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 03/19/2025

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 #: NJ00184347 CENSUS: 79 SAMPLE SIZE: 6 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 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider will 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;	A 401		

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

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A 401	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #: NJ00184347 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to enforce a resident's right to live in safe conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care for 5 unsampled residents and 3 of 6 sampled residents, Resident #4, #5, and #6. This deficient practice was evidenced by the following: On 3/19/25 at 10:58 a.m., the surveyor interviewed Unsampled Resident #5 to inquire if he/she received assistance in a timely manner following the activation of his/her call pendant. Unsampled Resident #5 stated that the call pendant was sometimes not answered for a half hour or longer. Unsampled Resident #5 stated that there were not enough aides to accommodate all the residents, and that the facility was short staffed often. At 11:03 a.m., the surveyor interviewed Certified Medical Assistant (CMA) #1 to inquire how long staff had to answer call pendants, and the CMA stated that the call pendants should be answered within seven to ten minutes. At 12:58 p.m., the surveyor interviewed Resident #3 to inquire if he/she received assistance in a timely manner following the activation of his/her call pendant. Resident #3 stated that the average time it took for staff to answer the call pendant was 40 minutes. At 1:01 p.m., the surveyor activated Resident #3's	A 401		

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A 401	Continued From page 2 call pendant. At 1:15 p.m., CMA #2 answered Resident #3's call pendant, 14 minutes later. At this time, the surveyor interviewed CMA #2 to inquire how long staff had to answer call pendants, and the CMA stated that the call pendants should be answered within seven to ten minutes. The surveyor then inquired the reason it took 15 minutes for the call pendant to be answered, and CMA #2 stated that she had just returned from her lunch break. The surveyor reviewed the "Device Activity Report," provided by the Executive Director (ED), which revealed the following: 1) On [NJ Exec Order 26], Resident #4 waited 72 minutes and 38 seconds for his/her call pendant to be answered. 2) On [NJ Exec Order 26.4] Resident #6 waited 69 minutes and 52 seconds for his/her call pendant to be answered. 3) On [NJ Exec Order 26], Resident #5 waited 60 minutes and 46 seconds for his/her call pendant to be answered. 4) On [NJ Exec Order 26.4] an Unsampled Resident #1 waited 86 minutes and 48 seconds for his/her call pendant to be answered. 5) On [NJ Exec Order 26.4] Resident #6 waited 70 minutes and 50 seconds for his/her call pendant to be answered. 6) On [NJ Exec Order 26.4] an Unsampled Resident #2 waited 63 minutes for his/her call pendant to be answered. 7) On [NJ Ex Order 26.4], an Unsampled Resident #3 waited 72 minutes and 34 seconds for his/her call pendant to be answered. 8) On [NJ Exec Order 26], an Unsampled Resident #4 waited 63 minutes and 12 seconds for his/her call pendant to be answered.	A 401		

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A 401	Continued From page 3 9) On NJ Exec Order 26, Resident #4 waited 71 minutes and 59 seconds for his/her call pendant to be answered. The surveyor reviewed Resident #4's face sheet, which indicated that the resident was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1 The surveyor also reviewed Resident #5's face sheet, which indicated that the resident was admitted to the facility in NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1 Lastly, the surveyor reviewed Resident #6's face sheet, which indicated that the resident was admitted to the facility in NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1 . At 2:44 p.m., the surveyor interviewed the ED and the Director of Nursing (DON) to inquire how long staff had to answer call pendants, and the ED and the DON stated that the call pendants should be answered in seven to ten minutes. The surveyor then inquired the reason the "Device Activity Report" indicated that some residents waited over an hour for their call pendants to be answered, and the ED and DON stated that they were working on improving the call pendant response times. At this time, the DON stated that the facility was "cutting staff". The surveyor reviewed the "Resident Council Minutes," dated 12/30/24, which indicated, " Pendant issue continues, over 35 minutes wait time". The surveyor then reviewed the "Plan of Correction for Resident Council Dated December 30th," which indicated that the facility was in the process of hiring more staff.	A 401		

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A 401	Continued From page 4 In addition, the surveyor reviewed the "Resident Council Minutes," dated 1/30/25, which indicated that some staff were "sleeping at times". Further review of the "Resident Council Minutes," dated 2/27/25, indicated, "Pendant issues continue mostly at night." The surveyor reviewed the facility's policy titled, "Resident Rights," which indicated that residents have,"... 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 care and service ..."	A 401		
A 537	8:36-5.7(a)(1) General Requirements (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following: 1. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and resident care services of the facility or program; This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility	A 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 537	Continued From page 5 documents, it was determined that the facility failed to ensure that a Policy and Procedure Manual (P&PM), that was reviewed at least annually, was always available in the facility to representatives of the Department of Health (DOH). This deficient practice was evidenced by the following: On 3/19/25 at 9:21 a.m., during entrance conference with the Executive Director (ED), the surveyor requested the facility's P&PM. The ED stated that the facility's P&PM was on NJ Exec Order 26.4b1 (a browser-based app that can be accessed through a web browser). The surveyor then requested access to NJ Exec Order 26.4b1 to view the P&PM, and the ED stated that she would have to request access from the regional nurse. The surveyor inquired who had access to the P&PM, and the ED stated that she, the Director of Nursing (DON), and the regional nurse had access. At this time, the surveyor inquired how residents, responsible parties, and staff accessed the P&PM. The ED stated that those who wanted access to a policy and procedure could request it from her and that she would provide them with the policy. In addition, the ED stated that the facility was introduced to NJ Exec Order 26.4b1 when the facility switched to a new management company in April of 2024. The ED stated that she was working on getting all managers at the facility access to NJ Exec Order 26.4b1 At 12:12 p.m., the ED stated that the regional nurse stated that she was not able to give the surveyor access to NJ Exec Order 26.4b1 to view the P&PM and that the surveyor would have to request which policy and procedures were needed. The surveyor requested policies and procedures at	A 537		

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A 537	Continued From page 6 this time. At 2:43 p.m., the surveyor went to the ED's office to invite the ED to the exit conference and the ED stated that she printed the P&PM. The ED provided the surveyor with the requested policies and procedures at this time. The surveyor reviewed the ED's job description, which indicated that an essential function was to maintain current departmental policies, procedures, and licenses in accordance with company, Federal, State, and local requirements.	A 537		

POC #2 rec'd 5/30/25

MIRA VIE
AT BRICK
ASSISTED LIVING | MEMORY CARE

May 28, 2025

A401

1) Resident # 4, Resident # 5, Resident # 6 were [redacted] by the untimely call pendant response time which may have impacted their care and safety. The Pendant Report was reviewed by the Executive Director, The Director of Health and Wellness and the Resident Care Coordinator on March 19, 2025.
2) All the residents have the potential to be affected by the untimely call pendant response time.
3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
    - The Executive Director and the Director of Health and Wellness (DHW) will continue to discuss the Call Pendant Report during the daily stand-up meeting to ensure timely staff responses. After reviewing the report, any issues identified will be addressed by the Executive Director or the DHW directly with the staff members assigned to the respective residents to ensure accountability and prompt corrective action. Effective March 20, 2025 and Ongoing.
    - On March 20, 2025, the Executive Director and the DHW called a staff meeting to remind them of the facility's policy prohibiting sleeping on duty, emphasizing that such behavior is unacceptable and will result in further disciplinary actions and/or immediate termination. The staff were also reminded of expectations for prompt call pendant response times and resident rights related to care and safety.
    - Starting March 20,2025, the Executive Director or the DHW will continue to review and adjust the staffing schedule based on occupancy and resident acuity bi-weekly.
    - On March 20, 2025 an additional beeper has been provided to the Concierge/Front desk. On March 20,2025 an in-service took place to instruct the concierge to announce any unanswered call pendants after five minutes to prompt follow-ups by available staff.
    - Resident Council minutes will be reviewed monthly by Executive Director and the Director of Health and Wellness to identify additional concerns related to pendant response time. Effective 4/1/2025 and will occur monthly.

MIRA VIE
AT BRICK
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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 recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- Starting on March 20, 2025, the corrective actions will be monitored by the Executive Director and the DHW to ensure that call pendant response times are reviewed during daily stand-up meetings by recording it on the Daily Stand-up Meeting form.
- Starting on March 20, 2025, The Executive Director and the DHW will continue to reinforce staff expectations around pendant response time, resident rights and adherence to policies prohibiting sleeping on duty. This will be monitored by documenting the on-going education and in-services by the Executive Director or DHW.
- The Executive Director or the Designee will conduct quarterly random, unscheduled visits during the night shift. These visits will serve to monitor staff performance and ensure a timely response to resident needs. Any concerns identified will be addressed promptly through additional training or disciplinary measures, as appropriate. This started on March 27, 2025 and will be ongoing.
- Starting March 20, 2025, staffing schedules will be monitored monthly by the Executive Director and the DHW by following a labor template based on occupancy and resident acuity.
- Starting on March 20, 2025, The Concierge/Front desk Beeper Procedure will be monitored by the Executive Director or Designee to ensure continued compliance and effectiveness by monthly evaluating the success of this measure.
- Resident feedback will continue to be gathered by the Director of Resident Experience during our monthly Resident Council and reported to the Executive Director and the DHW to identify additional concerns.
- Starting March 20, 2025, Pendent Response times will be reviewed monthly by Regional Vice President Clinical as specified in the Monthly Clinical Quality Report.

6/27/25

MIRA VIE

AT BRICK

ASSISTED LIVING | MEMORY CARE

A537

1) The residents, the families, the staff and regulatory agencies were affected by not having a printed Policy and Procedure Manual in a binder accessible to them.
    - On March 19, 2025, a binder containing the printed current Policy and Procedure Manual was assembled by the Executive Director and presented to the Surveyors during the Exit interview.
    - Meeting was immediately held with Department Heads and staff regarding placement of Policy and procedure Manual on March 19, 2025.
    - Residents reminded of Policy and Procedure manual location during Resident Council on April 29,2025.
    - Notification of placement of Policy and Procedure Manual also sent via Go Happy messaging App to all resident families and staff. Completed on May 29, 2025.

2) All Residents, the families, the staff and regulatory agencies have the potential to be affected by not having a printed Policy and Procedure Manual accessible.

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

    - On March 19, 2025, a binder containing the printed current Policy and Procedure Manual was assembled by the Executive Director and presented to the Surveyors during the Exit interview. The Policy & Procedure Binder is now located in the Copy Room and always available to the residents, the families, the staff and regulatory agencies.
    - On March 19, 2025, both Department Heads and community staff were all notified of the location of the Policy and Procedure binder. They were instructed on how to direct the residents, the families, the staff and the regulatory agencies to it when requested.
    - Residents reminded of Policy and Procedure manual location during Resident Council on May 29, 2025.
    - Notification of placement of Policy and Procedure Manual also sent via Go Happy messaging App to all resident families and staff. Completed on May 29, 2025.

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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 recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

- By March 20, 2025, A printed sign-off log for the department heads will be maintained by the Executive Director to document annual reviews and any updates in the Policy and Procedures. Any Policy and Procedure updates made to the Sharepoint system will be monitored by the Executive Director and will be immediately reflected in the printed Policy & Procedure binder.
- On March 19, 2025, the Executive Director or designee will ensure that the Policy and Procedure manual is consistently available by verifying that the binder is maintained in its designation location in the copy room. Bi-weekly spot-checks will be conducted by the Executive Director or designee to always confirm its presence and accessibility.

dated 3/27/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
65a007 Y1	A. Building B. Wing Y2	6/27/2025 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 A0401 Reg. # 8:36-4.1(a)(22) LSC	Correction Completed 05/30/2025	ID Prefix A0537 Reg. # 8:36-5.7(a)(1) LSC	Correction Completed 05/30/2025	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 3/19/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			