New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50A000	A. BUILDING: _____ B. WING _____	C 08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT EAST BRUNSWICK	606 CRANBURY ROAD EAST BRUNSWICK, NJ 08816

(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: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00186571 CENSUS: 82 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 09/22/25

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint # NJ00186571

Based on observation, interview and record review, it was determined that the Administrator failed to ensure the implementation and enforcement of the facility policy titled, "Elder Abuse/Neglect" for 1 of 2 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On 8/12/25 at 10:10 a.m., the surveyor observed Resident #2 seated in a wheelchair in the NJ Ex Order 26.4(b)(1) Neighborhood (NJ Ex Order 2 and upon greeting the resident, he/she NJ Exec Order 2 and took the surveyor's NJ Exec Orde . The surveyor was NJ Exec Order 2 to NJ Exec Order 26.4(b) the resident due to the resident's NJ Ex Order 26.4(b)(1).

At 11:00 a.m., the surveyor reviewed Resident #2's medical record (MR), which revealed that Resident #2 moved into the facility in NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order 26.4(b)(1).

The surveyor reviewed a progress note (PN) dated NJ Ex Order 26.4(at 1:53 p.m., written by a Licensed Practical Nurse (LPN), which indicated that the LPN was notified by a Certified Medication Aide (CMA) that Resident #2 was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) on the morning of NJ Ex Order 26.4(b) The PN also indicated that the LPN observed NJ Ex Order 26.4(b)(1) of Resident #2's NJ Ex Order and the resident was NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4 The LPN notified the Registered Nurse

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A 310	Continued From page 2 who assessed Resident #2 and observed that the resident had 'NJ Ex Order 26.4(b)(1) [redacted]" Additionally, the PN revealed that the Director of Health and Wellness (DHW) and the Executive Director (ED) were notified, and Resident #2 was transferred to the hospital for further evaluation. At 11:50 a.m., the surveyor reviewed the facility's "Investigative Summary for NJ Ex Order 26.4(b)(1) [redacted] (IS) which indicated that on [redacted] at approximately 8:40 p.m., a Certified Home Health Aide (CHHA #1), 'NJ Ex Order 26.4(b)(1) (Resident #2) from the common area and [redacted] (his/her) NJ Ex Order 26.4(b)(1) (his/her) [redacted] as she [redacted] (Resident #2) to (his/her) apartment." The employee 'NJ Ex Order 26.4(b)(1) to resident apartment and NJ Ex Order 26.4(b)(1) (him/her) [redacted] Appeared to be [redacted], door then re-opened and employee re-entered apartment. The employee exited. Resident was found on camera to be NJ Ex Order 26.4(b)(1) throughout common areas in the evening." At 12:10 p.m., during surveyor interview with the LPN and the Director of Nursing (DON), the DON stated that after the incident which involved Resident #2 and CHHA #1, that CHHA #1, was [redacted] on [redacted] and was [redacted] The surveyor reviewed a facility policy titled, " Elder Abuse/Neglect New Jersey" dated 4/2021, which revealed the following: "Policy and Procedure...Policy If any resident experiences abuse (by staff, residents, family, or others) or when abuse is suspected, as mandated reporters, staff is required to report this to the appropriate State agency. Staff are to immediately notify the Director of Health and	A 310		

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A 310	Continued From page 3 Wellness or Executive Director....Procedure ... 2) All staff at (facility)...are "mandated reporters." 3) If any Community staff member or volunteer has observed, suspects, had knowledge...of an incident which appears to be any form of abuse or neglect, the incident will be immediately reported to the Director of Health and Wellness. If the Director of Health and Wellness is not available, the incident will be reported to the Executive Director. In all cases the Executive Director is also to be notified ..." Refer to 8:36-4.1(a)(22)	A 310		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider shall post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care; This REQUIREMENT is not met as evidenced by: Complaint # NJ00186571 Based on observation, interview and record review, it was determined that the facility failed to	A 401		

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A 401	Continued From page 4 ensure a safe environment for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following: The Department of Health (DOH) received a Facility Reportable Event (FRE) (a document used to report events to the DOH), dated [NJ Ex Order 26.4(b)] regarding an NJ Ex Order 26.4(b)(1) [redacted]. According to the FRE, on the morning of [NJ Ex Order 26.4(b)], Resident #2 was observed with [NJ Ex Order 26.4(b)] and NJ Ex Order 26.4(b)(1) [redacted]. The FRE also indicated that Resident #2 was assessed by a Registered Nurse (RN), sent to the hospital for further evaluation and was admitted with NJ Ex Order 26.4(b)(1) [redacted] and an NJ Ex Order 26.4(b)(1) [redacted]. On 8/12/25 at 10:10 a.m., the surveyor observed Resident #2 seated in a wheelchair in the NJ Ex Order 26.4(b)(1) Neighborhood and upon greeting the resident, the resident [NJ Exec Order 2] and took the surveyor's [NJ Exec Orde]. The surveyor was [NJ Exec Order 26] to [NJ Exec Order 26.4b1] the resident due to the resident's NJ Ex Order 26.4(b)(1). At 11:00 a.m., the surveyor reviewed Resident #2's medical record (MR), which revealed that Resident #2 moved into the facility in [NJ Ex Order 26.4(b)(1)] [redacted] with a diagnosis of NJ Ex Order 26.4(b)(1). The surveyor reviewed a progress note (PN) dated [NJ Ex Order 26.4(b)] at 1:53 p.m., written by a Licensed Practical Nurse (LPN), which indicated that the LPN was notified by a Certified Medication Aide (CMA) that Resident #2 was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) [redacted] in the morning of [NJ Ex Order 26.4(b)]. The PN also indicated that the LPN observed NJ Ex Order 26.4(b)(1) Resident #2's [NJ Ex Order] and the resident was NJ Ex Order 26.4(b)(1) with a [NJ Exec Order 26]. The LPN notified the Registered Nurse	A 401		

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A 401	Continued From page 5 who assessed Resident #2 and observed that the resident had 'NJ Ex Order 26.4(b)(1) [redacted]." Additionally, the PN revealed that the Director of Health and Wellness (DHW) and the Executive Director (ED) were notified, and Resident #2 was transferred to the hospital for further evaluation. At 11:50 a.m., the surveyor reviewed the facility's "Investigative Summary for NJ Ex Order 26.4(b)(1) [redacted] (IS) which indicated that on NJ Ex Order 26.4(b) at approximately 8:40 p.m., a Certified Home Health Aide (CHHA #1), 'NJ Ex Order 26.4(b)(1) [Resident #2] from the common area and NJ Ex Ord [redacted] as she NJ Exec Order 26 Resident #2 to his/her apartment." The employee 'NJ Ex Order 26.4(b)(1) to resident apartment and NJ Ex O [redacted] him/her NJ Ex Or Appeared to be NJ Ex Order 26.4(b)(1) door then re-opened and employee re-entered apartment. The employee exited. Resident was found on camera to be NJ Ex Order 26.4(b)(1) throughout common areas in the evening." Further review of the IS revealed that CHHA #1 was immediately suspended pending investigation, NJ Ex Order 26.4(b)(1) was notified, and the employee was NJ Ex Order 26.4(b) by the NJ Ex Order 26.4(b)(1) department on NJ Ex Order 26.4(. The IS conclusion indicated that the investigation verified that 'NJ Ex Order 26.4(b)(1)' toward Resident #2 "did occur" and the employee was NJ Exec Order 26.4b1 The surveyor reviewed the employee file for CHHA #1 and observed a document titled, "Complaint Form", which indicated that the ED reported the incident of NJ Ex Order 26 involving CHHA #1 to the New Jersey Board of Nursing (NJBD) with confirmed receipt from the NJBN, dated NJ Ex Order 26.4(b)	A 401		

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A 401	Continued From page 6 The surveyor reviewed a statement from an additional care partner (CHHA #2), which indicated that on the evening of [redacted], CHHA #2 observed that CHHA #1 was trying to "put (Resident #2) [redacted]", and that when Resident #2 [redacted] "they got [redacted] " The statement further revealed that CHHA #2 observed that CHHA #1 [redacted] Resident #2 by his/her [redacted] and [redacted] the resident back to the resident's apartment trying to [redacted] At 12:10 p.m., during surveyor interview with the LPN and the Director of Nursing (DON), the DON stated that after the incident which involved Resident #2 and CHHA #1, that CHHA #1, was [redacted] and [redacted]. The Executive Director (ED) provided the surveyor with additional clarification and stated that CHHA #2 witnessed CHHA #1 [redacted] Resident #2's [redacted]; however, CHHA #2 failed to report the incident to administration and was therefore also [redacted] During continued surveyor interview with the ED, he explained that there were cameras in the common areas of the facility and that after any incident or fall, the cameras were reviewed as part of the investigation. The ED confirmed that he viewed the camera for the incident involving Resident #2 and CHHA #1 as part of his investigation. The ED further explained that the NJ Ex Order 26.4(b)(1) was called and CHHA #1 was NJ Ex Order 26.4(b)(1) The surveyor reviewed a facility policy, titled, "Ensuring Resident Rights and Dignity" dated 4/2021 which revealed the following: ..."Policy State...laws protect residents' rights. To provide quality of life to residents, we must protect the	A 401		

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A 401	Continued From page 7 right to be treated with dignity, respect and to be given the opportunity to choose ... Procedur ...7) Residents will not be mistreated or mishandled in any way... 10) Examples of everyday life choices ethat residents will be given: ... a) time to arise and go to bed ..."	A 401		

POC Received 9/22/25
POC acceptable

MIRA VIE
AT EAST BRUNSWICK
ASSISTED LIVING | MEMORY CARE

I am writing in response to the Survey report for Mira Vie at East Brunswick dated August 12, 2025. This letter details our Plan of Correction for Citation
8:36-3.4(a)(1) Administrator's Responsibilities

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.*
   - Resident #2 that NJ Ex Order 26.4(b)(1) by this deficient practice was sent to ER upon discovery of NJ Ex Order 26.4(b)(1) Investigation conducted by ED and found NJ Ex Order 26.4(b)(1) had occurred. Staff Member immediately NJ Exec Order 26.4b1 and eventually NJ Exec Order 26.4b1 Reported to NJ Ex Order 26.4(b)(1) department, Board of Nursing, and DOH. Completed on NJ Ex Order 26.4(b)(1)
   - Immediate staff education completed on NJ Ex Order 26.4(b)(1) Reporting Incidents, and Resident Rights completed on 5/19/25 to 5/21/25.
   - Staff member that witnessed incident also suspended immediately and then terminated after investigation. Completed on NJ Ex Order 26.4(b)(1)
2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.*
   - All residents are identified as having the potential to being affected by this deficient practice.
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.*
   - Review of Elder Abuse and Neglect, Incident Reporting, and Resident Rights reviewed monthly at all staff meeting by Executive Director. Completed 5/22/25 and Ongoing.
4. *How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.*
   - Staff education monitored during quarterly QI Meetings to monitor attendance and effectiveness which was held on June 25, 2025 and August 29, 2025.

Completion Date: August 29, 2025.

8:36-4.1(a)(16) Resident Rights

1. *How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.*
   - Resident #2 that has NJ Ex Order 26.4(b)(1) by this deficient practice has since returned to the community on NJ Ex Order 26.4(b)(1) from ER. Staff education has been provided by Senior NJ Exec Order 26.4b1 Director on how to care for residents with NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) SP updated with interventions to provide support and NJ Ex Order 26.4(b)(1)

MIRA VIE
AT EAST BRUNSWICK
ASSISTED LIVING | MEMORY CARE

2. *How the facility will identify other residents having the potential to be affected by the same deficient practice.*
   - All residents are identified as having the potential to be affected by the same deficient practice.
3. *What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.*
   - Additional education for all staff members on hire and quarterly, " Understanding and Responding to Behavioral Symptoms of Dementia". Completed 5/25/25.
   - Resident Service Plans will be updated accordingly by RN's in community based on need and changes in conditions. Immediate and Ongoing.

4. *4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.*
   - Executive Director/Designee will review all corrective actions at quarterly Safety and Quality meetings for effectiveness, next safety and quality meeting which was held on June 25, 2025 and August 29, 2025.

Completion Date: August 29, 2025.

NJ Ex Order 26.4(b)(1)

Executive Director

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
50A000		9/26/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT EAST BRUNSWICK	606 CRANBURY ROAD EAST BRUNSWICK, NJ 08816

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 08/29/2025	ID Prefix A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 08/29/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 8/12/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			