

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>21A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MIRA VIE AT BROOKFIELD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1 BROOKFIELD COURT BELVIDERE, NJ 07823</b>
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A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ00188243</p> <p>CENSUS: 88</p> <p>SAMPLE SIZE: 3</p> <p>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.</p>	A 000		
A 269	<p>8:36-3.1(a) Appointment of Administrator</p> <p>(a) An administrator shall be appointed and an alternate shall be designated in writing to act in the absence of the administrator. The administrator or a designated alternate shall be available at all times and shall be on-site at the facility on a full-time basis in facilities that have 60 or more licensed beds, and on a half-time basis in facilities that have fewer than 60 licensed beds, in accordance with the definition of "full-time" and "half-time" at N.J.A.C. 8:36-1.3.</p>	A 269		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

09/04/25

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A 269	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00188243 Based on observation and interview, it was determined that the facility failed to ensure that the Executive Director (ED) or a designated alternate was on-site at the facility on a full-time basis. This deficient practice was evidenced by the following:</p> <p>On 7/23/25 at 10:00 a.m., the surveyor arrived at the facility and requested to speak to the ED to discuss the New Jersey Department of Health (NJDOH) survey visit. The receptionist stated that the ED was on vacation and that she would notify the Director of Health and Wellness (DOHW) of the surveyor's arrival and request and will then call the Regional Vice President of Operations (RVPO).</p> <p>At 10:20 a.m., the DOHW stated that the RVPO was <b>NJ Ex Order 26, 4B1</b> away from the facility. The DOHW stated that the RVPO asked if she could participate in the survey over the phone.</p> <p>At 10:32 a.m., during a telephone interview when the surveyor asked about the ED, the RVPO stated and confirmed that the ED was on vacation and that in the ED's absence, she was the Alternate ED. The RVPO continued to say that she was <b>NJ Ex Order 26, 4B1</b> away from the facility and asked if she had to come in for the survey.</p> <p>At 10:41 a.m., during surveyor interview, the DOHW stated that she did not remember the last</p>	A 269		

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A 269	Continued From page 2  time she observed the RVPO at the facility and that she had not seen the RVPO since the ED had been <b>NJ Ex Order 26. 4B1</b>  At 12:43 p.m., the surveyor observed the RVPO, who stated that she had just arrived at the facility.	A 269		
A 363	8:36-4.1(a)(5) 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:  5. The right to make choices with respect to services and lifestyle;  This REQUIREMENT is not met as evidenced by: Complaint#: NJ00188243 Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident's right was enforced when <b>NJ Ex Order 26. 4B1</b> was administered to a resident who chose <b>NJ Ex Order 26.4(b)(1) NJ Ex Order 26. 4B1</b> , for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:  On 7/23/25, the surveyor reviewed Resident #2's	A 363		

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A 363	<p>Continued From page 3</p> <p>Medical Record (MR), which revealed that the resident was <b>NJ Ex Order 26. 4B1</b>. Further review of the resident's medical record revealed a <b>NJ Ex Order 26. 4</b> " order dated <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>The surveyor reviewed a "Resident Incident Report," signed by the Director of Health and Wellness (DOHW) on <b>NJ Ex Order 26</b>, for a <b>NJ Ex Order 26. 4B1</b> that occurred on <b>NJ Ex Order 26</b>. The report indicated that Resident #2 became <b>NJ Ex Order 26. 4B1</b>, and that the resident was <b>NJ Ex Order 26.4(b)(1)</b> for <b>NJ Ex Order 26. 4B1</b>.</p> <p>Continued surveyor review of the "Incident/Accident Investigative Witness Statement," completed by a Licensed Practical Nurse (LPN) and two Care Partners (CPs) who were present and witnessed Resident #2's <b>NJ Ex Order 26. 4B1</b> revealed the following:</p> <ol style="list-style-type: none"> <li>1) The LPN's statement indicated, <b>NJ Ex Order 26. 4B1</b> ..."</li> <li>2) CP #1's statement indicated that Resident #2 was <b>NJ Ex Order 26. 4B1</b>. The report also indicated, <b>NJ Ex Order 26. 4B1</b> .."</li> <li>3) CP #2's statement indicated that Resident #2 <b>NJ Ex Order 26.4(b)</b> <b>NJ Ex Order 26. 4B1</b>.</li> </ol> <p>Further review of the report revealed that the previously mentioned LPN performed the <b>NJ Ex Order 26. 4B1</b>, which was <b>NJ Ex Order 26.4(b)(1)</b>, so the resident was <b>NJ Ex Order 26.4(b)(1)</b> from his/her <b>NJ Ex Order</b> to the <b>NJ Ex Order 26. 4B1</b> ..."</p>	A 363		
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A 363	<p>Continued From page 4</p> <p>At 3:54 p.m., during an interview, the LPN confirmed that she <sup>NJ Ex Order</sup> Resident #2 <sup>NJ Ex Order 26.4(b)(1)</sup> and administered <sup>NJ Ex Order 26.4B1</sup>. In the same interview, when the surveyor asked about Resident #2's <sup>NJ Ex Order 26.4(b)(1)</sup>, the LPN stated that the resident was a <sup>NJ Ex Order</sup>.</p> <p>On 7/28/25 at 10:10 a.m., the surveyor had a telephone interview, when the surveyor asked if she investigated the reason the LPN administered <sup>NJ Ex Order</sup> to Resident #2 who was a <sup>NJ Ex Order</sup>, the DOHW stated that the LPN told her that she was taught that she could administer <sup>NJ Ex Order 2</sup> because the resident was <sup>NJ Ex Order 26.4B</sup> and was not <sup>NJ Ex Order 26.4(b)(1)</sup>. In the same interview, when, the surveyor asked if the DOHW completed any in-service training regarding <sup>NJ Ex Order</sup> and CPR with staff following the <sup>NJ Ex Order 26.4B</sup>, the DOHW stated that she did not.</p> <p>Surveyor review of a 4/2021 facility policy titled, "Protecting Resident Rights," indicated, "... 1. We address and respect resident rights in providing resident services ... 3. The resident has a right to staff and services that respect his or her personal values, beliefs, cultural and spiritual preferences, and life-long patterns of living ... 5. The resident has a right to make informed decisions about services ... 22. The resident has a right to formulate advance directives ..."</p> <p>Surveyor review of a 4/2021 facility policy titled, "CPR GUIDELINES," dated 04/2021, indicated, "... POLICY: CPR wishes of the resident will be requested and followed per state regulations and Community policy ... No CPR/No RN on Site 1) When a resident elects not to have CPR performed in the event of cardio/respiratory arrest, then staff will not begin any life sustaining</p>	A 363		
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A 363	Continued From page 5  measures. 2) If a Registered Nurse is not on site, the following procedure will be initiated: a) Call 911 and explain that the resident has no pulse or vital signs. Explain that the resident is a No Not Resuscitate ...."	A 363		
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 #: NJ00188243 Based on observation, interview and record review, it was determined that the facility failed to ensure that a safe environment was maintained while providing care and services to residents in the community for 2 of 3 residents reviewed, Resident #s 1 and 2. This deficient practice is evidenced by the following:  On 7/4/25, the Department of Health (DOH) received a Facility Reportable Event (FRE) completed by the Executive Director (ED) for an	A 401		

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A 401	<p>Continued From page 6</p> <p><b>NJ Ex Order 26.4(b)(1)</b> that occurred on <b>NJ Ex Order 26</b> at 6:57 p.m. The FRE revealed that a resident (Resident #2) had a possible <b>NJ Ex Order 26. 4B1</b> in the dining room, a Licensed Practice Nurse (LPN) and 3 aides arrived to the dining room and escorted the resident to his/her apartment, the resident <b>NJ Ex Order 26.4(b)</b> <b>NJ Ex Order 26. 4B1</b> and staff performed the <b>NJ Ex Order 26. 4B1</b>, but it was <b>NJ Ex C</b>. The FRE then indicated that Resident #2 was <b>NJ Ex Order 26.4(b)(1)</b> to <b>NJ Ex Order 26.4(b)(1)</b> <b>NJ Ex Order 26. 4B1</b> was started, and the resident's <b>NJ Ex Order 26</b> was swept to <b>NJ Ex Order 26.4(b)(1)</b>. The FRE indicated that Resident #2 was in and out of <b>NJ Ex Order 26. 4B1</b>, and that the resident <b>NJ Ex</b> his/her <b>NJ Ex Order 26. 4B1</b>. Resident #2 remained on his/her <b>NJ Ex Ord</b> <b>NJ Ex Order 26. 4B1</b> until emergency services arrived and took over. The FRE further indicated that Resident #2 went <b>NJ Ex Order 26. 4B1</b>, and that emergency services performed the <b>NJ Ex Order 26. 4B1</b> and transported the resident to a local hospital.</p> <p>On 7/23/25, the surveyor reviewed a "Resident Incident Report (RIR)," signed by the Director of Health and Wellness (DOHW) on <b>NJ Ex Order 26.4</b> for the <b>"NJ Ex Order 26. 4B1"</b> that occurred in the dining room on <b>NJ Ex Order 26.4</b>. Upon surveyor review, the RIR indicated that Resident #2 had difficulty <b>NJ Ex Order 26. 4B1</b> and was encouraged to <b>NJ Ex Order 26</b>. The RIR also indicated that Resident #2 requested to go to his/her apartment and two nursing care staff transported the resident to his/her apartment, where the resident became <b>NJ Ex Order 26. 4B1</b> <b>NJ Ex Order 26. 4B1</b> was called and that <b>NJ Ex Order 26. 4B1</b> and the <b>NJ Ex Order 26. 4B1</b> were performed. The report indicated that the resident became <b>NJ Ex Order 26. 4B1</b>, and that the resident was <b>NJ Ex Order 26.4(b)</b> to the <b>NJ Ex Order 26.4(b)</b> <b>NJ Ex Order 26. 4B1</b>. The report indicated that emergency services arrived and transported Resident #2 to a local hospital and that the</p>	A 401		
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A 401	<p>Continued From page 7</p> <p>resident <b>NJ Ex Order 26. 4B1</b>. Additionally, the RIR indicated that the <b>NJ Ex Order 26. 4B1</b> took place at 6:30 p.m., and that emergency services were not called until 6:40 p.m. Continued surveyor review of the RIR revealed that Resident #2 had a plan in place for <b>NJ Ex Order 26. 4B1</b> prior to this incident.</p> <p>Surveyor review of a second RIR signed by DOHW on <b>NJ Ex Order 26.4B1</b> for a "<b>NJ Ex Order 26. 4B1</b>" that occurred on <b>NJ Ex Order 26. 4B1</b>. The report indicated that Resident #2 was observed in the dining hall and "<b>NJ Ex Order 26. 4B1</b>." The RIR also indicated that <b>NJ Ex Or</b> was called, <b>NJ Ex Order 26. 4B1</b> were administered, and Resident #2 <b>NJ Ex Order 26. 4B1</b> a <b>NJ Ex Order</b> and began <b>NJ Ex Order 26. 4B1</b>, then moments later Resident #2 "<b>NJ Ex Order 26. 4B1</b>," and that the resident stopped <b>NJ Ex Order 26. 4B1</b> and the resident's <b>NJ Ex Order 26. 4B1</b>. The report indicated that the <b>NJ Ex Order 26. 4B1</b> was performed, and Resident #2 became <b>NJ Ex Order 26. 4B1</b>. In addition, the report indicated that emergency services arrived and performed the <b>NJ Ex Order 26. 4B1</b> until Resident #2 let out a <b>NJ Ex Order 26. 4B1</b> and <b>NJ Ex Order 26.4(b)(1)</b> was <b>NJ Ex Order 26. 4B1</b>. Further review of the report confirmed that Resident #2 had a <b>NJ Ex Order 26. 4B1</b> and that the resident had a previous <b>NJ Ex Order 26. 4B1</b>. The report indicated that after this <b>NJ Ex Order 26. 4B1</b>, Resident #2's responsible party informed facility staff that the resident was seen by <b>NJ Ex Order 26. 4B1</b>, who recommended a <b>NJ Ex Order 26. 4B1</b> for the resident.</p> <p>Record review of a <b>NJ Ex Order 26.4(b)(1)</b> Note <b>NJ Ex Order 26. 4B1</b> dated <b>NJ Ex Order 26.4(b)</b>, revealed that Resident #2 was on a <b>NJ Ex Order 26. 4B1</b> and that the resident desired a <b>NJ Ex Or</b> upgrade. The <b>NJ Ex Order</b> also indicated that Resident #2 was seen by <b>NJ Ex Order 26. 4B1</b> on <b>NJ Ex Order 26.4(b)</b>, and a <b>NJ Ex Order 26. 4B1</b> was completed. The</p>	A 401		
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A 401	<p>Continued From page 8</p> <p><b>NJ Ex Order 26.4B1</b> indicated that Resident #2 had <b>NJ Ex Order 26.4B1</b> [REDACTED]. The SLP recommended a <b>NJ Ex Order 26.4B1</b> [REDACTED].</p> <p>Surveyor review of the Medical Record (MR) for Resident #2 revealed an <b>NJ Ex Order 26.4B1</b> [REDACTED]. Review of the MR revealed, "<b>NJ Ex Order 26.4B1</b> [REDACTED]" order dated <b>NJ Ex Order 26.4(b)(1)</b> [REDACTED].</p> <p>Review of Resident #2's "Service Plan (SP)" revealed no documentation of interventions or a Health Service Plan (HSP) that was put into place based on the <b>NJ Ex Order 26.4B1</b> [REDACTED] findings/recommendations for a <b>NJ Ex Order 26.4B1</b> [REDACTED].</p> <p>At 12:52 p.m., the surveyor interviewed Dietary Aide #1, who stated that Resident #2 had <b>NJ Ex Order 26.4B1</b> [REDACTED] many times in the past and that he had given the resident the <b>NJ Ex Order 26.4B1</b> [REDACTED] approximately a <b>NJ Ex Order 26.4B1</b> [REDACTED].</p> <p>Dietary Aide #1 stated that Resident #2 <b>NJ Ex Order 26.4B1</b> [REDACTED] to <b>NJ Ex Order 26.4(b)(1)</b> [REDACTED] and that dietary staff thought the resident should be on a <b>NJ Ex Order 26.4B1</b> [REDACTED]. The surveyor inquired if Dietary Aide #1 informed anyone, and the dietary aide stated that the ED and nurses were aware. Dietary Aide #1 explained that nothing was done because Resident #2 and the resident's responsible party wanted the resident to eat what the resident <b>NJ Ex Order 26.4(b)(1)</b> [REDACTED]. Dietary Aide #1 stated that he would always look at Resident #2 during meals because he was <b>NJ Ex Order 26.4B1</b> [REDACTED] the resident would <b>NJ Ex Order 26.4B1</b> [REDACTED]. Dietary Aide #1 stated that there were no staff that sat in the dining hall for the whole duration of meals. In the same interview, Dietary Aide #1 also stated that</p>	A 401		

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A 401	<p>Continued From page 9</p> <p>he administered the <b>NJ Ex Order 26. 4B1</b> to another resident, Resident #1, when the resident <b>NJ Ex Order 26. 4B1</b> <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>2. Surveyor review of the MR for Resident #1 revealed an <b>NJ Ex Order 26. 4B1</b> <b>NJ Ex Order 26. 4B1</b>. The surveyor reviewed a Progress Note (PN) in Resident #1's MR, which confirmed that the resident had a <b>NJ Ex Order 26. 4B1</b>. Resident #1's service plan reveal no documentation of any interventions that were put in place or that a HSP was developed following the aforementioned <b>NJ Ex Order 26. 4B1</b> <b>NJ Ex Order 26. 4B1</b>.</p> <p>At 1:43 p.m., the surveyor requested Resident #2's <b>NJ Ex Order 26. 4B1</b> notes from the DOHW, and the DOHW stated that Resident #2 refused to see <b>NJ Ex Order 26. 4B1</b> upon return to the facility because the resident did not want his/her <b>NJ Ex Order 26.4(b)(1)</b>. At this time, the DOHW also confirmed that Resident #2 had <b>NJ Ex Order 26. 4B1</b>.</p> <p>At 2:03 p.m., the surveyor interviewed Dietary Aide #2, who stated that she witnessed Resident #2 <b>NJ Ex Order 26. 4B1</b> everyday while eating and that she reported t to nurses and <b>NJ Ex Order 26. 4B1</b>. During this interview, Dietary Aide #2 stated that Resident #2 had <b>NJ Ex Order 26. 4B1</b> and that there were no staff that sat in the dining hall for the duration of meals.</p> <p>At 3:33 p.m., the surveyor interviewed the DOHW to inquire what interventions were put into place following the previously mentioned <b>NJ Ex Order 26. 4B1</b> <b>NJ Ex Order 26. 4B1</b>. The DOHW stated that Resident #2's first <b>NJ Ex Order 26. 4B1</b> and that she was not employed at the facility during that time. The DOHW stated that after Resident #2's <b>NJ Ex Order 26. 4B1</b>, Resident #2</p>	A 401		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>21A001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MIRA VIE AT BROOKFIELD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1 BROOKFIELD COURT BELVIDERE, NJ 07823</b>
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A 401	<p>Continued From page 10</p> <p>had a diet change, a care conference was held, the resident was informed that he/she could only <b>NJ Ex Order 26. 4B1</b>, and an in-service training on <b>NJ Ex Order 26. 4B1</b> (AED), <b>NJ Ex Order 26. 4B1</b> was provided to staff. The DOHW stated that she did not provide staff with in-services or re-training after Resident #2's <b>NJ Ex Order 26. 4B1</b>.</p> <p>In the same interview, the surveyor asked about the reason Resident #2's service plan did not include monitoring during <b>NJ Ex Order 26. 4B1</b> or other preventative interventions, the DOHW stated that the facility could not provide someone to sit with the resident and that the resident's responsible party did not want the resident <b>NJ Ex Order 26. 4B1</b>.</p> <p>At 3:54 p.m., the surveyor interviewed the Licensed Practical Nurse (LPN) who was involved in Resident #2's <b>NJ Ex Order 26. 4B1</b>. The LPN stated that she responded to an emergency call over the walkie from kitchen staff, who requested nursing assistance in the dining room, and observed Resident #2 <b>NJ Ex Order 26. 4B1</b>. The LPN stated that while <b>NJ Ex Order 26. 4B1</b>, Resident #2 requested to go back to his/her apartment and that she and a Care Partner (CP) [Aide] took the wheelchair-bound resident back to his/her apartment. The LPN stated that once in Resident #2's apartment, she administered <b>NJ Ex Order 26. 4B1</b>. The LPN stated that Resident #2's condition <b>NJ Ex Order 26. 4B1</b>, so she performed the <b>NJ Ex Order 26. 4B1</b>. The LPN then stated that she left Resident #2 with the CP and went to call <b>NJ Ex Or</b>. The surveyor inquired the reason the LPN did not send the CP to call <b>NJ Ex Or</b>, so that she could continue to assist</p>	A 401		
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New Jersey Department of Health

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A 401	<p>Continued From page 11</p> <p>Resident #2. The LPN stated that Resident #2 was <b>NJ Ex Order 26. 4B1</b> and that she thought the resident was safe. The surveyor then inquired if Resident #2 was <b>NJ Ex Order 26.4(b)(1)</b> when she left to call <b>NJ Ex Order 26.4(b)(1)</b>, and the LPN stated that the resident was <b>NJ Ex Order 26.4(b)(1)</b> at that time. The LPN stated that when she returned Resident #2 <b>"NJ Ex Order 26. 4B1"</b>, so she performed the <b>NJ Ex Order 26. 4B1</b> again and the resident became <b>NJ Ex Order 26. 4B1</b>. The LPN then stated that she <b>NJ Ex Order 26.4(b)(1)</b> Resident #2 <b>NJ Ex Order 26.4(b)(1)</b> and administered <b>NJ Ex Order 26. 4B1</b>, and that emergency services arrived at that time. The LPN stated that emergency services was able to <b>NJ Ex Order 26. 4B1</b> a <b>"NJ Ex Order 26.4(b)(1)"</b> The LPN stated that the previously mentioned incident was Resident #2's <b>NJ Ex Order 26. 4B1</b>.</p> <p>The surveyor reviewed the LPN's written incident investigative witness statement, dated <b>NJ Ex Order 26.4(b)(1)</b> which indicated, "I was called to the dining room during supper, Resident was having <b>NJ Ex Order 26.4(b)(1)</b> <b>NJ Ex Order 26. 4B1</b>..."</p> <p>On 7/24/25 at 1:00 p.m., the surveyor conducted a post-survey telephone interview with a CP who was also involved in Resident #2's <b>NJ Ex Order 26. 4B1</b> <b>NJ Ex Order 26. 4B1</b>, to ask what happened. The CP stated that on <b>NJ Ex Order 26. 4B1</b>, she responded to a call for immediate assistance in the dining room and observed Resident #2 <b>NJ Ex Order 26. 4B1</b>. The CP stated that she immediately directed a staff member to call the nurse and began to encourage Resident #2 to continue <b>NJ Ex Order 26. 4B1</b>. The CP stated that the previously mentioned LPN arrived and stated, <b>"NJ Ex Order 26. 4B1"</b> The CP stated that she and the LPN escorted Resident #2 to his/her apartment and continued to encourage the resident to <b>NJ Ex Order 26. 4B1</b>. The CP also stated that on the way to the room</p>	A 401		
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NAME OF PROVIDER OR SUPPLIER  <b>MIRA VIE AT BROOKFIELD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1 BROOKFIELD COURT BELVIDERE, NJ 07823</b>
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A 401	<p>Continued From page 12</p> <p>they directed another staff member to call [redacted] and that another CP came into the resident's apartment with them. The CP stated that Resident #2 was <b>NJ Ex Order 26. 4B1</b> in the room and then <b>NJ Ex Order 26.4(b)(1)</b> and became <b>NJ Ex Order 26. 4B1</b>. The CP stated that the LPN attempted the <b>NJ Ex Order 26. 4B1</b> while Resident #2 remained in the wheelchair and that it was <b>NJ Ex Order 26.4(b)(1)</b>. The CP stated that she and the LPN <b>NJ Ex Order 26.4(b)(1)</b> Resident #2 to <b>NJ Ex Order 26.4(b)</b> and the LPN gave the resident <b>NJ Ex Order 26. 4B1</b> and that she (the CP) did a <b>NJ Ex Order 26. 4B1</b> of Resident #2's <b>NJ Ex Order 26</b> and <b>NJ Ex Order 26.4(b)(1)</b>. The CP stated that she and the LPN turned Resident #2 on his/her side and delivered <b>NJ Ex Order 26. 4B1</b>. The CP stated that they then noticed <b>NJ Ex Order 26. 4B1</b> of Resident #2's <b>NJ Ex Order 26.4</b>. The CP stated that Resident #2 was <b>NJ Ex Order 26. 4B1</b> and then emergency services arrived. The CP stated that she went to stand by the door and then observed emergency services perform the <b>NJ Ex Order 26. 4B1</b> on Resident #2. The surveyor inquired the reason Resident #2 was moved to his/her apartment as the resident <b>NJ Ex Order 26. 4B1</b>, and the CP stated that she was instructed by staff that in an emergency the resident should be moved away from other residents. The surveyor then inquired if the CP was left alone in the room alone at any time with Resident #2 and the CP stated that she was not, and that the LPN and another CP was in the room with her for the duration of the incident.</p> <p>The surveyor reviewed a 4/2021 facility policy titled, "CPR GUIDELINES," indicated, "... POLICY: CPR wishes of the resident will be requested and followed per state regulations and Community policy ... No CPR/No RN on Site 1) When a resident elects not to have CPR performed in the event of cardio/respiratory arrest, then staff will not begin any life sustaining</p>	A 401		
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A 401	Continued From page 13  measures. 2) If a Registered Nurse is not on site, the following procedure will be initiated: a) Call 911 and explain that the resident has no pulse or vital signs. Explain that the resident is a No Not Resuscitate ..."  Surveyor review of a 4/2021 facility policy titled, "Service Plans," indicated, "... Policy: Individualized service plans are used to plan for and meet resident needs using an Interdisciplinary approach ... 3. The Director of Health and Wellness updates the service plan whenever a change is noted and service changes are necessary ...."  Surveyor review of a 4/2021 facility policy titled, "Service Plans and Assessments New Jersey," indicated, "... 8. The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to care provided and any changes in the resident's physical or cognitive status ... 10. Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan ...."	A 401		
A 735	8:36-7.2(e)(1-5) Health Care Assmnt. and Health Service Plan  (e) Based on the health care assessment, a written health service plan shall be developed. The health service plan shall include, but not be limited to, the following:  1. Orders for treatment or services, medications, and diet, if needed;  2. The resident's needs and preferences for	A 735		

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A 735	<p>Continued From page 14</p> <p>himself or herself;</p> <p>3. The specific goals of treatment or services, if appropriate;</p> <p>4. The time intervals at which the resident's response to treatment will be reviewed; and</p> <p>5. The measures to be used to assess the effects of treatment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that service plans were updated, and Health Service Plans (HSPs) were developed following incidents of <b>NJ Ex Order 26.4B1</b> for 2 of 3 residents reviewed, Resident #s 1 and #2. This deficient practice was evidenced by the following:</p> <p>On 7/23/25, the surveyor reviewed a "Resident Incident Report (RIR)," signed by the Director of Health and Wellness (DOHW) on <b>NJ Ex Order 26.4(b)</b> for a <b>"NJ Ex Order 26.4B1"</b> that occurred on <b>NJ Ex Order 26.4(b)</b>. The RIR indicated that Resident #2 had a <b>NJ Ex Order 26.4B1</b> <b>[REDACTED]</b>. The RIR indicated that after the previously mentioned incident, Resident #2's responsible party informed facility staff that the resident was seen by <b>NJ Ex Order 26.4B1</b>, who recommended a <b>NJ Ex Order 26.4B1</b> for the resident.</p>	A 735		

New Jersey Department of Health

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A 735	<p>Continued From page 15</p> <p>Record review of a 'NJ Ex Order 26.4(b)(1)' dated [redacted], revealed that Resident #2 was on a [redacted] and that the resident desired upgrade. The [redacted] also indicated that Resident #2 was seen by [redacted] on [redacted], and a [redacted] was completed. The [redacted] indicated that Resident #2 had [redacted]. The [redacted] recommended a [redacted].</p> <p>1. Surveyor review of the Medical Record (MR) for Resident #2 revealed an [redacted]. Record review of Resident #2's "Service Plan (SP)" did not reveal any documentation of interventions or a Health Service Plan (HSP) that was put into place based on the [redacted] findings/recommendations for a [redacted].</p> <p>2. Surveyor review of the MR for Resident #1 revealed an [redacted]. The surveyor reviewed a Progress Note (PN) in Resident #1's MR, which confirmed that the resident had a [redacted]. Resident #1's SP revealed no documentation of any interventions that were put in place or the development of a HSP following the aforementioned [redacted].</p> <p>At 1:43 p.m., the surveyor requested [redacted] notes from the DOHW, and the DOHW stated that Resident #2 refused [redacted] upon return to the facility because the resident did</p>	A 735		
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A 735	<p>Continued From page 16</p> <p>not want his/her <b>NJ Ex Order 26.4(b)(1)</b>. At this time, the DOHW also confirmed that Resident #2 had <b>NJ Ex Order 26. 4B1</b>.</p> <p>At 3:33 p.m., the surveyor interviewed the DOHW to inquire what interventions were put into place following the previously mentioned <b>NJ Ex Order 26. 4B1</b>. The DOHW stated that Resident #2's <b>NJ Ex Order 26. 4B1</b> and that she was not employed at the facility during that time. The DOHW stated that after Resident #2's <b>NJ Ex Order 26. 4B1</b>, Resident #2 had a <b>NJ Ex Order 26. 4B1</b>, a care conference was held, the resident was informed that he/she could only eat in the dining hall so that people were around, and an in-service training on <b>NJ Ex Order 26. 4B1</b> (AED), <b>NJ Ex Order 26. 4B1</b> (CPR) was provided to staff. The DOHW stated that she did not provide staff with in-services or re-training after Resident #2's <b>NJ Ex Order 26. 4B1</b>.</p> <p>In the same interview, the surveyor asked the reason Resident #2's service plan did not include monitoring during meals or other preventative interventions, the DOHW stated that the facility could not provide someone to sit with the resident during meals and that the resident's responsible party did not want the resident <b>NJ Ex Order 26. 4B1</b>.</p> <p>The facility did not ensure appropriate interventions were initiated and the HSP updated to address the resident's <b>NJ Ex Order 26. 4B1</b>.</p> <p>Surveyor review of a 04/2021 facility policy titled, "Resident Medical Record," indicated, "... Policy: An accurate and properly updated Resident</p>	A 735		

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A 735	<p>Continued From page 17</p> <p>Record will assist us in managing the health care of our residents ... 1. Each Resident Record contains at a minimum ... j) Updated Resident Service Plan ...."</p> <p>Surveyor review of a 4/2021 facility policy titled, "Service Plans," dated 04/2021, indicated, "... Policy: Individualized service plans are used to plan for and meet resident needs using an Interdisciplinary approach ... 3. The Director of Health and Wellness updates the service plan whenever a change is noted and service changes are necessary ...."</p> <p>Surveyor review of a 4/2021 facility policy titled, "Service Plans and Assessments New Jersey," indicated, "... 8. The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to care provided and any changes in the resident's physical or cognitive status ... 10. Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan ...."</p>	A 735		



Poc #4  
accepted  
10/15/25

October 3<sup>rd</sup>, 2025

Complaint Survey: 7/23/2025

Tag A269

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
  - Letter regarding designated alternate administrator has been posted at the front desk 7/24/2025 and will continue ongoing.
  - Department of Health was notified of our alternate administrator on 10/2/2025.
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.
  - Department head team and concierge team were educated on the letter posted in the lobby notifying all visitors, staff, and residents of the designated alternate administrator is in the Executive Director's absence. Started and completed on 7/31/25.
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.
  - Executive Director (ED) or designee will be responsible for ensuring the alternate administrator sign is posted with the designated alternate administrator during any absence. This will be monitored at all times during daily operations.
  - Executive Director requires "request off" forms to be submitted by management team. This form is filled out by our team anytime someone would like to request a day off and signed off on by the ED. This will ensure



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that the ED is aware of the alternate administrator's absence and will therefore designate another alternative if needed.

**Completion Date: 10/2/2025**



Tag A363

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
  - Resident #2 **NJ Ex Order 26. 4B1** Resident **NJ Ex Order 26. 4B1**.
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.
  - Inservice completed on “Choking, Medical Emergency, CPR/AED” with Nursing and Food Service Staff on 7/29/2025. Completed by Director of Health and Wellness (DHW).
  - Team support meeting occurred on 8/5/25 where all staff were invited to attend. Choking/CPR/DNR education reviewed by DHW.
  - Reviewed resident choking/CPR/DNR at Town Hall with all staff present in community on 8/27/2025. Reviewed residents who are a DNR and where to find listings: Kitchen, Activity Department, Front Desk, Nursing. Completed by Executive Director (ED).
  - Reviewed policy on “Protecting Resident Rights” with all staff. Specifically reviewed the right to choose advanced directives and to respect the resident’s wishes. Completed 9/5/2025 by ED.
  - The LPN involved in this incident **NJ Ex Order 26. 4B1**
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.



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- Policy on “Protecting Resident Rights” will be reviewed quarterly by the ED with specific detail on choosing advanced directives and to respect the resident’s wishes, starting on 10/21/2025 and ongoing.
- Staff Education on “Choking, Medical Emergency, CPR/AED” with Nursing and Food Service Staff completed quarterly by Director of Health and Wellness.
- Education on Protecting Resident Rights and Choking, Medical Emergency, CPR/AED will be reviewed for completion by ED and managers during quarterly QI Meetings. Starting on 10/16/25 and ongoing.

**Completion Date: 9/5/2025**



Tag A401

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
  - Resident #1's Service Plan was updated on 7/24/2025 by the Director of Health and Wellness (DHW) to include **NJ Ex Order 26.4B1** with interventions of **NJ Ex Order 26.4(b)(1)** staff to report s/s of **NJ Ex Order 26.4(b)(1)** immediately.
  - DHW educated staff to report any **NJ Ex Order 26.4(b)(1)** or change in conditions with Resident #1 and all residents, especially during meals. Completed on 8/5/2025.
  - Resident #2 **NJ Ex Order 26.4B1**. Resident **NJ Ex Order 26.4B1**.
  - Resident #1 remains comfortably in the community.
  
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.
  - Nursing and Food Service Staff Inservice on Dysphagia and Choking completed 7/29/2025 by Director of Health and Wellness. This included Medical Emergency Policy review along with calling 911 immediately to prevent delay in care.
  - The LPN involved in this incident **NJ Ex Order 26.4B1**
  - DNR Audit started on 7/30/2025 and completed on 7/31/2025 by Resident Care Coordinator.
  - All residents that are a DNR currently have a \* on the back of their pendant, DNR hanging on the inside of their closet door, AED has a current list. Updated with move-in, move-out, change in condition/update in code status.



- Inservice on resident choking/CPR/DNR at Town Hall with staff started and completed on 8/27/2025. Reviewed residents who are a DNR and where to find listings: Kitchen, Activity Department, Front Desk, Nursing. Completed by Executive Director (ED).
  - General Service Plan and Assessment Policies reviewed with Wellness Nurses by Director of Health and Wellness on 9/5/2025 with no revisions made.
  - Executive Director reviewed policy on “Protecting Resident Rights” with all staff. Completed 9/5/2025.
  - Audit completed by Director of Health and Wellness for all residents on modified diets with updates to service plan related to Dysphagia and interventions to support team with reminders and recognizing residents at risk for aspiration/choking. Completed on 7/31/25.
  - Master Assessment started and completed on 9/23/25 by Senior Vice President of Nursing to pull residents that assess at risk for aspiration/choking/modified diets to automatically pull service plan interventions for Aspiration Precautions/ At Risk for Choking. This will be updated for all residents on change of condition and every 6 months as audit has already been completed on 7/31/25.
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.
- Quarterly Audit of residents on Modified Diets with comparison to Service Plan interventions in place to be completed by Director of Health and Wellness. Findings reported at Quarterly QI Meeting. Next Meeting 10/16/25.
  - Education on reporting resident changes in condition completed monthly during employee Town Hall Meeting by Executive Director. Completed on 8/27/25 and monthly.
  - All residents that are a DNR currently have a \* on the back of their pendant, DNR hanging on the inside of their closet door, AED has a current list. This is



# MIRA VIE

AT BROOKFIELD

audited quarterly and reported during QI. Audit completed on 7/31/2025 and ongoing. Next Quarterly QI Meeting is 10/16/25.

- Education on Protecting Resident Rights and Choking, Medical Emergency, CPR/AED will be reviewed for completion during quarterly QI Meetings by ED and management team. Starting on 10/16/25 and ongoing.

**Completion Date: 9/23/25**



Tag A735

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
  - Resident #1's Service Plan was updated on <sup>NJ Ex Order 26.4(b)(1)</sup> [redacted] by the Director of Health and Wellness (DHW) to include **NJ Ex Order 26. 4B1** with interventions of **NJ Ex Order 26.4(b)(1)** [redacted] staff to report s/s of <sup>NJ Ex Order 26.4(b)(1)</sup> [redacted] immediately.
  - Resident number #1 remains comfortably in our community.
  - Resident #2 is <sup>NJ Ex Order 26. 4B1</sup> [redacted] Resident **NJ Ex Order 26. 4B1** [redacted].
  
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.
  - General Service Plan, Health Service Plan, and Assessment Policies reviewed on 9/5/2025 with Wellness Staff by Director of Health and Wellness with no revisions made.
  - Director of Health and Wellness was educated by Regional Vice President (RVP) of Clinical regarding policy on General Service Plans, Health Service Plans, and Assessments as required. Effective 7/23/25 and Ongoing.
  - Audit completed by Director of Health and Wellness for all residents on modified diets with updates to service plan related to Dysphagia and interventions to support team with reminders and recognizing residents at risk for aspiration/choking. Completed on 7/31/25.



- General Service Plan/Health Service Plan Audit completed by Director of Health and Wellness on 8/16/25 with interventions noted on resident service plans for residents at risk for Aspiration/Choking.

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.
  - Quarterly Audit of residents on Modified Diets with comparison to Service Plan interventions in place to be completed by Director of Health and Wellness. Findings reported at Quarterly QI Meeting. Starting on 10/16/25 and ongoing.
  - Monthly Audit by RVP Clinical to ensure timely completions of resident assessments, service plans/updates, and health service plans. Completed 9/5/2025 and Ongoing.

**Completion Date: 9/5/2025**

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 21A001 <span style="float: right;">Y1</span>	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 10/15/2025 <span style="float: right;">Y3</span>
NAME OF FACILITY MIRA VIE AT BROOKFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 1 BROOKFIELD COURT BELVIDERE, NJ 07823	

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 <u>A0269</u>	<u>Correction</u>	ID Prefix <u>A0363</u>	<u>Correction</u>	ID Prefix <u>A0401</u>	<u>Correction</u>
Reg. # <u>8:36-3.1(a)</u>	<u>Completed</u>	Reg. # <u>8:36-4.1(a)(5)</u>	<u>Completed</u>	Reg. # <u>8:36-4.1(a)(22)</u>	<u>Completed</u>
LSC <u></u>	<u>10/02/2025</u>	LSC <u></u>	<u>09/05/2025</u>	LSC <u></u>	<u>09/23/2025</u>
ID Prefix <u>A0735</u>	<u>Correction</u>	ID Prefix <u></u>	<u>Correction</u>	ID Prefix <u></u>	<u>Correction</u>
Reg. # <u>8:36-7.2(e)(1-5)</u>	<u>Completed</u>	Reg. # <u></u>	<u>Completed</u>	Reg. # <u></u>	<u>Completed</u>
LSC <u></u>	<u>09/05/2025</u>	LSC <u></u>	<u></u>	LSC <u></u>	<u></u>
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REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/23/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

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Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
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