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 01/11/2024

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 #: NJ00168505 CENSUS: 85 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 389	8:36-4.1(a)(16) 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: 16. The right to be free from physical and mental abuse and/or neglect;	A 389		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/04/24

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A 389	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #'s NJ00168505, NJ00168537 Based on interview, medical record review, observation, and the review of facility provided video footage dated NJ Ex Order 26.4b1 it was determined that the facility failed to that each resident's right to be free from abuse was enforced when 1 of 3 residents reviewed for abuse experienced NJ Exec Order 26.4b1, Resident #2. This deficient practice was evidenced by the following: On NJ Exec Order 26.4b1 at 5:35 p.m., The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE), a document used by healthcare facilities to report incidents to the NJDOH. The report included a document titled, "Investigative Summary" (IS) which revealed that on NJ Exec Order 26.4b1, at approximately 12:30 p.m., Resident #2 reported to the facility's Business Office Manager that on NJ Exec Order 26.4b1, at approximately 8:00 p.m., after receiving evening medications, a facility Home Health Aide (HHA) attempted to have NJ Exec Order 26.4b1 with the resident. In addition, Resident #2 stated that the HHA also NJ Exec Order 26.4b1 to him/her. The IS revealed that on NJ Exec Order 26.4b1 at 12:45 p.m., the facility's Executive Director (ED) interviewed Resident #2, who reported that the facility's HHA entered his/her apartment and NJ Exec Order 26.4b1 the resident's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Resident #2 also reported that the NJ Exec Order 26.4b1 into the resident's NJ Exec Order 26.4b1. According to the IS, Resident #2 and his/her Power of Attorney (POA) NJ Exec Order 26 the ED's offer to be examined at a community hospital and NJ Exec Order 26 to NJ Exec Order 26.4b1	A 389		

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A 389	Continued From page 2 The IS also revealed that the facility's ED, and Health Service Director (HSD) reviewed the facility's video footage of the common area adjacent to Resident #2's apartment which captured a view of Resident #2's apartment front door for on the night of [NJ Exec Order 26.4b1] The IS indicated that the video footage revealed the following events: On [NJ Exec Order 26.4b1] at 7:11 p.m., the video footage revealed that the HHA entered Resident #2's apartment and removed trash. During the 7:11 p.m. encounter, which lasted for 2 minutes, Resident #2's door remained open the whole time. The video footage showed that Resident #2 stood up, and [NJ Exec Order 26.4b1], and the HHA exited the resident's apartment at approximately 7:13 p.m. The video footage also revealed that at approximately 8:20 p.m., the HHA returned to Resident #2's apartment, entered the apartment, and closed the door behind him. The video footage revealed that the HHA spent approximately 33 minutes in Resident #2's apartment before exiting. The IS revealed Resident #2 did not push his/her call bell for assistance at the time of the incident, and was [NJ Exec Order 26.4b1] with activities of daily living, except for [NJ Exec Order 26.4b1] The IS also revealed that the resident did not report receiving a [NJ Exec Order 2] at that time. Continued surveyor review of the IS revealed that on [NJ Exec Order 26.4b1], the facility's ED interviewed the HHA who stated he only went into Resident #2's apartment one time on the evening of [NJ Exec Order 26.4b1] to dispose of Resident #2's trash. The HHA	A 389		

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A 389	Continued From page 3	A 389		

denied going to Resident #2's apartment an additional time.

Further review of the facility's IS revealed that the HHA was NJ Exec Order 26.4b1 The IS revealed Resident #2's Primary Care Physician (PCP) was notified of the incident and assessed Resident #2 at the facility the following day. The IS also revealed that NJ Exec Order 26.4b1 support was coordinated for Resident #2, and new PCP orders were carried out as ordered. According to the IS, the NJ Exec Order 26.4b1 department was notified and a NJ Exec Order 26.4b1 from the county's NJ Exec Order 26.4b1 Unit visited the facility and was able to encourage Resident #2 to be assessed at the local community hospital.

On 1/11/2024 at 11:57 a.m., the surveyor interviewed Resident #2, who declined to discuss the incident that occurred on NJ Exec Order 26.4b1.

At 12:15 p.m., the surveyor reviewed Resident #2's Medical Record (MR), which included a document titled, "Resident Information Sheet" and observed that the resident moved into the facility on NJ Exec Order 26.4b1, and had diagnoses that included NJ Exec Order 26.4b1

Resident #2 MR included a document titled, "Plan of Care" (A form that summarizes a resident's health conditions, specific care needs and treatment including a problem, a goal, and interventions in place to achieve the goal) that was developed on NJ Exec Order 26.4b1 and was revised on NJ Exec Order 26.4b1 The Plan of Care revision included the intervention of not having a NJ Exec Order 26.4b1 assigned to care for Resident #2.

Resident #2 Nurse's Note (NN) dated NJ Exec Order 26.4b1

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A 389	Continued From page 4 at 3:22 p.m., revealed the resident reported that a NJ Exec Order staff member NJ Exec Order 26 him/her NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 comments to him/her. Resident #2 NN dated NJ Exec Order 26.4b1 at 1:21 p.m., revealed that Resident #2 spoke with a NJ Exec Order officer and was assessed by his/her PCP. Resident #2 NN dated NJ Exec Order 26.4b1 at 2:08 p.m., revealed that Resident #2 spoke with a NJ Exec Order 26.4b1 and agreed to be transported the community hospital's emergency room to be examined. The NN also revealed that NJ Exec Order 26.4b1 was consulted and that the resident's POA was made aware. Resident #2 NN dated NJ Exec Order 26.4b1 at 9:00 p.m., revealed that Resident #2 was accompanied by a facility's nursing staff member to the community hospital emergency room to be examined. On 1/11/2024 at 12:45 p.m., the surveyor interviewed the facility's ED, who stated that the HHA did not work at the facility when the incident was reported on NJ Exec Order 26.4b1 and that the HHA was informed that he was suspended prior to his next scheduled shift. At 12:50 p.m., the surveyor interviewed the facility HSD, in the presence of the Administrator, who stated that the facility's Administration was able to confirm that the HHA was in the resident's room with the door closed for approximately 32 minutes; the HSD also stated that the HHA exited the room NJ Exec Order 26.4b1 and NJ Exec Order 26.4b after reviewing the facility's video footage. The surveyor requested, at that time, a access to view the video footage. The ED stated that he would make the video available to the	A 389		

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A 389	Continued From page 5	A 389		

surveyor.

At 12:54 p.m., during continued surveyor interview with the facility's ED, he stated that he contacted the New Jersey's Board of Nursing and reported the NJ Exec Order 26.4b1 incident which involved the HHA and Resident #2.

On 1/22/2024 at 12:35 p.m., the surveyor conducted a post survey telephone interview with the facility's HSD who stated that the video footage did not save properly and that the facility's ED was in the process of requesting the video footage from the NJ Exec Order 26.4b assigned to Resident #2's case.

At 12:39 p.m., the surveyor conducted a telephone interview with the NJ Exec Order 26.4b assigned to Resident #2's case who stated that there had been no resolution to Resident #2's case, and that the investigation was ongoing. The NJ Exec Order 26.4b requested the surveyor contact him on NJ Exec Order 26.4b1 at 10:30 a.m. The surveyor attempted to reach the NJ Exec Order 26.4b as requested but was unable to contact the NJ Exec Order 26.4b at the provided telephone number on NJ Exec Order 26.4b1

On 1/22/2024 at 12:45 p.m., the surveyor conducted a telephone interview with the HHA identified in the FRE who denied Resident #2's account of the events/allegations of NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1. The HHA stated that on the evening of NJ Exec Order 26.4b1, he went to Resident #2's apartment to collect her trash and Resident #2 offered him cookies, in which he declined. The HHA stated that after declining the cookies, Resident #2 requested the HHA take the cookies to the community dining room to share with other residents. The HHA stated that he refused to take the cookies at the time due to

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A 389	Continued From page 6	A 389		

having trash in his hands.

During continued surveyor interview, the HHA stated that after he completed taking out the garbage, he returned to Resident #2's apartment, knocked on the door and entered the apartment. The HHA stated that the resident was in the bathroom at the time and that he grabbed the cookies off the table in the apartment and exited the apartment quickly. The HHA denied closing Resident #2's apartment door while inside, as well as being in Resident #2's apartment for more than 30 minutes.

On 2/15/2024 at 12:45 p.m., the surveyor conducted a telephone interview with the facility's ED that stated the facility would provide the NJDOH with access to the facility's portal to access the facility's video footage for the night of NJ Ex Order 26.4b1. The ED stated that he would provide the surveyor with a log in to the facility's portal to view and download the video footage.

On 2/21/2024 at 9:53 a.m., after not receiving access to the facility's portal, the surveyor conducted a telephone interview with the facility's ED who stated that he would provide the surveyor with access to the portal on 2/21/2024. The ED also stated that he spoke with a representative from the NJ Exec Order 26.4b1 office who informed him that NJ Exec Order 26.4b1 had been filed against the facility's HHA identified in the facility's IS.

On 2/21/2024 at 3:30 p.m., the surveyor reviewed the facility provided video footage time stamped on Tuesday NJ Exec Order 26.4b1. The video footage revealed the facility's HHA entered Resident #2's apartment on NJ Exec Order 26.4b1 at 8:20:11 p.m. and closed Resident #2's apartment's door behind him, and exited Resident #2's apartment on

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A 389	Continued From page 7 NJ Exec Order 26.4b1 at 8:53:02 p.m. with a small white box in his hand. Additionally, the surveyor observed on the video footage the HHA actions at 7:11 p.m., as indicated in the facility's IS report. According to facility policy titled, "Resident Rights," with a revised date of 3/1/2010, and documented the following: "Residents will be made aware of their rights as prescribed by law and consistent with the concepts of assisted living. These rights will be respected and supported by the Residence." Among the rights documented in the facility policy and procedure was the right "... To be free from physical and mental abuse." Additionally, the facility policy titled, "Resident Abuse," with a revised date of 2/10/2022, which documented the definition of abuse as follows: "Abuse is defined as a willful infliction of injury unreasonable confinement, intimidation, punishment, pain and/or mental anguish, or deprivation of goods or services necessary to attain or maintain physical, mental and psychosocial well-being. The eight categories of resident abuse are : a. Physical b. Sexual c. Emotional or Psychological..." According to surveyor review of the IS, the HHA was NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 for violating the facility policy.	A 389		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
50A000		4/4/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 A0389 Reg. # 8:36-4.1(a)(16) LSC	Correction Completed 02/29/2024	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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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	
1/11/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: 25QR12