STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21A001	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT BROOKFIELD	1 BROOKFIELD COURT BELVIDERE, NJ 07823

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A 000	Initial Comments Initial Comments: Type of Survey: Complaint Complaint #: NJ00187312 Census: 90 Sample Size: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administrator's Responsibilities (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/15/25

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00187312

Based on interview and record review, it was determined that the facility Executive Director (ED) failed to implement and enforce the policies and procedures titled, "Alert Charting" and "24-Hour Book" for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On 6/16/25 at 10:36 a.m., the surveyor reviewed the electronic and paper medical record (MR) of Resident #2 which revealed that the resident moved *NJ Ex Order 26. 4B1* [redacted]

At 11:41 a.m., the surveyor interviewed the Director of Health and Wellness (DHW) regarding Resident #2. The DHW stated that in NJ Ex Order 26.4(b)(1) [redacted] she noticed a *NJ Ex Order 26. 4B1* Resident #2's *NJ Ex Order 26. 4B1* [redacted]. The DHW continued to state that around that time, staff had notified her that *NJ Ex Order 26. 4B1* Resident #2 had become *NJ Ex Order 26. 4B1* and they, the staff, were concerned they may injury themselves while *NJ Ex Order 26. 4B1* Resident #2 due to the resident *NJ Ex Order 26. 4B1* [redacted].

During continued review of Resident #2's MR, the surveyor did not observe any documentation of which indicated Resident #2 had a *NJ Ex Order 26. 4B1*

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A 310	Continued From page 2 NJ Ex Order 26. 4B until after Resident #2 had NJ Ex Order 26.4(b)(1) NJ Ex on NJ Ex Order 26.4 At 1:50 p.m., the surveyor reviewed documents titled "24 HOUR RESIDENT REPORT" with dates ranging from NJ Ex Order 26 to NJ Ex Order 26.4(b) Continued review of the reports revealed that Resident #2 had notes on the following dates: NJ Ex Order 26. 4B1 . The surveyor did not observe a progress note in Resident #2's MR related to the "24-Hour Report" notes for four of the seven dates listed above: on NJ Ex Order 26. 4B1 Review of Resident #2's 24- Hour Resident reports revealed the following instructions and guide regarding the 24- Hour Report, "...the 24-hour report does not replace required documentation in NJ Ex Order 26.4(b)(1) it is a quick guide to concerns that you see. Any concerns identified on this report must also have a progress note in NJ Ex Order 26.4(b)(1) The surveyor reviewed the following policies and procedures: "Alert Charting", dated 4/2021, which indicated, "Definition ...Change in Condition: a. A decline in a resident's status that will not resolve itself without intervention by staff or implementation of interventions ... Policy [-] Changes in condition will be identified and will initiate documentation and assessment procedures ..." "24-Hour Book" dated 4/2021, which indicated, "Procedure...1) 24-hour Resident Report ...The 24-hour report does not replace documentation in Eldermark notes. Nurses, Medication aides and Care Partners will review 24-hour report during	A 310		

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A 310	Continued From page 3 each shift change...." The facility failed to follow it policies which resulted in Resident #2's chart not being updated with documentation to reflect that the staff reported NJ Ex Order 26. 4B1 prior to the resident's documented [redacted] on [redacted]	A 310		
A 605	8:36-5.14(b) Involuntary Discharge (b) In an emergency situation, as stated in N.J.A.C. 8:36-5.1(d), for the protection of the life and safety of the resident or others, the facility or program may transfer the resident without 30 days notice. The Department shall be notified in the event of such discharge. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00187312 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to notify the Department of Health (DOH) of an NJ Ex Order 26. 4B1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following: During the survey on 6/16/25 at 10:36 a.m., the surveyor reviewed the electronic and paper medical record (MR) Resident #2 which revealed that the resident moved NJ Ex Order 26. 4B1 [redacted]	A 605		

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A 605	Continued From page 4 *NJ Ex Order 26. 4B1* During continued surveyor review of Resident #2's MR the surveyor observed the following progress notes (PN) dated NJ Ex Order 26.4(t written by the Director of Health and Wellness (DHW) which documented: 1. "*NJ Ex Order 26. 4B1* ." 2. "*NJ Ex Order 26. 4B1* ..." At 11:41 a.m., the surveyor interviewed the DHW regarding Resident #2. The DHW stated that in NJ Ex Order 26.4(b)(1), she noticed a *NJ Ex Order 26. 4B1* Resident #2' s *NJ Ex Order 26. 4B1*. The DHW continued to state that around that time staff had notified her that *NJ Ex Order 26. 4B1* Resident #2 had become *NJ Ex Order* and the staff were concerned they may injure themselves while *NJ Ex Order 26. 4B1* Resident #2 due to the resident not being able to *NJ Ex Order 26. 4B1* . Additionally, the DHW confirmed that there was no documentation related to Resident #2's reported *NJ Ex Order 26. 4B1* until after the resident had a NJ Ex Order 26.4(b)(1) *NJ Ex* at the facility on NJ Ex Order 26. At 1:39 p.m., the surveyor interviewed the ED and	A 605		

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A 605	Continued From page 5 the DHW to inquire the reason Resident #2 was provided a NJ Ex Order 26. 4B1 from the facility. The ED and DHW stated that Resident #2 was served an immediate NJ Ex Order 26. 4B1 from the facility on NJ Ex Order 26 for the safety of Resident #2 and the facility staff during NJ Ex Order 26. 4B1. Both the ED and DHW confirmed that Resident #2's NJ Ex Order 26. 4B1 was not acute yet instead the facility staff had noticed a NJ Ex Order 26. 4B1 in Resident #2's NJ Ex Order 26. 4B. During continued interview, the surveyor asked the ED and DHW if the facility had any Facility Reportable Events over the past three months and both the ED and the DHW said, "No." The ED and DHW were not able to provide the surveyor with documented evidence that the Department of Health (DOH) was notified of Resident #2's NJ Ex Order 26. 4B1 . In addition, the surveyor review of Resident #2's signed "Resident and Care Agreement", dated 7/15/2024, revealed a section titled, "VII. TRANSFERS FROM APARTMENT A. Transfer for More Appropriate Care." which documented, " ...You may remain in the Apartment at The Community as long as doing so is permitted by ... your care needs and level of functioning are consistent with those of the other residents and with the level of staffing ...."	A 605		
A 751	8:36-7.3(b) General and Health Service Plans (b) The resident health service plan shall be reviewed, and if necessary, revised quarterly, and as needed, based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.	A 751		

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A 751	Continued From page 6 This REQUIREMENT is not met as evidenced by: Complaint#: NJ00187312 Based on interview and record review it was determined that the facility failed to ensure that a Health Service Plan (HSP) was updated with interventions when a resident had a NJ Ex Order 26. 4B1 [redacted] of 3 residents, Resident #2. This deficient practice was evidenced by the following: On 6/16/25 at 10:36 a.m., the surveyor reviewed the electronic and paper medical record (MR) Resident #2 which revealed Resident moved NJ Ex Or [redacted] During continued surveyor review of Resident #2's MR, the surveyor observed a document titled "Care Plan" (CP). The CP had "Problems/Needs" listed as NJ Ex Order 26. 4B1 with a start date of NJ Ex Order 26.4(b) and was last reviewed date of NJ Ex Order 26.4(b) The CP indicated a "Desired Outcome" of NJ Ex Order 26. 4B1 for Resident #2. The CP did not have any listed "Services/Interventions" for Resident #2. At 12:36 p.m. the surveyor observed Resident #2 during the following NJ Ex Order 26. 4B1: NJ Ex Order 26.4(b)(1) [redacted]. During NJ Ex Order 26. 4B1 the surveyor noticed that Resident #2 was NJ Ex Order 26.4(b)(by NJ Ex Or care partners, that Resident #2 did not NJ Ex Order 26.4(b)(1)	A 751		

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A 751	Continued From page 7	A 751		

to his/her NJ Ex Order 26. 4B1 during nay of the NJ Ex Order 26. 4B1 and applied NJ Ex Order 26.4(b)(1) to his/her NJ Ex Order 26. 4B during NJ Ex Order 26.4(b from the NJ Ex Order to the wheelchair.

The surveyor was unable to locate any progress notes or documentation in Resident #2's MR which indicated that the *NJ Ex Order 26. 4B1* ended.

At 12:53 p.m., the surveyor interviewed the NJ Ex Order 26.4(b)(1)), in the presences of the Director of Health and Wellness (DHW), regarding Resident #2. The NJ Ex stated that he had Resident #2 on his services on and off for almost NJ Ex Order 26. 4B, in which Resident #2 was most recently on his services form NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) The NJ Ex continued to state that when Resident #2 started *NJ Ex Order 26. 4B1* in NJ Ex Order 26.4(b)(1) he/she stated off with *NJ Ex Order 26. 4B1* which is about 50 percent of the resident NJ Ex Order 26.4(b)(1) and 50 percent of the staff NJ Ex Order 26.4(b)(1) which NJ Ex Order 26.4(b)(1) by the time Resident #2 was *NJ Ex Order 26. 4B1* to the facility staff NJ Ex Order 26.4(b)(1) and the resident NJ Ex Order 26.4(b)(1). The NJ Ex continued to state that *NJ Ex Order 26. 4B1* stopped in NJ Ex Orde due to Resident #2 requiring *NJ Ex Order 26. 4B1*. Upon completion of the surveyor interview with the NJ Ex O he provided the surveyor with progress reports from NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1)

At 1:56 p.m. the surveyor interviewed the DHW and Executive Director (ED) regarding Resident #2's CP. The DHW stated that the document titled, "CP" was Resident #2's Health Service Plan. The DHW confirmed there were no documented interventions on the CP. The ED and DHW both stated that the documentation for Resident #2 needed to be "better."

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A 751	Continued From page 8 The facility failed to update and implement interventions to Resident #2's CP to address the resident's [redacted].	A 751		
A 763	8:36-7.4(b) Health Care Services (b) A registered professional nurse shall be responsible for developing nursing practice policies and procedures and the coordination of all health care services required in the resident's health service plan. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00187312 Based on interview and record review, it was determined that a Registered Nurse failed to coordinate health care services for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On 6/16/25 at 10:36 a.m., the surveyor reviewed the electronic and paper medical record (MR) Resident #2 which revealed the resident moved [redacted] During continued surveyor review of Resident #2's MR, the surveyor observed the following progress note (PN) dated [redacted] written by the Director of Health and Wellness (DHW) which	A 763		

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A 763	Continued From page 9	A 763		

indicated that NJ Ex Order 26 the DHW, Executive Director (ED), and the NJ Ex Order 26.4(b)(1)) had a meeting with Resident #2's family to discuss the resident's current health status.

The PN continued to indicate that the facility had "ongoing" concerns related to Resident #2's NJ Ex Order 26. 4B1 Additionally, the PN indicated, " ... NJ Ex Order 26. 4B1 This writer discussed the need for resident to have NJ Ex Order 26. 4B1 outside of what this community can provide. [NJ Ex Order 26. 4B1 name] stated she will reach out to NJ Ex Order 26. 4B1 to see if they can cover any cost ..."

During continued review of Resident #2's MR the surveyor observed another PN written by the DHW on NJ Ex Order 26 which indicated that the ED spoke with Resident #2's NJ Ex Order 26. 4B1 on NJ Ex Order 26 and notified her that Resident #2 needed an "NJ Ex Order 26. 4B1 " NJ Ex Order 26. 4B1 .

The surveyor did not observe any documentation that the facility followed up with Resident #2's need for a NJ Ex Order 26. 4B1 nor did the facility provide the resident with a NJ Ex Order 26. 4B1 .

At 12:12 p.m., the surveyor interviewed the ED and DHW regarding Resident #2. The ED and DHW stated that following the meeting on NJ Ex Order 26.4 Resident #2's family never followed up regarding Resident #2 obtaining a NJ Ex Order 26. 4B1 . The ED and DHW confirmed that the facility did not follow up with Resident #2's NJ Ex Order to inquire the status of

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A 763	Continued From page 10 Resident #2 obtaining a [NJ Ex Order 26. 4B1]. The facility's Registered Nurse failed to coordinate and follow-up on the status of Resident #2 obtaining a [NJ Ex Order 26. 4B1] to ensure Resident #2 received [NJ Ex Order 26. 4B1] and provided the appropriate assistance needed to meet his/her needs that the facility identified for safe [NJ Ex Order 26. 4B1].	A 763		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00187312 Based on interview and record review, it was determined that the facility failed to provide documented evidence that a resident was assessed appropriately for [NJ Ex Order 26. 4B1], and documentation of timely interventions initiated for 1 or 3 residents, Resident #2. This deficient	A1073		

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A1073	Continued From page 11 practice was evidenced by the following: On 6/16/25 at 10:36 a.m., the surveyor reviewed the electronic and paper medical record (MR) Resident #2 which revealed Resident #2 moved [redacted] During continued surveyor review of Resident #2's MR, the surveyor noted three documents titled "DL Master Assessment" (DMA), a registered nurse assessment tool. Review of the last three DMAs revealed that Resident #2 had a [redacted] with each assessment. The first DMA with a date of [redacted] indicated that Resident #2 needed an assist of one staff member for [redacted], the DMA with the date of [redacted] indicated Resident #2 [redacted] with reminders for [redacted] and the DMA dated [redacted] which indicated Resident #2 [redacted] on [redacted], had [redacted], and now requited the assistance of [redacted] staff members for a [redacted]. At 11:05 a.m., the surveyor interviewed Resident #2. Resident #2 stated that [redacted] liked the facility and had no issues. Resident #2 continued to state that on [redacted] while being [redacted] the [redacted] he/she [redacted] on his/her [redacted] and since the [redacted], has had an [redacted]. Additionally, Resident #2 stated that he/she does get [redacted] and is [redacted]. At 11:14 a.m.. the surveyor interviewed Care Partner (CP) #1 regarding Resident #2. CP #1 stated that [redacted] ago, when she started	A1073		

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A1073	Continued From page 12	A1073		

working at the facility, Resident #2 needed an assist of one during NJ Ex Order 26. 4B1. CP #1 continued to state that NJ Ex Order 26. 4B1 into her employment at the facility she noticed Resident #2's NJ Ex Order 26. 4B1 [redacted]. The surveyor then inquired how the CP's noticed NJ Ex Order 26. 4B1 [redacted] are communicated to the nurse. CP #1 stated that they verbally notify the Licensed Practical Nurse and/or Director of Health and Wellness (DHW) as well a document on the 24-hour report.

At 11:30 a.m. the surveyor interviewed Care Partner/Certified Medication Aide (CP/CMA) #1 regarding Resident #2. CP/CMA #1 stated that she has worked at the facility for NJ Ex Order 26. 4B1 [redacted] and over that time, Resident #2 has NJ Ex Order 26. 4B1 [redacted], to one person assist, and now NJ Ex Or [redacted] persons assist with NJ Ex Order 26. 4B1. CP/CMA #1 stated that for about NJ Ex Order 26. 4B1, Resident #2 needed a NJ Ex Or [redacted]-person assist with NJ Ex Order 26. 4B1 as Resident #2 does not put his/her NJ Ex Or [redacted] on the ground when NJ Ex Order 26. 4B1, yet could not identify if it was his/her NJ Ex Order 26. 4B1 at the time of interview. Additionally, CP/CMA #1 stated that Resident #2 NJ Ex Order 26. 4B1 [redacted] during assistance with NJ Ex Order 26. 4B1 which makes it "the hardest part."

During continued surveyor interview with CP/CMA # 1, she stated that when there is a NJ Ex Order 26. 4B1 [redacted], she should notify the nurse and document on the 24-hour report.

At 11:41 a.m., the surveyor interviewed the Director of Health and Wellness/Registered Nurse (DHW) regarding Resident #2. The DHW stated that in NJ Ex Order 26.4(b)(1), she noticed that CPs began notifying her that it was NJ Ex Order 26. 4B1 [redacted] Resident #2 because the resident would not NJ Ex Order 26.4(b)(1) during NJ Ex Order 26. 4B1. The DHW stated

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT BROOKFIELD	1 BROOKFIELD COURT BELVIDERE, NJ 07823

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1073	Continued From page 13	A1073		

that Resident #2 has a NJ Ex Order 26. 4B1 .
Additionally, the DHW stated that due to the CPs' NJ Ex Order 26. 4B1 concerns with Resident #2, Resident #2 was referred to the facility's NJ Ex Order 26. 4B1 company in NJ Ex Order 26.4(b)(1

At 12:12 p.m., the surveyor interviewed the Executive Director (ED) and DHW regarding Resident #2. The ED stated that facility noted Resident #2 had a NJ Ex Order 26. 4B1 over the past NJ Ex Order 26. 4B1 and that the resident had NJ Ex Order 26. 4B1 stay about NJ Ex Order 26. 4B1 ago also for NJ Ex Order 26. 4B1. The ED and DHW stated that the family was notified of the NJ Ex Order 26. 4. The ED and DHW continued to state that NJ Ex O meetings were held with Resident #1's family to discuss the resident's NJ Ex Order 26. 4B1. The ED stated that during the first meeting with the family, held on NJ Ex Order 26, the facility suggested a NJ Ex Order 26. 4B1 for Resident #2 to assist with the resident's NJ Ex Order 26. 4B1 / However, following the discussion at the meeting, the family did not follow-up and Resident #2 was never provided with a NJ Ex Order 26. 4B1 .

At 12:36 p.m. the surveyor observed Resident #2 during the following NJ Ex Order 26. 4B1: NJ Ex Order 26.4(b)(1) During NJ Ex Order 26. 4B1 the surveyor noticed that Resident #2 was NJ Ex Order 26.4(b)(by NJ Ex O care partners, that Resident #2 did not NJ Ex Order 26.4(b)(1) to his/her NJ Ex Order 26. 4B1 during any of the NJ Ex Order 26. 4B1 and NJ Ex Order 26.4(b)(1) to his/her NJ Ex Order 26. 4B during NJ Ex Order 26.4(b from the NJ Ex Order to the wheelchair.

At 12:53 p.m. the surveyor interviewed the NJ Ex Order 26.4(b)(1)), in the presences of the DHW, regarding Resident #2. The NJ EX stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21A001	A. BUILDING: _____ B. WING _____	C 06/16/2025

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MIRA VIE AT BROOKFIELD	1 BROOKFIELD COURT BELVIDERE, NJ 07823

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1073	Continued From page 14	A1073		

he had Resident #2 on his services on and off for almost [NJ Ex Order 26. 4B], in which Resident #2 was most recently on his services form [NJ Ex Order 26.4(b)(1)] to [NJ Ex Order 26.4(b)(1)]. The [NJ Ex] continued to state that when Resident #2 started ***NJ Ex Order 26. 4B1*** in [NJ Ex Order 26.4(b)(1)] he/she stated off with [NJ Ex Order 26. 4B1] which is about 50 percent of the resident [NJ Ex Order 26.4(b)(1)] and 50 percent of the staff doing the work which increased by the time Resident #2 was ***NJ Ex Order 26. 4B1*** to the facility staff [NJ Ex Order 26.4(b)(1)] and the resident only [NJ Ex Order 26.4(b)(1)]. The [NJ Ex] continued to state that ***NJ Ex Order 26. 4B1*** stopped in [NJ Ex Orde] due to Resident #2 requiring ***NJ Ex Order 26. 4B1***. Upon completion of the surveyor interview with the [NJ Ex O] the [NJ Ex] provided the surveyor with ***NJ Ex Order 26. 4B1*** progress reports from [NJ Ex Order 26.4(b)(1)] to [NJ Ex Order 26.4(b)(1)] which were not a part of Resident #2's chart. Surveyor review of the progress report confirmed in the information the [NJ Ex] provided to the surveyor upon interview.

Further review of Resident #2's MR, revealed that there was no documentation to indicate that Resident #2 had a progressive ***NJ Ex Order 26. 4B1*** prior to the resident's [NJ Ex] at the facility on [NJ Ex Order 26.4(b)]

At 1:39 p.m., the surveyor conducted another interview with the ED and DHW regarding Resident #2 and documentation. The ED and DHW both stated that they have not frequently assisted Resident #2 during a [NJ Ex Order 26. 4B] yet when they did, Resident #2 only required [NJ Ex O] people to [NJ Ex Order 26. 4B] 50 percent of the time. The ED and DHW also both confirmed that there was no documentation of Resident #2's [NJ Ex Order 26. 4B1] in the resident's chart prior to the resident's [NJ Ex] on [NJ Ex Order 26]. Both the ED and DHW stated that the documentation needs to be better.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21A001	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT BROOKFIELD	**1 BROOKFIELD COURT BELVIDERE, NJ 07823**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1073	Continued From page 15 The facility failed to document Resident #2's observed change in condition prior to Resident #2's [NJ Ex C] on [NJ Ex Order 26]	A1073		

MIRA VIE
AT BROOKFIELD

Rec'd 7/9/25 [redacted] POC#1

July 17th, 2025

Complaint Survey 6/16/2025

Tag A310:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

[redacted] The community will follow their policy on Alert Charting and 24-Hour Book.
Director of Health and Wellness (DHW) and Assistant DHW will audit alert charting on a routine basis.
Staff education will ensure staff read the 24-hour book and continue with alert charting where appropriate.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
    - All residents in our community have the potential to be affected by these deficient practices.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.
    - Director of Health and Wellness (DHW) and Director of Memory Support will bring 24-hour book to daily department head meetings to review documentation with ED. Effective Immediately 6/18/25.

[redacted] DHW, ADHW, and/or ED will follow-up at daily nursing meetings to ensure documentation occurs in Eldermark. Effective Immediately 6/18/25
Staff education completed on 6/17/2025 and 6/18/2025 on communicating change in condition and utilizing the 24- hour book, reporting immediately so that documentation occurs timely.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.

MIRA VIE
AT BROOKFIELD

- Monthly audits will be performed by DHW and/or ADHW to determine areas of improvement with documentation and in-service/ re-educate when needed. Completed on 6/20/25 and Monthly.
- Alert Charting/24 Hour Report Compliance will be part of the Quarterly QAPI Meetings starting on 8/15/2025 to monitor efficacy of interventions in place.

Tag A605: NJ Ex Order 26. 4B1 [redacted]

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

NJ Ex Order 26. 4B1 [redacted]

- All requested documents were provided to DOH during complaint visit.
- Moving forward, all residents given Notice of NJ Ex Order 26.4(b)(1) will be reported to DOH per state regulations. Effective 6/17/25.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
   - All residents have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.

NJ Ex Order 26. 4B1 [redacted]

DHW and ED will review a list of Reportable Events on a weekly basis and ensure that all reportable events have been reported to DOH. Effective 7/17/25 and Ongoing.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.
   - Reportable Events and reporting will be reviewed during Quarterly QAPI Meetings by ED, DHW, and Management Team. Effective 8/15/25 and Ongoing. NJ Ex Order 26. 4B1 [redacted]

Tag A751:

MIRA VIE
AT BROOKFIELD

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
    - General and Health Service Plan has been reviewed to ensure it is up to date with most recent needs and information for Resident #2. Completed 6/17/25.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
    - All residents in our community have the potential of being affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.

NJ Ex Order 26. 4B1 [redacted]

Policy/Education review completed on 7/17/25 with nursing team who are responsible for General and Health Service plans.

Community Nurses will follow Policy where General Service Plans will be updated every 6 months and/or change in condition with appropriate interventions. Completed 6/18/25 and Ongoing.

- Community Nurses will follow Policy where Health Service Plans will be updated Quarterly and/or change in condition with appropriate interventions. Completed 6/18/25 and Ongoing.
- DHW and/or ADHW will meet with a member from the NJ Ex Order 26. 4B1 and any ancillary Home Health/Hospice Services on a biweekly basis to ensure notes are updated accordingly. Completed 7/21/25 and Ongoing.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.
    - The DHW and/or ADHW will conduct quarterly audits to review General Service Plan and Health Service Plan accuracy. Results will submitted during quarterly QAPI Meetings. Audit completed 7/21/25. Next Quarterly QAPI Meeting scheduled 8/15/25.
    - Monthly Clinical Quality Report will be emailed to RVP Clinical detailing all outside providers and HSP's completed. This will be completed by 8/5/2025 for the month of July and ongoing.

NJ Ex Order 26. 4B1 [redacted]

MIRA VIE
AT BROOKFIELD

Tag A763:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

   - Resident Number 2 was found to not need to the service of a [redacted] and the community has supplemented with [redacted] staff members at a time.
   - DHW has placed a follow up note in resident chart as well as conversation with [redacted] that [redacted] is not necessary, and community has provided [redacted] staff members for resident care. Completed 6/17/25.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

   - All residents have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.

   - Daily review of 24 hour report and Alert Charting by DHW/ED to ensure that coordination of resident care is occurring. Completed 7/17/25 and ongoing.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.

   - Coordination of Resident Care will be monitored during quarterly QAPI meetings by DHW/ED. Next scheduled Meeting 8/15/25.

Tag A1073:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

   - Resident #2's records have been thoroughly reviewed by RVP Clinical and DHW to ensure accuracy in current assessment and service plan. Completed 6/18/25.

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AT BROOKFIELD

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

   - All residents had the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.

   - Staff education completed on 6/17/2025 and 6/18/2025 on communicating change in condition and utilizing the 24- hour book, reporting immediately so that documentation occurs timely.
   - Policy review "Service Plans and Assessments" completed on 7/17/25 with nursing team.
   - 24-Hour Book in-service completed on 7/16/2025. Nursing team to review 24-hour book at every shift change and document change of condition as needed. NJ Ex Order 26. 4B1 [redacted]

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.

   - DHW, ADHW, DMS, and/or ED to review 24-hour book at both daily at department head meeting and nursing meetings to be sure changes of condition are documented timely. Initiated and completed on 6/17/25 and will be ongoing daily.
   - Audit to ensure that any change of condition translates to an updated assessment, updated service plan, and any other essential documentation to occur monthly by DHW/ADHW. Completed on 7/17/25 and Ongoing.

This Plan of Correction has been completed as of 7/17/25.

Thank you,

NJ Ex Order 26.4(b)(1)

Executive Director

MIRA VIE
AT BROOKFIELD

POC #2
Rec'd
8/5/25

August 4th, 2025

Complaint Survey 6/16/2025

Tag A310:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
    - Director of Health and Wellness (DHW) performed an audit of Resident #2's alert charting along with assessment and care notes on 6/17/2025.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
    - All residents in our community have the potential to be affected by these deficient practices.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.
    - DHW and Director of Memory Support (DMS) will bring 24-hour book to daily department head meetings to review documentation with Executive Director (ED). Effective Immediately 6/18/25.
    - DHW, Assistant Director of Health and Wellness (ADHW), and/or ED will follow-up at daily nursing meetings to ensure the appropriate documentation occurs in Eldermark. Effective Immediately 6/18/25
    - Policies reviewed with nursing staff on 6/17/2025, 6/18/2025 and ongoing regarding communicating change in resident status, utilizing the 24- hour book, and alert charting.
    - Staff education for all staff completed on 6/18/2025 on reporting change of condition timely to the nursing team to ensure documentation occurs timely.
    - Policies and Procedures on "Alert Charting" and "24-Hour Book" were reviewed on 6/18/2025. No revisions were made.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.

- Monthly audits will be performed by DHW and/or ADHW to determine areas of improvement with documentation and in-service/ re-educate when needed. Completed on 6/20/25 and Monthly. ED will ensure this is completed.
- Alert Charting/24 Hour Report Compliance will be part of the Quarterly Quality Assurance and Performance Improvement (QAPI) Meetings starting on 8/12/2025 to monitor efficacy of interventions in place. ED will be responsible for ensuring this is reported at QAPI.

Completion Date: 6/20/2025

Tag A605:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
    - Resident #2's Admission Agreement has been reviewed by Director of Health and Wellness (DHW) and Executive Director (ED) on 7/30/2025.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
    - All residents have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.
    - (DHW) and (ED) will review any incidents to determine if they are considered a reportable event.
    - DHW and ED reviewed list of the reportable events from the state website on 7/15/2025.
    - All department heads have been emailed the list of the reportable events from the state website. Effective 8/2/2025.

MIRA VIE
AT BROOKFIELD

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.

    - Reportable Events and reporting will be reviewed during quarterly Quality Assurance and Performance Improvement Meetings by ED, DHW, and Management Team. Effective 8/12/25 and Ongoing. ED will ensure this occurs.
    - Moving forward, all residents given Notice of Involuntary Discharge will be reported to DOH per state regulations. Effective 6/17/25.

    Completion Date: 8/2/2025

Tag A751:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
    - General and Health Service Plan has been reviewed to ensure it is up to date with most recent needs and information for Resident #2. Completed 6/17/25.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
    - All residents in our community have the potential of being affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.
    - Policy/Education on "General and Health Service Plans" review completed on 7/17/25 with nursing team who are responsible for General and Health Service plans.
    - Designated community nurses will follow Policy where General Service Plans will be updated every 6 months and/or change in condition with appropriate interventions. Completed 6/18/25 and Ongoing.

- Designated community nurses will follow Policy where Health Service Plans will be updated Quarterly and/or change in condition with appropriate interventions. Completed 6/18/25 and Ongoing.
- Director of Health and Wellness (DHW) and/or Assistant Director of Health and Wellness (ADHW) will meet with a member from the [NJ Ex Order 26. 4B1] therapy and any ancillary Home Health/Hospice Services on a biweekly basis to ensure notes are updated accordingly. Completed 6/21/25 and Ongoing.
- Discussions at daily nursing meeting will prompt designated community nurses to evaluate the need for health service plans for all residents.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.
    - The DHW and/or ADHW will conduct weekly audits for one month starting in August, then continue monthly audits through December 2025 to review General Service Plan and Health Service Plan accuracy.
    - Monthly Clinical Quality Report will be emailed to RVP Clinical detailing all outside providers and HSP's completed. This will be completed by 8/6/2025 and ongoing.

    Completion Date: 8/6/2025

Tag A763:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

    - Resident Number 2 was found to not need the service of a [NJ Ex Or] and the community has supplemented with [NJ Ex Orde] staff members at a time for [NJ Ex Order 26. 4B1]. Effective 6/17/2025

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

- All residents have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.

   - Review of 24 hour report and Alert Charting policy by Director of Health and Wellness (DHW)/Executive Director (ED) to ensure that coordination of resident care is occurring. Completed 6/18/25 and ongoing.
   - Education completed with DHW on providing safe necessary care to any resident who might be waiting discharge due to involuntary discharges. AL regulations reviewed. Effective 7/30/2025

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.

   - Coordination of Resident Care will be monitored during quarterly QAPI meetings by DHW/ED. Next scheduled Meeting 8/12/25.
   - Coordination of Resident Care will be monitored through discussion taking place at daily nursing meetings. Interventions will be implemented and updated as needed by the designated community nurse. Effective 6/17/2025

   Completion Date: 7/30/2025

Tag A1073:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

   - Resident #2's records have been thoroughly reviewed by Regional Vice President (RVP) Clinical and Director of Health and Wellness (DHW) to ensure accuracy in current assessment and service plan. Completed 6/18/25.

MIRA VIE
AT BROOKFIELD

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

    - All residents had the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.

    - Policy Review and nursing staff education completed on 6/17/2025 and 6/18/2025 on communicating change in resident status and utilizing the 24-hour book, reporting immediately so that documentation occurs timely.
    - Policy review "Service Plans and Assessments" completed on 7/17/25 with nursing team. No revisions made.
    - 24-Hour Book education completed on 7/16/2025 with nursing staff. Nursing team to review 24-hour book at every shift change and document change of condition as needed.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.

    - DHW, Assistant Director of Health and Wellness (ADHW), Director of Memory Support (DMS), and/or Executive Director (ED) to review 24-hour book at both department head meeting and nursing meetings to be sure changes of condition are documented timely. Initiated and completed on 6/17/25 and will be ongoing.
    - DHW/ADHW or designated community nurse will perform a medical record audit to ensure that any change of condition translates to an updated assessment, updated service plan, and any other essential documentation. Completed on 7/17/25 and at Quality Assurance and Performance Improvement meetings.

    Completion Date: 7/17/25

MIRA VIE
AT BROOKFIELD

POC #3
rec'd 8/12/25
acceptable

August 12th, 2025

Complaint Survey 6/16/2025

Tag A310:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
    - Director of Health and Wellness (DHW) performed an audit of Resident #2's alert charting along with assessment and care notes on 6/17/2025.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
    - All residents in our community have the potential to be affected by these deficient practices.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.
    - DHW and Director of Memory Support (DMS) will bring 24-hour book to daily department head meetings to review documentation with Executive Director (ED). Effective Immediately 6/18/25.
    - DHW, Assistant Director of Health and Wellness (ADHW), and/or ED will follow-up at daily nursing meetings to ensure the appropriate documentation occurs in Eldermark. Effective Immediately 6/18/25
    - Policies reviewed with nursing staff on 6/17/2025, 6/18/2025 and ongoing regarding communicating change in resident status, utilizing the 24- hour book, and alert charting.
    - Staff education for all staff completed on 6/18/2025 on reporting change of condition timely to the nursing team to ensure documentation occurs timely. Education will continue annually, as needed, and upon hire.
    - Policies and Procedures on "Alert Charting" and "24-Hour Book" were reviewed on 6/18/2025. No revisions were made.

MIRA VIE
AT BROOKFIELD

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.

    - Monthly audits will be performed by DHW and/or ADHW to determine areas of improvement with documentation and in-service/ re-educate when needed. Completed on 6/20/25 and Monthly. ED will ensure this is completed.
    - Alert Charting/24 Hour Report Compliance will be part of the Quarterly Quality Assurance and Performance Improvement (QAPI) Meetings starting on 8/12/2025 to monitor efficacy of interventions in place. ED will be responsible for ensuring this is reported at QAPI.

    Completion Date: 6/20/2025

Tag A605:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
    - Resident #2's Admission Agreement has been reviewed by Director of Health and Wellness (DHW) and Executive Director (ED) on 7/30/2025.
    - *NJ Ex Order 26. 4B1* under review. Waiting for assessment to be completed on Resident #2 by *NJ Ex Order 26. 4B1* nurse.
    - Department of Health will be notified moving forward if there is an *NJ Ex Order 26. 4B1* for Resident #2.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
    - All residents have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.

- (DHW) and (ED) will review any incidents to determine if they are considered a reportable event.
- DHW and ED reviewed list of the reportable events from the state website on 7/15/2025.
- All department heads have been emailed the list of the reportable events from the state website. Effective 8/2/2025.
- Moving forward, all residents given Notice of Involuntary Discharge will be reported to DOH per state regulations. Effective 6/17/25.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.

    - Reportable Events and reporting will be reviewed during quarterly Quality Assurance and Performance Improvement Meetings by ED, DHW, and Management Team. Effective 8/12/25 and Ongoing. ED will ensure this occurs.

      Completion Date: 8/2/2025

Tag A751:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
    - General and Health Service Plan has been reviewed to ensure it is up to date with most recent needs and information for Resident #2. Completed 6/17/25.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
    - All residents in our community have the potential of being affected by this deficient practice.

MIRA VIE
AT BROOKFIELD

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.
    - Policy/Education on "General and Health Service Plans" review completed on 7/17/25 with all Registered Nurses (RN) and Assistant Director of Health and Wellness (ADHW who are responsible for General and Health Service plans.
    - RNs and ADHW will follow Policy where General Service Plans will be updated every 6 months and/or change in condition with appropriate interventions. Completed 6/18/25 and Ongoing.
    - RNs and ADHW will follow Policy where Health Service Plans will be updated Quarterly and/or change in condition with appropriate interventions. Completed 6/18/25 and Ongoing.
    - Director of Health and Wellness (DHW) and/or Assistant Director of Health and Wellness (ADHW) will meet with a member from rehab services and any ancillary outside providers/services on a biweekly basis to ensure notes are updated accordingly. Completed 6/21/25 and Ongoing.
    - Discussions and review of 24-hour book at daily nursing meeting will prompt designated community DHW/ADHW to evaluate the need for health service plans for all residents.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.
    - The DHW and/or ADHW will conduct weekly audits for one month starting in August, then continue monthly audits through December 2025 to review General Service Plan and Health Service Plan accuracy.
    - Monthly Clinical Quality Report will be emailed to Regional Vice President (RVP) Clinical detailing all outside providers and HSP's completed. This will be completed by 8/6/2025 and ongoing.
    - Clinical Quality Reports will be submitted at Quality Assurance and Performance Improvement meetings.

MIRA VIE
AT BROOKFIELD

Completion Date: 8/6/2025

Tag A763:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

    - Resident Number 2 was found to not need the service of a [redacted] and the community has supplemented with [redacted] staff members at a time for [redacted]. Effective 6/17/2025

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

    - All residents have the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.

    - Review of 24 hour report and Alert Charting policy by Director of Health and Wellness (DHW)/Executive Director (ED) to ensure that coordination of resident care is occurring. Completed 6/18/25 and ongoing.
    - Education completed with DHW on safe and necessary coordination of care based on provider orders/recommendations. Reviewed regulations on emergency discharges. Assisted Living regulations reviewed. Effective 7/30/2025

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.

    - Coordination of Resident Care will be monitored during quarterly QAPI meetings by DHW/ED. Next scheduled Meeting 8/12/25.

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- Coordination of Resident Care will be monitored through discussion taking place at daily nursing meetings. Interventions will be implemented and updated as needed by the designated community nurse. Effective 6/17/2025

Completion Date: 7/30/2025

Tag A1073:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

    - Resident #2's records have been thoroughly reviewed by Regional Vice President (RVP) Clinical and Director of Health and Wellness (DHW) to ensure accuracy in current assessment and service plan. Completed 6/18/25.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

    - All residents had the potential to be affected by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.

    - Policy Review and nursing staff education completed on 6/17/2025 and 6/18/2025 on communicating change in resident status and utilizing the 24-hour book, reporting immediately so that documentation occurs timely.
    - Policy review "Service Plans and Assessments" completed on 7/17/25 with nursing team. No revisions made.
    - 24-Hour Book education completed on 7/16/2025 with nursing staff. Nursing team to review 24-hour book at every shift change and document change of condition as needed.

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4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.

    - DHW, Assistant Director of Health and Wellness (ADHW), Director of Memory Support (DMS), and/or Executive Director (ED) to review 24-hour book at both department head meeting and nursing meetings to be sure changes of condition are documented timely. Initiated and completed on 6/17/25 and will be ongoing.
    - DHW/ADHW or designated community nurse will perform a medical record audit to ensure that any change of condition translates to an updated assessment, updated service plan, and any other essential documentation. Completed on 7/17/25 and at Quality Assurance and Performance Improvement meetings.

    Completion Date: 7/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21A001	A. BUILDING: _____ B. WING _____	R-C 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT BROOKFIELD	1 BROOKFIELD COURT BELVIDERE, NJ 07823

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments Initial Comments:	{A 000}		
{A 310}	8:36-3.4(a)(1) Administrator's Responsibilities (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by:	{A 310}		
{A 605}	8:36-5.14(b) Involuntary Discharge (b) In an emergency situation, as stated in N.J.A.C. 8:36-5.1(d), for the protection of the life and safety of the resident or others, the facility or program may transfer the resident without 30 days notice. The Department shall be notified in the event of such discharge.	{A 605}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21A001	A. BUILDING: _____ B. WING _____	R-C 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT BROOKFIELD	1 BROOKFIELD COURT BELVIDERE, NJ 07823

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{A 605}	Continued From page 1 This REQUIREMENT is not met as evidenced by:	{A 605}		
{A 751}	8:36-7.3(b) General and Health Service Plans (b) The resident health service plan shall be reviewed, and if necessary, revised quarterly, and as needed, based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status. This REQUIREMENT is not met as evidenced by:	{A 751}		
{A 763}	8:36-7.4(b) Health Care Services (b) A registered professional nurse shall be responsible for developing nursing practice policies and procedures and the coordination of all health care services required in the resident's health service plan. This REQUIREMENT is not met as evidenced by:	{A 763}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21A001	A. BUILDING: _____ B. WING _____	R-C 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT BROOKFIELD	**1 BROOKFIELD COURT BELVIDERE, NJ 07823**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 763}	Continued From page 2	{A 763}		
{A1073}	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice. This REQUIREMENT is not met as evidenced by:	{A1073}		