offhand, how many people she was licensed for. I took the names of those 12 residents, and I started to make calls myself to some of the same places that she had already called, or had had one of her staff call. I think a friend of hers was there helping her to make placements. And I called the Director of the agency to try to provide direction on how we were going to proceed.

It was shortly thereafter that I heard from you, Assemblyman Rooney. We talked about the need for a judge to hear this matter and to get an attorney, and you referred me to the Bergen County Prosecutor's office. Well, to get to the Prosecutor's office on a Saturday, one needs to go to the Bergen County Police and wait for someone to call back. By the time the person from the Prosecutor's office called me back,

our Director, Ed Testa, had alreary gotten in touch with our own staff attorney, who was also trying to get in touch with a judge to hear this matter, and that staff attorney was on his way over to my house, so we could write up the complaint, have it signed, so the attorney could hand deliver it to the judge, wherever he was, to have him sign it.

When the Prosecutor's office got back to me, they basically said they would try to locate a judge, as well, but they cautioned me that the matter was beyond their purview because it involved a civil, rather than a criminal complaint. So, you know, I don't know exactly where that would have gone.

ASSEMBLYMAN ROONEY: Well, I think I mentioned to you at the time that there had to be a notification period -- that they were in violation of that. That I was sure of. There was no question in my mind that they did not meet the requirement for notification. I didn't think it was civil; I think at that point it was the State law, which says they must give that notification. The State should have stepped in, or some agency of the State should have stepped in -- or a county agency, or whatever was necessary. That should have happened. That was my opinion. I could have had a judge that day and could have had that injunction done very quickly. We were corresponding back and forth.

These are things we are all learning from this. This is something we are trying to do -- to find out how we can do it better. Hopefully, it will never happen again. We don't want to have something like this happen, where the elderly are put into a situation where it is total turmoil, as it was that day. Even my father-in-law, who is a pretty strong and ornery cuss, to say the least, was visibly upset by the whole situation. That is not like him. He would never show that.

MS. MacLELLAN: I was just trying to get the time frames--

ASSEMBLYMAN ROONEY: If you have a copy of that (referring to notes Ms. MacLellan is using), I would appreciate having it for my record. Also, I think on your testimony earlier, I don't think you left a copy of your testimony. It would help our people in transcribing it -- very much so. So, we would appreciate that. I think the press also wants copies of your original testimony. But that I would be concerned with, because we have some differences. I don't think it is going to make any difference at this point, as far as time frame. What we are trying to do is correct it for the next time.

MS. MacLELLAN: All right. I just want to make the point, though, that Ms. Fishman was working from her home this whole time. I was working from my home, trying to contact facilities in and around the State. We were trying to get in touch with Fred Hebeler, from the Department of Health, to try to see what his Department was going to do, because he represents the regulatory agent here. He is the licensing agent. We wanted to know whether his Department was going to seek an injunction to keep the place open.

ASSEMBLYMAN ROONEY: I was working from home that day, too, and my wife was down at the facility.

MS. MacLELLAN: When I arrived at the facility at 3:30, I had already typed the restraining order so we could get it signed by the judge. I had also tried to make as many placements as I could from home.

ASSEMBLYMAN ROONEY: I appreciate that. There are probably some things we could suggest to local officials -- local elected officials -- or the police departments, in the future, whereby they could be empowered to act on behalf of the State agencies, you know, as municipal officials. These are some things we can look at. The police were there at nine o'clock in the morning. They should have been able to say, "Wait a minute, you can't do this." They should have been in

direct contact with-- At nine o'clock in the morning, we were told, in no uncertain terms, that she was closing that day. The police already knew about it at nine o'clock in the morning. So, there is some problem there. The local officials should have been in touch with county agencies and State agencies to say that that shouldn't happen.

MS. ROONEY: I can clarify that, because I did speak to the police officer. He was on-site for quite a while, and then when he had to start patrols again, he kept checking in. The police had notified everyone. With all of the calls they made, I am sure they were in touch with your office and with all of the emergency numbers. But the police officer told me that he had no power whatsoever. He could do absolutely nothing, but keep order.

ASSEMBLYMAN ROONEY: Well, that is possibly an area we can look into. I think someone else has a comment. Would you please come up, Ms. Fishman, to the microphone?

MS. FISHMAN: I feel I have a right to say something, because I was there that day. It was utter bedlam when I got there. I walked in from shopping at about 12 or 12:30, and I received a message that Ms. MacLellan had called me twice. I called her back, and found out what the problem was. I got on the phone, called River Vale, got some home numbers, but I could not reach half of the relatives -- could not reach most of the relatives. I think I got one.

ASSEMBLYMAN ROONEY: Just for the record, this is Ms. Fishman again.

MS. FISHMAN: I am the Supervisor at the Bergen County Board of Social Services. I called Mr. Hebeler. I called Linda back. The calls just went on and on. Finally, at about 1:30, I decided that I was getting nowhere. I was making phone calls and not reaching the relatives. I decided to go up there to see what was happening. I went up there, but I got lost, I'm sorry to say. I live in Teaneck. I took the wrong route, and ended up, you know--

ASSEMBLYMAN ROONEY: In Northvale, probably.

MS. FISHMAN: In Northvale, right.

ASSEMBLYMAN ROONEY: You can only find this place when you are lost.

MS. FISHMAN: I estimated that I got there about 2:30. My timing may have been off because of getting lost. When I got there, there was utter bedlam. She handed me-- We have a list of residential health care facilities in the county. She handed me the list, and she said, "Oh, here. These four are going to" -- I'll just use the name Tarlton (phonetic spelling) House, which was one of them -- "Tarlton House." No, Mrs. Tarlton called, and Mrs. Such said, "Oh, here, she's taking four." I got on the phone, and Mrs. Tarlton said, "I am not taking anybody from there. That place is an abomination, and I am not taking anybody from there." This is the way the whole thing began. These four who were supposed to go there, weren't going there. This one who was supposed to be going here, wasn't going here. This one who was supposed to be placed, wasn't placed. After all was said and done, we ended up with five SSIs and one private pay who didn't have any family we could contact.

Linda called facilities. All of the facilities in the county were exhausted. We could not get these SSI residents in anywhere. She called facilities in Morris County; she called facilities in Passaic County. We couldn't get anywhere. It was only because someone had called me from Lakewood -- someone who owned a facility in Lakewood once -- to tell me that she had openings for SSI recipients. Because she had done that, I had it in the back of my head, and when Mr. Hebeler called, I checked to see if it was, indeed, a licensed residential health care facility. It was. We knew early on that she had openings, and we knew that would be a last resort. In the meantime, we called all of these others. We did it because it was a last resort.

In terms of the Dumont Mental Health Center -- the Community Mental Health Center -- I put a call in to them. I was well aware that we had people there. They certainly didn't want to go to Lakewood. They did not. I am not going to say that they wanted to go. This was where their lives were. There was no way we could find-- They responded, but no one from the day program called me. I put in a call later on in the day, because when we knew we were sending them to Lakewood, I had to have their Medicaid numbers. Not all of their records were so straight there. We didn't have all their numbers. Some of them had their numbers; some of them didn't have their numbers. We knew they were on medication, and we knew we needed a Medicaid number for them to continue getting the medication once they went to Lakewood.

We waited. I put in a call to try to get the nurse, to try to get the doctor, in order to get the Medicaid number, if for nothing else. That did not come through until Monday morning. The first thing I did when I got in-- I gave one of the workers the number, and I said, "Call, and make sure they call this Lexington Rest Home and get the Medicaid numbers there. And that was it. It is probably the big one you're talking about. It has 265 beds.

ASSEMBLYMAN SINGER: Yeah, it is.

ASSEMBLYMAN ROONEY: This is the Mayor of Lakewood.

ASSEMBLYMAN SINGER: It's not the end of the world coming to Lakewood, as the Mayor of the town.

MS. FISHMAN: No, but I know they were displaced, and two of them have since come back. One finally went into a transitional residence; the other one went into another facility up here. We had to pay, for one of those people-- Oh, I don't know if this was mentioned. You may say she is not all bad (referring to Mrs. Such), but she stopped the checks on many of these people. She stopped them on the most vulnerable people. She gave them back the checks, but when they went to

deposit the checks, they had been stopped. Those were the people she stopped them on. She didn't stop them on the private pay. She didn't stop them on your father-in-law, because she probably knew she would get into more trouble. But she stopped them on the little man who was a day patient.

So, we ended up-- When a person is on SSI, we do have the right-- It is a situation over which they had no control and opportunity. We paid the woman in Lakewood. We sent money out of petty cash for them to have cigarettes, to get a candy bar, or something, so they were able to manage until such time as they got their checks again.

ASSEMBLYMAN SINGER: There is one other thing that was brought up that is another valid point that is an offshoot of this. Unfortunately, in these facilities, there is no quantity, for example, of releasees from deinstitutionalization, so proportionately a senior citizen who is fine, but who needs some kind of a place to stay, can be thrown in amongst a large percentage of deinstitutionalized people.

MS. FISHMAN: No question about it.

ASSEMBLYMAN SINGER: That is part of the travesty of the whole thing, because the deinstitutionalized people in these facilities need special care. That is one problem, as opposed to the senior who needs other care. There is not enough money nor services. You know, there is no requirement anywhere that they have a social worker on staff; that they have a recreational person on staff. You cannot imagine the size of a 250- or 260-bed facility. You walk into a smoke-filled lobby. One of the largest activities of the day is either smoking or waiting for the next meal. It is really a travesty. And that is not knocking the operator, because the place is clean and modern. It's not that, but I think the backup services, all the things that make life nicer, are missing in many of these cases. There is no requirement that they be there.

MS. FISHMAN: But, most of the people who are in the RHCFs who are deinstitutionalized are the SSI recipients. They get very little. I am not, you know--

ASSEMBLYMAN SINGER: Exactly right. You are 100% right.

MS. FISHMAN: The operator does not get much money to take this person in. If you go into the boarding homes, the RHCFs that are on the upper end of the pole, which run maybe $2000 or $3000 a month, you will see every kind of arts and crafts and every kind of service available. But, when you are getting $464 a month, and you have to monitor their medication, that's a different story.

ASSEMBLYMAN SINGER: There is no question about that. That is why they have to serve cheese sandwiches, and things of that sort. Again, there are certain understandings about that, but that is part of the problem. That is why no new facility can be built, and they have to go to the conversions of the older facilities. And that is part of the problem -- the money available. There is no question about that.

MS. FISHMAN: This closing happened because she just pulled out, or her staff pulled out, or whatever the real reason was. But, fortunately, we haven't had a fire, which many of them down in the south have had.

ASSEMBLYMAN SINGER: Thank God, not in Lakewood. But, you're right, down the shore there have been--

MS. FISHMAN: No, but with that last minute sort of thing, they will shove them anywhere, and into anything, because they have to house them.

ASSEMBLYMAN SINGER: You know, the standards change from county to county. Don't think it is set throughout the State. When the State has to, it looks. If a place is overcrowded and they have to look the other way, they do. That is a fact that is also a point. It is not uniform throughout the State. They do bend when they have to.

ASSEMBLYMAN ROONEY: Right. Thank you, Ms. Fishman. Ms. MacLellan, another comment?

MS. MacLELLAN: Just this past week, I was at a meeting where a Department of Human Services' representative, Tom Naughton, was speaking about the need for an increase in the rate of SSI. The Department of Human Services was asking the Department of Health, to no avail, for some figures on what they would think would be an adequate amount of increase for the SSI supplement. They came up with a figure of $30 per month as a cost of living increase. Well, we all know that $30 in really quite inadequate, especially in this county, for anyone to operate a RHCF. I just offer that as a comment. We should look into that a little bit better.

In addition, the Department of Human Services is also looking into the fact that boarding homes -- not RHCFs, but boarding homes now -- do not receive any supplement for their SSI residents -- none. They are looking into whether or not boarding homes should be receiving some type of supplement. That is a very difficult problem, because the boarding homes in this county are running approximately $500-$550 a month. If someone is on SSI, we cannot place him or her there, because we do not have the means to supplement their stay. Many of the residents of the Homeless Shelter in Bergen County are SSI recipients, or are awaiting SSI assistance and are on general assistance, which is an even lower figure. There is no place for them to be placed.

ASSEMBLYMAN ROONEY: We appreciate your comments. Is there anyone else at this time who wishes to be heard on the record? (no response)

Again, I want to thank you all for coming. I appreciate all of the comments. We will have this finished up in a short period of time, I'm sure. We will be looking at the report to see if there is something we can do to prevent this in the future, or possibly to do something different.

Hopefully, we won't see any more closings, but I am sure we are all mature to understand that it is going to happen, especially when we see situations where the price of land -- especially in Bergen County -- has gone up so much, that people are saying, "I would rather just develop that land and sell it, rather than continue with one of these places." This is a major problem in Bergen. I think we are going to have to do much more.

I appreciate Social Services coming up. If you have any other comments at all, just give me a holler at any time. My legislative office is in Emerson. I would like to work very closely with you in the future. Again, thank you to the Ombudsman's office, and no thanks to the Department of Health. They will be hearing from me. You can be sure of that.

Thank you all again for coming.

**(HEARING CONCLUDED)**

# APPENDIX

THOMAS H. KEAN
GOVERNOR

STATE OF NEW JERSEY
OFFICE OF THE OMBUDSMAN
FOR THE INSTITUTIONALIZED ELDERLY

JACK R. D'AMBROSIO, JR.
OMBUDSMAN

CN 808, Trenton, New Jersey 08625-0808
(609) 292-8016

October 31, 1986

Honorable Molly Coye, M.D., M.P.H.
Commissioner
Department of Health
CN 367
Trenton, New Jersey 08625

Re: Rivervale Manor
Rivervale, N.J.

Dear Commissioner Coye:

Rivervale Manor, 585 Rivervale Road, Rivervale, New Jersey, was a Residential Health Care Facility, licensed by the the New Jersey State Department of Health (DOH) and operated by Purita P. Such. This facility, which had announced its intention to close on August 30, 1986, unexpectedly and without warning, ceased operations on August 16, 1986. Purpose of this letter is to recommend that the DOH initiate punitive action against Mrs. Purita Such for the manner in which Rivervale Manor was closed. Set forth below is a summary of information obtained by this office relating to the closing of captioned facility.

A typed letter bearing an illegible signature, dated July 27, 1986, but received at this office August 6, 1986, addressed to the Governor of New Jersey, and the Commissioner of the New Jersey State DOH, announced that Rivervale Manor, also known as Twin Pines Incorporated, would close as of August 30, 1986. Reason given for the closing was, "continued operation of the facility compromises life safety and well being of our residents and facility interest due to the long delay inherent in coordination of the financing and architectural plans of the necessary life safety improvements."

On August 7, 1986, Rivervale Manor was visited by a representative of the DOH, who ascertained that although families of residents were notified, residents themselves had not been given a 30 day letter notifying them of intended closing of facility and subsequent relocation. The facility was cited by DOH for this violation. Other deficiencies, mainly in the area of environmental control, were also cited at the time of the visit.

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On the morning of August 16, 1986, Purita Such, or her representative, telephonically notified the Rivervale Police Department, the Bergen County Bureau of Social Services (BSS), DOH, and the Ombudsman's Office that the facility was being closed that date, as the full-time, permanent employee had left the previous evening without warning, and it would not be possible for her to get someone to stay with the residents.

Representatives of the Begen County BSS arrived at the facility on August 16, 1986, for the purpose of insuring that the rights and dignity of residents were protected and to assist in the relocation of these residents. During this time a number of telephone calls were effected between representatives of Bergen County BSS, DOH, and the Ombudsman's Office. A restraining order was obtained by Bergen BSS requiring the facility to remain open until August 30, 1986, but it was not invoked, as arrangements had been made to relocate all residents by the evening of August 16, 1986. Bergen BSS had also contacted Medical Personnel Pool, Saddle River, New Jersey, and arranged for a nurse and an aide to report to the facility. When both arrived, it was decided that only the nurse need remain as arrangements had virtually been effected to relocate all the then remaining residents. Of the 18 residents at the facility the morning of August 16, 1986, all were relocated by that evening in the following manner: eleven were placed in similarly licensed facilities throughout the State of New Jersey, four were relocated with family and or relatives and three were relocated to a facility in New York State owned by Purita Such.

During the relocation of these residents on August 16, 1986, information surfaced that these residents had not been fed, and there was no food in the facility. Original source of this information could not be determined by this office. Inquiry conducted, however, did determine that the residents had been fed breakfast and lunch on August 16, 1986, by the facility, a fast food meal had been served in the early evening by Mrs. Such, and snacks were provided later that evening for the remaining six residents by Bergen BSS. It was also determined that the facility as of August 16, 1986, did have an ample supply of food in freezers, refrigerator, and basement storage area.

Of the 15 residents relocated from Rivervale to various locations in New Jersey, this office was able to contact 11 such residents and/or members of their family. In general, there were no complaints made concerning general care and food served at the facility. Almost all averred that they had not been given the necessary 30 day closing notice. All, with the exception of one, expressed satisfaction with present relocation. The one exception was unhappy that he was moved out of the area, and efforts were being made to relocate him back to the North Jersey area. Some family members expressed dissatisfaction with having to take a resident home with them, but efforts were being made for such individuals to be relocated into another facility providing the appropriate level of care.

Of the 18 residents relocated, this office has information indicating that the finances of at least 5 residents have yet to be satisfactorily resolved with the facility.

Inquiry conducted among former employees at the facility, as well as residents residing at the facility as of August 16, 1986, failed to uncover any information indicating that the sudden closing of the facility on that date was premeditated or was occasioned by any reason other than the sudden departure of Paterno (Pat) Deloraya, full-time employee, on the evening of August 15, 1986. Conversely, no information was obtained indicating that Mrs. Such, upon learning of the departure of Mr. Deloraya, took any positive steps to keep the facility open until August 30, 1986, the date set by her in her July 27, 1986 notification to agencies and residents. It was noted, however, that information received from those interviewed gave reason to believe that the facility was not properly supervised during the latter period of its operation. No exact dates could be obtained from the memory of those interviewed, but information received indicates that the facility during the latter stages of it's operation was supervised only by Mr. Deloraya, who was supposedly on the premises 24 hours per day 7 days a week. Mr. Deloraya was assisted by part-time cook, Tracy (Tessie) Corpuz, who worked from 7:00 AM to 12:00 noon, Monday thru Saturday, preparing breakfast and lunch for the residents.

In order to clarify reasons behind closing of the facility and the manner which it was effected; to determine how much supervision the facility was receiving; to determine how much effort was made to keep the facility open until August 30, 1986; and to insure that all amounts of monies owed residents were accounted for and reimbursements made where necessary, this office made numerous attempts to arrange for an interview of Mrs. Such. During a telephone contact on August 26, 1986, Mrs. Such responded with a few generalities, but, when asked for specifics, stated that she did not wish to continue the conversation. On August 29, 1986, Mr. Dominick Such, husband of Purita Such, telephonically advised that all future questions concerning Rivervale Manor should be directed to attorney, Robert Cherry, Esq., who was representing Mrs. Such. Several contacts with Mr. Cherry, or a representative from his office, ascertained that he had been unable to make contact with his client, Mrs. Such, for the purpose of setting up an interview. On 9/25/86, this office served a subpoena requesting the presence of Mrs. Such, with appropriate records, at the Ombudsman's Office on October 2, 1986. At the request of Mr. Cherry, the appearance date was delayed until October 7, 1986. On that date, Mr. Cherry telephonically advised that Mrs. Such was ill, under a doctors care, and would not be able to respond as ordered. He advised that he would send this office a copy of a doctor's certificate for Mrs. Such as well as a copy of records pertaining to the operations of Rivervale, which he had in his possession. To date this office has received neither. The Ombudsman's Office is currently engaging in court proceedings to enforce the terms and conditions of this subpoena Ad Testificandum.

As a result of information set forth above, and from inquiry conducted by this office, it is believed that the closing of Rivervale Manor on August 16, 1986, was not premeditated, but, rather, was precipitated by the unexpected departure of the only employee, other than a part-time cook, affording supervision to the facility. At the same time, however, this office believes that no efforts were made by the facility owner, Mrs. Such, to obtain interim assistance to keep the facility open and comply with the August 30, 1986 commitment date made by her to State and local agencies, as well as to residents and families. Interim assistance of this nature was available and required only a minimum of effort on her part, as proven by the actions of the Bergen BSS, which, in a few hours time, was able to secure the services of agency personnel to supervise the operations of the facility. The lack of action taken by Mrs. Such in this regard demonstrates a significant lack of concern for the dignity and welfare of the residents under her charge. Residents were forced to suffer the traumatic experience of being forced to move without proper preparation; move without their sparse possessions, which, in many cases, are their life line to reality; and one resident had to move to an area distant and foreign to his normal and every day existence and which could preclude visits by relatives and friends.

From information appearing above, this office must also express its dissatisfaction with the manner in which DOH reacted to the closing of Rivervale Manor. It is the understanding of this office that DOH considers this matter to be closed, and no action is contemplated against the operator of Rivervale Manor with regard to the manner in which the facility was closed.

It is the belief of this office that, upon receipt of information on August 16, 1986, as to the intentions of Mrs. Such to close the facility, DOH should have taken stronger action to keep the facility open to insure that the relocation of those residents was handled in a manner designed to protect their needs and desires. As noted above, Bergen BSS secured an injunction on August 16, 1986, requiring the facility to remain open until August 30, 1986. This injunction, however, was not invoked, upon advice from DOH, when it was learned that all residents would be relocated before the end of that day. Further, it is the belief of this office that a number of standards/regulations were violated by Mrs. Such with regard to this closing, and these matters should have been vigorously pursued by DOH, especially in view of the fact that Mrs. Such is the owner of other health care facilities in New Jersey currently licensed by DOH. Standards which should have been considered as being violated are set forth below:

1. Chapter one, Section 2 of the Manual of Standards for Licensure of Residential Health Care Facilities, which states that the operator of a boarding home must have a sincere interest in the health and comfort of the residents, and must preserve the dignity and individual rights of the residents.

2. Chapter seven, Section 7.4.4 of the Manual of Standards (supra) which requires that residents be given at least 30 days advance written notice of impending transfers or discharges.

3. N.J.A.C.8:33-2.6(a)2, which requires that DOH be notified in writing 60 days prior to the discontinuance or substantial reduction of any health care service, for which a facility is recognized for reimbursement.

In addition to the above recommended actions, it is also suggested that DOH give consideration to new legislation or changes in existing regulations in the following areas:

1. When a facility intends to close, notification of such action to both DOH and residents/families, must be accomplished thru certified mail.

2. When such notice is given, it is the responsibility of the facility owner to insure that adequate personnel, services and supplies are available to maintain operations of the facility in accordance with existing regulations until the date of closing.

3. That DOH circulate to all licensed facilities and appropriate agencies the telephone number at which a representative of DOH can be reached during off hours and in times of an emergency when an immediate response is needed. It is the experience of this office that the telephone number appearing in the posters hanging in the facilities only takes recorded messages during off hours and no response is given until the following working day.

Although it is not believed that responsibility for relocation of residents was a problem with regard to the closing of Rivervale, it is the recommendation of this office that consideration be given to the drafting of a Memorandum of Understanding between the Department of Health and BSS's throughout the State, setting forth responsibility for relocating residents when an RHCF, for whatever reason, ceases to function. This memorandum could be similar to one currently in existence between the Department of Community Affairs (DCA) and BSS's concerning the closing of facilities under DCA jurisdiction.

Above matters are being referred for your consideration as it is felt that the manner in which the closing of Rivervale Manor was handled both by Mrs. Such, the operator, and by DOH did a great disservice not only to the residents involved, but also to DOH field personnel responsible for monitoring the activities of this type facility. It is hoped that above recommendations, along with stronger action on the part of the DOH, will sufficiently serve notice upon all RHCF operators that they have a responsibility to their residents that is not to be taken lightly. Those RHCF operators not ready to make the full committment should be made to realize that DOH will not turn it's back or react lightly when the operator of a facility fails to go "the full mile" in insuring that the dignity, welfare and comfort of residents are afforded primary consideration.

It is respectfully requested that you afford above matters your personal attention. It is also requested that your response reach this office at your earliest convenience, as it would not be in the best interest of RHCF residents throughout the State or responsible State or local agencies to have a repeat occurence similar to the closing of Rivervale. Should you have any questions concerning any of the above, please feel free to call.

Sincerely,

Jack R. D'Ambrosio, Jr.

JACK R. D'AMBROSIO, Jr.
OMBUDSMAN

JRD/dm/1859A

cc: Dr. Solomon Goldberg, DOH
Mr. Edward Testa, Bergen County, BSS
Mr. Robert Cherry, Esq.

## THE CLOSING OF RIVERVALE MANOR- August 16,1986

### BACKGROUND

The Bergen County Board of Social Services (BCBSS) pays for a 24-hour, toll-free hot-line to accept reports of abuse, neglect and exploitation made by or on behalf of adults residing in Bergen County. This service is a part of the Adult Intervention Project (AIP), a State funded pilot program established in 1984 to provide protective services to vulnerable adults. The responsibility for the hot-line is jointly shared by BCBSS and another program in Bergen County, Protective Services for the Frail Elderly, with each agency having responsibility for assigning staff to man the hot-line every other week. Natalie Webb from Protective Services for the Frail Elderly was on primary duty and Linda MacLellan from BCBSS was on back-up duty the week starting 8/15/86.

### EVENTS OF AUGUST16, 1986:

The first call to the Protective Services Hotline number was made at approximately 9AM on Saturday, August 16, 1986. At that time the caller indicated that the residents at Rivervale Manor did not have any food, had not been served breakfast, and that there were no employees available to care for the residents. Natalie Webb contacted Linda MacLellan and then immediatedly called Rivervale Manor. She determined that the owner of the facility, Mrs. Purita Such, was on her way to Rivervale Manor from her home located out of Bergen County. About 10:30 AM Mrs. MacLellan was informed by Natalie Webb, who had received a follow-up call, that Mrs. Such was voluntarily closing the facility that day. Mrs. MacLellan immediately called Mrs. Such who informed her that all the employees at Rivervale Manor had walked off their jobs and that the facility was to be closed that day. Mrs. Such requested help with the placement of residents. Mrs. MacLellan told Mrs.. Such that she thought that Mrs. Such should try to secure assistance from an agency hiring temporary help so that the facility could be kept open. Although Mrs. MacLellan offered help with securing temporary staff, Mrs. Such was adamant about her decision to close the facility. Mrs. MacLellan asked Mrs. Such for the list of residents who would be displaced. Mrs. Such provided a list of approximately 12 residents. Mrs. MacLellan then proceeded to make initial calls to Ed Testa, the Director of BCBSS, and to other facilities in Bergen County which she thought might be appropriate for placement of the remaining residents.

Mrs. MacLellan spoke with Assemblyman Rooney in the late morning of 8/16/86. At that point she did not know exactly how BCBSS, the New Jersey State Department of Health (the official licensing agent) or the New Jersey State Ombudsmen's Office were going to proceed in this matter as it was the first time that an owner of a facility in Bergen County had decided to close on such short notice. Mrs. MacLellan was aware of the role of BCBSS as mandated by the Rooming and Boarding House Act of 1979. This role was to coordinate with the New Jersey State Department of Health in the placement of residents who would be left homeless.

Mr. Rooney suggested to Mrs. MacLellan that she secure an attorney and referred her to the Bergen County Prosecutor's Office. She called there, was told to call the Bergen County Police, who stated to her that they would ask someone from the Prosecutor's to get back to her. In the meantime Edward Testa returned the emergency call that Mrs. MacLellan had made to him prior to her conversation with Mr. Rooney. Mr. Testa stated that he would try to get in touch with one of the attorneys who are employed by BCBSS. Later that day he returned the call to Mrs. MacLellan stating that Richard Williams, Esq., BCBSS attorney, would go to her home to have her sign a complaint.

When the Prosecutors Office returned the call to Mrs. MacLellan the individual returning the call stated that he would try to locate a Judge who would be willing to hear this matter but cautioned that this matter was beyond the purview of the Prosecutor's Office because it involved a civil rather than a criminal complaint.

Prior to speaking with Assemblyman Rooney, Mrs. MacLellan had placed a call to Naomi Fishman, BCBSS Supervisor of the Boarding Home unit. When Mrs. Fishman returned the call to Mrs. MacLellan, they split up responsibility between themselves for calling all other facilities in Bergen County which they felt would be appropriate for emergency placement. Mrs. Fishman called Rivervale Manor to secure a list of relatives of the residents needing placement and then started to call these relatives. Mrs. Fishman also placed a call to the New Jersey State Department of Health (DOH), Fred Hebeler, Director. Mrs. Fishman stayed at home awaiting his return call. He returned the call in the early afternoon. Mrs. Fishman explained that BCBSS was attempting to have a restraining order signed and queried him about what DOH was going to do. He stated that he saw no point in DOH trying to keep the facility open because the owners of the facility had planned to close at the end of August, 1986. While BCBSS may have disagreed with this decision, Mrs. MacLellan and Mrs. Fishman felt that there was nothing more to do than proceed with seeking a restraining order and facilitating the

placement of residents. BCBSS does not have authority over DOH. After this call from Mr. Hebeler, Mrs. Fishman contacted Mrs. Maclellan to further coordinate their efforts and then left her home, located at the other end of the County, arriving at Rivervale Manor at about 2:30PM.

As Mrs. MacLellan was awaiting the arrival of the BCBSS attorney, she continued to try to make placements from her home. She also tried to contact some other members of her staff who she knew had been working with some of the residents of the facility. She was unsuccessful because this situation happened on a Saturday and not every BCBSS staff member is on call off hours. She also made arrangements with a private home health care agency to have a nurse and a home health aide sent to Rivervale Manor, at the expense of the BCBSS, to care for the remaining residents.

At approximately 2PM that day Richard Williams, who had done some preliminary work trying to locate a Judge who would hear this matter, arrived at Mrs. MacLellan's home where they composed the restraining order. Mrs. MacLellan typed the order so that the attorney could hand-deliver it to Judge Lucchi that afternoon and, if the Judge signed it, he could then hand-deliver it to the owners of Rivervale Manor. As soon as this process was completed, Mrs. MacLellan left her home for Rivervale Manor, arriving there at approvimately 3:45 PM.

When she arrived at Rivervale Manor she introduced herself to Mrs. Rooney, the wife of Assemblyman Rooney. Mrs. Rooney was at Rivervale Manor because her father was a resident. Mrs. MacLellan told her that a temporary restraining order was to be served later that afternoon.

The restraining order was signed by Judge Lucchi. This order temporarily restrained the **owner** from closing the facility through Tuesday morning, August 19, 1986, when a hearing was scheduled. BCBSS does not have any legal authority or mandate to run or mange a privately owned facility. It was therefore vital that the owner remain at Rivervale Manor to continue her responsibility. Richard Williams, BCBSS attorney hand-delivered the restraining order to Mrs. Such. At that time Mrs. Such stated that under no circumstances was she going to remain at the facility -- that she and her husband had pressing family matters to attend to on Sunday and during the early part of that next week. It became obvious to Mrs. MacLellan that, if at all possible, all residents would have to be placed by that evening.

Mr. Hebeler, DOH, called Rivervale Manor shortly thereafter. Mrs. MacLellan explained to him that she was having a great deal of difficulty placing the remaining seven residents. He gave her the names of facilities in Passaic an

Morris Counties. Mrs. MacLellan called EVERY facility on that list seeking placement. This was to no avail. All of the facilities contacted either were at capacity, would not take a placement sight unseen, would not accept any resident with a history of physichiatric illness or a diagnosis of alcholism, or were hesitent about accepting recipients of Supplemental Security Income (SSI).

During that afternoon Mrs. MacLellan and Mrs. Fishman had also placed several calls to the emergency number of the Community Center for Mental Health (CCMH) trying to seek placement at one of their transitional residences for two residents who had been receiving services at that Center. At Mrs. Rooney's suggestion, we asked specifically to speak with Dr. Woncier, the psychiatrist at CCMH. While all of these calls were returned by an emergency worker from CCMH, and he was very sympathetic and understanding, he was unable to help negotiate placement. (Shortly after this incident, Mrs. MacLellan spoke with Kitty Small, Director of the Community Center for Mental Health, who stated that even if Mrs. MacLellan had been able to get in touch with a transitional worker, all the residences run by the CCMH were at capacity on that day.)

Mrs. Fishman then remembered that an owner of a RHCF in Ocean County had called BCBSS recently stating she had vacancies and seeking placements. Mrs. MacLellan confirmed with Mr. Hebeler that the facility was licensed by the Department of Health and started to make the calls to the owner requesting placement of the remaining seven residents. It was then that Mrs. Fishman suggested to Mrs. Rooney that she take her father home with her because she knew that the only option would have been to place him at this facility in Ocean County.

The owner of the RHCF in Ocean County was hesitent to take one of the residents because of his severe alcoholism. She gave Mrs. MacLellan the name of another RHCF in Ocean County who she thought might accept this individual. After a series of phone calls, and a great deal of negotiation, Mrs. MacLellan was able to place this last remaining individual as well. Mrs. MacLellan then located an ambulance service to transport the residents, also at BCBSS expense. Mrs. Fishman left Rivervale Manor at 8:30 PM. Mrs. MacLellan stayed, along with the nurse that she had arranged, until the six residents, along with all of their belongings, were placed on the van to be transported to Ocean County. This was approximately 10:15 PM.

During the next few weeks BCBSS was again asked to intervene on behalf of some of the former residents. BCBSS sent a van with our employees to Rivervale Manor to procure the belongings of some of the residents who had

already left Rivervale Manor prior to the arrival of Mrs. Fishman on 8/16/86. BCBSS staff subsequently delivered all of the belongings to these residents at their new residences. In addition, Mrs. Such put stop-payments on some of the checks she had given to the residents representing one-half of the monthly fee and security owed to some of the residents. In some cases, this has meant that BCBSS has processed payment on behalf of those residents receiving SSI so that they could remain in the new facility.

## SUMMARY

BCBSS has no control over the availability of, or lack of, licensed homes and beds in Bergen County. Nor is the BCBSS in anyway responsible for the payment of current or potential residents except if they are recipients of Supplemental Security Income (SSI) and are homeless. In those situations we are responsible for two months after the month in which the emergency occurs. The residents who were placed in the two facilities in Ocean County were, with one exception, recipients of SSI. The other resident who was placed did not have a family member who could be contacted to act on his behalf.

Throughout this whole occurrance, caused by the owner of the facility, BCBSS has tried not only to meet its responsibility as stated in the Rooming and Boarding House Act of 1979, but has gone beyond its legal mandate. Some may disagree with the actions of BCBSS staff, but they were the only representatives of any State agency that visited Rivervale Manor on 8/16/86, investigated the situation and took the emergency action necessary to secure the health and safety of the residents.

The purpose of the Rooming and Boarding House Act of 1979 is to help ensure that residents are being cared for appropriate to their level of need, that complaints of abuse, neglect or exploitation made by or on behalf of residents are handled expeditiously, that the two Departments in the State mandated to be responsible for these facilities - the New Jersey Department of Community Affairs and the New Jersey Department of Health - will coordinate their efforts to ensure that all facilities in the State meet strict licensing requirements, and that the 21 County Boards of Social Services will provide services to those residents who need or request them if those services are appropriate and available. BCBSS recognizes the limitations of this law. However we also recognize that no law could prevent the closing of a facility by an owner at whim.