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
	65a007	A. BUILDING: _____ B. WING _____	C 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT BRICK	458 JACK MARTIN BLVD. BRICK, NJ 08724

(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 #: NJ 00189410 CENSUS: 93 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 01/27/26

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00189410

Based on interview and record review, it was determined that the Administrator failed to ensure the implementation and enforcement of the facility policy titled, "Missing Resident - Elopement Prevention Program", for 1 of 3 residents reviewed, Resident #2 who [redacted] from the facility. This deficient practice was evidenced by the following:

On 12/3/25 at 10:45 a.m., the surveyor reviewed Resident #2's medical record (MR), which revealed that Resident #2 moved into the facility in [redacted] with diagnoses of [redacted] and [redacted]. An assessment completed by the Director of Health and Wellness (DHW) dated [redacted], indicated that Resident #2 was [redacted] had [redacted] and was [redacted] at times.

The surveyor reviewed a progress note (PN) dated [redacted] at 12:05 p.m., written by a Regional Registered Nurse (RN), which revealed that Resident #2 was [redacted] by the Aide in the resident's [redacted] at 12:00 a.m. with a [redacted]. The resident stated that he/she [redacted] The Regional RN further documented that the Aide reminded Resident #2 that it was too [redacted].

The PN revealed that at approximately 7:00 a.m.,

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A 310	Continued From page 2	A 310		

when a Certified Medication Aide (CMA) went to administer morning medications to the resident, the CMA was NJ Exec Order 26.4b1 Resident #2 in his/her room. The PN indicated that the facility cameras were reviewed and showed that at 12:25 a.m., Resident #2 was seen NJ Exec Order 26.4b1 of his/her NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1. The camera further revealed that at 3:45 a.m., Resident #2 NJ Exec Order 26.4b1.

Further review of the MR revealed an "Incident" PN dated NJ Exec Order 26.4b at 12:24 p.m., documented by the RN which revealed that at approximately 9:00 a.m., Resident #2's family called and informed the facility that Resident #2 was NJ Exec Order 26.4b1 and was transported to the hospital for evaluation. An additional PN dated NJ Exec Order 26.4b1 at 2:01 p.m. by the DHW indicated that Resident #2 was admitted to the hospital with NJ Exec Order 26.4b1

At 12:30 p.m. the surveyor interviewed the Executive Director (ED) in the presence of the DHW and inquired about Resident #2's NJ Exec Order 26.4b1 on NJ Exec Order 26.4b. The ED stated that Resident #2 was NJ Exec Order 26.4b1 and that the staff was unaware that Resident #2 was NJ Exec Order 26.4 and had NJ Exec Order 26 until the CMA attempted to administer morning medications to the resident the morning of NJ Exec Order 26.4b at approximately 8:00 a.m.

The surveyor inquired what should have happened when the Aide observed Resident #2 NJ Exec Order 26.4b1 at midnight. The ED stated that the Aide should have immediately notified the nurse.

The surveyor reviewed the facility policy dated

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A 310	Continued From page 3 4/2021 titled, "Missing Resident - Elopement Prevention Program", provided by the ED which revealed, "...Policy Residents have the right to live at ease, in a safe and secure environment. The community is responsible for ensuring effective systems are implemented to reduce the risk of elopement. When a resident elopement occurs, community employees will provide a coordinated effort to ensure a prompt thorough search for the missing resident...Wandering Behaviors...5. ...j. Employee resident observations and monitoring for changes in the resident's status, needs, are important with communication on the 24-hour report, resident record and Executive Director/ Designee and Director of Health and Wellness communication...Preventative Checks 1. The Maintenance Director/Designee is responsible for managing and maintaining the functionality of community doors, windows and community physical plant operations...3. Door and Equipment Checks form are used...or utilize TELS for documentation of completed tasks and follow-up..." Refer to 8:36- 17.1 [A1179]	A 310		
A1179	8:36-17.1(a) Provision of Services (a) The facility shall provide and maintain a sanitary and safe environment for residents. This REQUIREMENT is not met as evidenced	A1179		

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A1179	Continued From page 4 by: Complaint #: NJ00189410 Based on interview and record review, it was determined that the facility failed to ensure a safe environment for a facility resident who [NJ Exec Order 26.4b1] for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following: The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE) (a form utilized by health care facilities to report events to the DOH) dated [NJ Exec Order 26.4b1]. The FRE indicated that on [NJ Exec Order 26.4b] at 8:19 a.m., the Executive Director (ED) was notified by a Wellness Licensed Practical Nurse (LPN), that a resident (Resident #2) who resided in the assisted living, [NJ Exec Order 26.4b1] within the community. On 12/3/25 at 10:45 a.m., the surveyor reviewed Resident #2's medical record (MR), which revealed that Resident #2 moved into the facility in [NJ Exec Order 26.4b1] with diagnoses of [NJ Exec Order 26.4b] and [NJ Exec Order 26.4b1]. An assessment conducted by the Director of Health and Wellness (DHW) dated [NJ Exec Order 26.4b], indicated that Resident #2 was [NJ Exec Order 26.4b1], had [NJ Exec Orde] and was [NJ Exec Order 26.4b] at times. The surveyor reviewed a [NJ Exec Order 26.4b1] dated [NJ Exec Order 26.4b], that was conducted by the DHW, which indicated a score of [NJ Exec]. The surveyor observed that the [NJ Exec Order 26.] included an "Interpretation of the [NJ Exec Order 26.] Scores" which indicated the following: "1. Select the appropriate score: [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] degree of [NJ Exec Order 26.4b1] Formal assessment may	A1179		

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A1179	Continued From page 5 be helpful to better determine pattern and extent of deficits ..." The surveyor reviewed a progress note (PN) dated NJ Exec Order 26.4b1 at 12:05 p.m., documented by a Regional Registered Nurse (RN), which revealed that Resident #2 was NJ Exec Order 26.4b1 by the Aide in the resident's NJ Exec Order 26.4b1 at 12:00 a.m. with a NJ Exec Order 26.4b1. The resident stated that NJ Exec Order 26.4b1 The RN further documented that the Aide reminded Resident #2 that it was NJ Exec Order 26.4b The PN revealed that at approximately 7:00 a.m., when a Certified Medication Aide (CMA) went to administer morning medications to the resident, the CMA was NJ Exec Order 26.4b1 Resident #2 in his/her room. The PN indicated that the facility cameras were reviewed and showed that at 12:25 a.m., Resident #2 was NJ Exec Order 26.4b1 . The camera further revealed that at 3:45 a.m., Resident #2 NJ Exec Order 26.4b1 . Further review of the MR revealed an "Incident" PN dated NJ Exec Order 26.4b at 12:24 p.m., documented by the RN which revealed that at approximately 9:00 a.m., Resident #2's family called and informed the facility that Resident #2 was NJ Exec Order 26.4b1 . An additional PN dated NJ Exec Order 26.4b at 2:01 p.m. by the DHW documented that Resident #2 was admitted to the hospital with NJ Exec Order 26.4b1 The resident was not available for interview and NJ Exec Order 26.4b1 as of survey date NJ Exec Order 26.4b. At 11:30 a.m. the surveyor accompanied the Plant Operations Director (POD) on a facility tour	A1179		

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A1179	Continued From page 6 which included observation of the [NJ Exec Order 26.4b1] [redacted]. The surveyor observed the [NJ Exec Order 26.4b1] [redacted] confirmed was the door that Resident #2 [NJ Exec Order] through when he/she [NJ Exec Order 26.4b1] [redacted]. The surveyor observed that there was a rectangular shaped "push to open" button located on the inside wall to the left of the front lobby door; and, above that button there was a second round, red button which was enclosed in a box labeled "mag lock" (locking device that uses an electromagnetic force to keep doors securely closed until released). During interview with the POD, the surveyor inquired about the front door security and the mag lock. The POD explained that after 8:00 p.m., the receptionist locked the front lobby door, but that if someone opened the box and pressed the mag log, that pressing the mag lock would release the front door lock and a person could then exit. The surveyor observed a smaller box located on the top of front lobby door and the POD explained that was the door alarm which connected to the aide's pagers and the "[NJ Exec Order] [redacted] call system computer. The POD further explained that there must have been a "glitch or a low battery" because if someone pressed the mag lock after 8:00 p.m., an alarm should have triggered. The POD stated that the aides never received an alarm to their pagers or the call system when Resident #2 [NJ Exec Order 26.4b1] [redacted]. During continued interview, the surveyor inquired whose responsibility it was to check the door alarm batteries, and the POD stated that it was his responsibility. The surveyor inquired how	A1179		

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A1179	Continued From page 7 often the batteries on the door alarms were checked and the POD stated that the facility utilized a "[NJ Exec Order 2]" system (building services a facility management platform for senior care) and that he checked the batteries regularly but was not able to state an exact time frame. At 12:30 p.m. the surveyor interviewed the Executive Director (ED) in the presence of the DHW and inquired about Resident #2's [NJ Exec Order 26.4b1] or [NJ Exec Order 26.4b1] The ED stated that Resident #2 was [NJ Exec Order 26.4b1] and that the staff was unaware that Resident #2 was [NJ Exec Order 26.4b1] until the CMA attempted to administer morning medications to the resident the morning of [NJ Exec Order 26.4b1] at approximately 8:00 a.m. The surveyor inquired what should have happened with the Aide observed Resident #2 with his/her [NJ Exec Order 26.4b1]. The ED stated that the Aide should have immediately notified the nurse. During further interview with the ED, she stated that she concluded that, Resident #2 [NJ Exec Order 26.4b1] The surveyor inquired whether the [NJ Exec Order 26.4b1] was checked to ensure functioning and the ED stated that the front door alarm battery was changed immediately after the elopement and was now functioning properly. The surveyor reviewed the investigation timeline provided by the ED which the ED stated was verified by review of the facility camera's footage. The timeline included but was not limited to the following regarding Resident #2's whereabouts on the night of the [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b]:	A1179		

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A1179	Continued From page 8 12:01 a.m.- Exited his/her room 12:03 a.m.-NJ Exec Order 26.4b1 ... 12:07 a.m.-NJ Exec Order 26.4b1 12:08 a.m.-NJ Exec Order 26.4b1 . 12:16 a.m.-NJ Exec Order 26.4b1 ... 12:23 a.m.-NJ Exec Order 26.4b1 ... 3:30 a.m. -NJ Exec Order 26.4b1 3:31 a.m.-NJ Exec Order 26.4b1 3:32 am.-NJ Exec Order 26.4b1 3:34 a.m.-NJ Exec Order 26.4b1 ... 3:40 a.m.-NJ Exec Order 26.4b1 Review of the timeline conclusion indicated that NJ Exec Order 26.4b1 into Resident #2's NJ Exec Order 26.4b1 until 7:59 a.m. During a follow up interview with the ED, the surveyor inquired exactly where Resident #2 was NJ Exec Orde and she confirmed that Resident #2 was NJ Exec Order 26.4b1. The ED also stated that all staff who worked the NJ Exec Orl and remained NJ Exec Order 26.4b1 pending Regional and Human Resource review of investigation. At 3:15 p.m., after exiting the facilty, the surveyor	A1179		

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A1179	Continued From page 9 drove to the stated location where Resident #2 was [NJ Exec Orde] after the [NJ Exec Order 26.4b1] The surveyor observed that the facility was NJ Exec Order 26.4b1 [redacted].	A1179		

acceptable POC (#3)
Received 2/13/26

MIRA VIE
AT BRICK
ASSISTED LIVING | MEMORY SUPPORT
A DISTINCTIVE LIVING COMMUNITY

February 13, 2026

Please find the Plan of Correction related to the complaint survey conducted on 12/4/2025.
A310 8:365: 3.4(a)(1) Administration

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
    - Staff education conducted by Executive Director and Director of Health & Wellness on elopements, resident rights, wandering behaviors, and door checks -11/21/2025 with a completion date of 11/26/2025
    - Community will follow policies and procedures as it relates to elopements, wandering behaviors, resident rights, door checks, and emergency call response.
    - Elopement binder implemented and staff in-service conducted by Executive Director and Director of Health & Wellness -11/21/2025 with a completion date of 11/26/2025
    - Completion 12/11/2025 and on-going.
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.
    - Completion 12/11/2025 and on-going.
3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.
    - Executive Director or designee to ensure all staff are trained upon hire and monthly on elopements, resident rights, wandering behaviors, door checks, and emergency call response.
    - Department managers and line staff educated on policies with door checks implemented by Director of Plant Operations weekly and documented in records. Executive Director and/or designee will spot check to ensure compliance. Initiated on 11/21/2025 with a completion date of 11/26/2025
    - All staff educated by Executive Director and Director of Health & Wellness on Missing Resident-Elopement Prevention Program. Executive Director and/or designee to continue with monthly elopement drills and education. Will review during quarterly safety meetings.

- The documents related to elopements, resident rights, door checks, and elopement prevention program were reviewed and staff educated on the policies. All staff in-serviced by Executive Director and Director of Health & Wellness on the policies with a completion date of 11/26/2025.
- Director of Plant Operations to check all doors weekly and document in electronic system(TELS) effective 11/21/2025.
- Completion 12/11/2025 and on-going.

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/review regarding elopements, resident rights, door checks and elopement prevention will be conducted upon hire and on-going.
   - Monitored on Quarterly QA by Executive Director.
   - Executive Director and/or Designee will ensure policies are being adhered to. Executive Director and/or Designee will review to ensure all processes are in place with Regional Vice President of Clinical Services.
   - Completion 12/11/2025 and on-going.

A401 8:36-17.1(a) Provision of Services

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
   - Staff education on elopements, resident rights, wandering behaviors, and door checks conducted and completed 11/26/2025.
   - Residents determined to have dementia or related diagnosis are in facility elopement binder.
   - Exterior exits are alarmed to avoid unintended egress.
   - Door alarms are checked weekly and documented in [redacted] by Director of Plant Operations or designee. Equipment failure will be reported to Executive Director immediately. Initiated on 11/21/2025 and ongoing.
2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
   - Residents #2 currently reside in [redacted]. Service plans updated on [redacted] to reflect interventions regarding [redacted] and [redacted] risk.
   - MMSE and Elopement Risk assessments completed on all assisted living residents with cognitive impairment diagnosis to identify additional interventions as necessary for resident safety.
   - All residents have the potential to be affected by this practice.
3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.
   - Door alarm checks in place weekly as part of [redacted] tracking system with report to Executive Director for any equipment failure.
   - All residents with cognitive impairment diagnosis put in Elopement Risk binder.
   - Any resident with cognitive impairment diagnosis has updated care plan and service plan to reflect interventions. 11/21/2025 and will be reviewed and revised as needed every 6 months and with any change of condition.
   - Staff educated to report any residents displaying change in cognition to the Registered Nurse 11/21/2025 and on-going.

4. How the facility will monitor is 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/review by Executive Director and Director of Health & Wellness regarding Resident Rights, Door alarm checks.
    - Monitoring weekly and as part of quarterly QA meeting by Executive Director.
    - Completion 12/11/2025 and on-going.

Signed:

[redacted]
Executive Director

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
65a007 Y1	A. Building B. Wing Y2	2/13/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT BRICK	458 JACK MARTIN BLVD. BRICK, NJ 08724

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 12/11/2025	ID Prefix A1179 Reg. # 8:36-17.1(a) LSC	Correction Completed 12/11/2025	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
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

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	
12/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

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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 12/11/2025	ID Prefix A1179 Reg. # 8:36-17.1(a) LSC	Correction Completed 12/11/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 12/4/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**