

New Jersey Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 082462 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 11/21/2025 |
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| NAME OF PROVIDER OR SUPPLIER MIRA VIE AT FORSGATE | STREET ADDRESS, CITY, STATE, ZIP CODE 319 FORSGATE DRIVE JAMESBURG, NJ 08831 |
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| A 000 | <p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00189249 and NJ00179429 CENSUS: 112 SAMPLE SIZE: 5 SURVEY DATE: 11/17/2025 - 11/21/2025</p> <p>The facility is not in substantial compliance with all 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, based on this Complaint Survey.</p> <p>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 389 | <p>8:36-4.1(a)(16) Resident Rights</p> <p>(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:</p> <p>16. The right to be free from physical and mental abuse and/or neglect;</p> <p>This REQUIREMENT is not met as evidenced</p> | A 389 | | |

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

TITLE

(X6) DATE

01/06/26

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| A 389 | <p>Continued From page 1</p> <p>by: Based on interview, record review, and facility document and policy review, the facility failed to protect residents who resided on the [redacted] unit from [redacted] for 3 (Residents #2, #4, and #5) of 5 residents reviewed for [redacted] and/or [redacted]. Specifically, on [redacted], Resident #1 [redacted] Resident #2's [redacted] while both residents were seated next to each other in the common area of the [redacted] unit. On [redacted], Resident #1 was observed on closed captioned television (CCTV) footage seated next to Resident #4 in the common area of the [redacted] unit when Resident #1 [redacted] and [redacted] Resident #4's [redacted]. On [redacted], Resident #1 and Resident #5 were in the [redacted] unit dining room for the breakfast meal when Resident #1 [redacted] Resident #5's [redacted] as Resident #5 was leaving the dining room.</p> <p>It was determined the facility's non-compliance with one or more requirements had caused, or was likely to cause, serious injury, serious harm, serious impairment, or death to residents</p> <p>On 11/21/2025 at 12:00 PM, Executive Director (ED) #1 and Director of Nursing/Director of Health & Wellness (DON/DHW) #2 were verbally informed of the immediacy of the situation involving [redacted].</p> <p>Findings included:</p> <p>A facility policy titled, "Elder Abuse/Neglect," revised 05/2025, revealed, the section titled, "Definitions," included, "Elder abuse includes physical, emotional or sexual harm inflicted upon an older adult, financial exploitation or neglect of their welfare by people who are directly</p> | A 389 | | |
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| A 389 | <p>Continued From page 2</p> <p>responsible for their care." Further review revealed, "Sexual Abuse: Sexual contact with an elderly person without their consent including inappropriate touching or coercion." The policy revealed the section titled, "Procedure," included, "4) Upon the notice of reported, observed, suspected or at imminent risk of abuse or exploitation: a) Immediate steps will be taken to ensure that the resident is protected from potential future abuse and neglect while the investigation is being conducted."</p> <p>A "Face Sheet" indicated the facility admitted Resident #1 on [redacted NJ Exec Order 26.4b1]. According to the Face Sheet, the resident had a medical history that included diagnoses of [redacted NJ Exec Order 26.4b1].</p> <p>Resident #1's "[Facility Name] Service Plan," effective [redacted NJ Exec Order 26.4b1] revealed Resident #1 had [redacted NJ Exec Order 26.4b1] and required [redacted NJ Exec Order 26.4b1] staff to [redacted NJ Exec Order 26.4b1] the resident's status.</p> <p>A "[redacted NJ Exec Order 26.4b1]" dated [redacted NJ Exec Order 26.4b1] revealed Resident #1's [redacted NJ Exec Order 26.4b1] score was [redacted NJ] which indicated [redacted NJ Exec Order 26.4b1] likely requiring [redacted NJ Exec Order 26.4b1].</p> <p>A "Face Sheet" indicated the facility admitted Resident #2 on [redacted NJ Exec Order 26.4b1]. According to the Face Sheet, the resident had a medical history that included a diagnosis of [redacted NJ Exec Order 26.4b1].</p> <p>A "[redacted NJ Exec Order 26.4b1]" dated [redacted NJ Exec Order 26.4b1] revealed Resident #2's [redacted NJ Exec Order 26.4b1] score was [redacted NJ] which indicated a [redacted NJ Exec Order 26.4b1].</p> | A 389 | | |

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| A 389 | <p>Continued From page 3 of NJ Exec Order 26.4b1.</p> <p>Resident #2's "[Facility Name] Service Plan," effective NJ Exec Order 26.4b1, revealed Resident #2 had NJ Exec Order 26.4b1 and required NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to support resident safety and fulfill unmet needs.</p> <p>Resident #1's "Progress Notes," dated NJ Exec Order 26.4b1 at 4:22 PM, revealed a late entry note for NJ Exec Order 26.4b1 at 4:00 PM, written by the Assistant Director of Nursing (ADON) that indicated Resident #1 and another resident were seated in the common area away from each other when Resident #1 got up, sat on the couch next to the other resident, and NJ Exec Order 26.4b1. The note revealed that the Memory Support Director (MSD) witnessed the incident and immediately NJ Exec Order 26.4b1 Resident #1 to their room.</p> <p>Resident #2's "Progress Notes," dated NJ Exec Order 26.4b1 at 10:53 AM, revealed an incident note for an NJ Exec Order 26.4b1: Resident to Resident" incident that occurred on NJ Exec Order 26.4b1 at 3:15 PM. The note was written by DON/DHW #4 and indicated that a NJ Exec Order 26.4b1 event (a patient safety incident that results in NJ Exec Order 26.4b1 that is unrelated to the patient's NJ Exec Order 26.4b1 occurred. The note revealed that Resident #2 was sitting on a couch watching television when another resident sat down next to them and NJ Exec Order 26.4b1. The note revealed that the other resident was moved to their room and Resident #2 was checked by an aide. The note revealed NJ Exec Order 26.4b1 were noted on Resident #2. The note revealed Resident #2's family was notified on NJ Exec Order 26.4b1 at 9:00 AM.</p> <p>A "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, revealed that on NJ Exec Order 26.4b1 at 3:15</p> | A 389 | | |
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| A 389 | <p>Continued From page 4</p> <p>PM, a significant event occurred in the facility regarding an NJ Exec Order 26.4b1 [redacted]. According to the Reportable Event Record/Report, the MSD witnessed Resident #1 [redacted] Resident #2's [redacted] while both residents were seated next to each other in the common area of the [redacted] unit. According to the Reportable Event Record/Report, the MSD intervened, removed Resident #1 from the common area, and staff kept Resident #1 and Resident #2 [redacted].</p> <p>Resident #1's [redacted] "NJ Exec Order 26.4b1" Progress Note," dated [redacted] written by the Advanced Practice Nurse [redacted] Mental Health Nurse Practitioner (APN [redacted]) included a section titled "HPI [History of Present Illness]" that revealed a note dated [redacted] which indicated a [redacted] referral was completed due to a history of NJ Exec Order 26.4b1 [redacted], and the resident was evaluated for recent NJ Exec Order 26.4b1 [redacted]. The note indicated that Resident #1 [redacted] their [redacted] [redacted] when interviewed. The note revealed the resident was noted to be [redacted] and [redacted] and was [redacted] to [redacted] and [redacted]. The note revealed a recommendation for [redacted] [redacted] daily.</p> <p>Resident #1's "[Facility Name] Service Plan," effective [redacted], revealed a service area that included a [redacted] management plan that indicated the resident was to be [redacted] from Resident #2.</p> <p>During an interview on 11/17/2025 at 1:55 PM with Resident #2, when asked if anyone in the facility [redacted] them in a way they [redacted], the resident said, "NJ Exec Order 26.4b1 [redacted]." When [redacted].</p> | A 389 | | |

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| A 389 | <p>Continued From page 5</p> <p>asked if the resident felt ^{NJ Exec O} in the facility, the resident said, NJ Exec Order 26.4b1</p> <p>During an interview on 11/17/2025 at 12:12 PM, the MSD stated that there was an incident of NJ Exec Order 26.4b1 that occurred in the NJ Exec Order 26.4b1 unit when Resident #1 ^{NJ Exec Order 26.4} the ^{NJ Exec Order} of Resident #2. The MSD stated that she could not recall if Resident #2 reported the incident to her or if a staff member told her, but she did not recall witnessing the incident because it had been so long ago. The MSD further stated that staff ^{NJ Ex Order 26.4(b)(1)} Resident #1 ^{NJ Ex Order} from residents of the NJ Exec Order 26.4b1 and kept the resident ^{NJ Exec Order 26.4b1} from them.</p> <p>During a telephone interview on 11/20/2025 at 10:03 AM, DON/DHW #4 said she was notified the next day, ^{NJ Exec Order 26.4b1} of the NJ Exec Order 26.4b1 incident between Resident #1 and Resident #2 that occurred on ^{NJ Exec Order 26.4b1} and she immediately notified ED #3. DON/DHW #4 stated that both residents were assessed. DON/DHW #4 stated Resident #1 was referred to ^{NJ Exec Order 26.4b1} services, and Resident #2 was referred to their medical doctor.</p> <p>A "Face Sheet" indicated the facility admitted Resident #4 on ^{NJ Exec Order 26.4b1}. According to the Face Sheet, the resident had a medical history that included a diagnosis of ^{NJ Exec Order 26.4b1} without NJ Exec Order 26.4b1.</p> <p>Resident #4's "[Facility Name] Service Plan," effective ^{NJ Exec Order 26.4b1}, revealed a service area that included a NJ Exec Order 26.4b1 plan initiated on ^{NJ Exec Order 26.4b1} that indicated the resident was in a NJ Exec Order 26.4b1. Interventions</p> | A 389 | | |

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| A 389 | <p>Continued From page 6</p> <p>included a [redacted] referral for [redacted] a [redacted] incident, and staff were to maintain [redacted] in the common area. Further review revealed a service area initiated on [redacted] that indicated the resident required [redacted]. Interventions directed staff to ensure the resident felt [redacted] and [redacted] in the common area and in their room at night, and to check on the resident's status.</p> <p>Resident #4's "Progress Note," dated [redacted] at 5:54 PM, revealed an incident note for an "NJ Exec Order 26.4b1 [redacted]" that occurred on [redacted] at 12:59 PM. The note was written by the DON/DHW #2 and indicated a [redacted] occurred when Resident #4 reported to staff and their family that Resident #1 [redacted]. The note revealed staff immediately intervened and removed Resident #1. The note indicated that the family, physician, and the Regional Operations Specialist (ROS) were notified on [redacted].</p> <p>A "Reportable Event Record/Report," dated [redacted] revealed the facility submitted a report to the State Agency regarding an [redacted] that occurred on [redacted] at approximately 1:00 PM. According to the Reportable Event Record/Report, Resident #1 was observed on closed captioned television (CCTV) footage seated next to Resident #4 in the common area of the [redacted] unit when Resident #1 reached over and [redacted] Resident #4's [redacted]. According to the Reportable Event Record/Report, the CCTV footage revealed that when the incident occurred Resident #4 [redacted] away the [redacted] of Resident #1, and staff immediately intervened and [redacted] the residents.</p> | A 389 | | |
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| A 389 | <p>Continued From page 7</p> <p>Resident #1's "NJ Exec Order 26.4b1 Progress Note," dated NJ Ex Order 26.4(b)(1), written by the APN, NJ Exec Order 26.4b1 included a section titled "HPI" that revealed a note dated NJ Exec Order 26.4b1 that indicated the resident was referred to NJ Exec Order 26.4b1 services for recent NJ Exec Order 26.4b1. The note indicated that Resident #1 NJ Exec Order 26.4b1 exhibiting any NJ Exec Order 26.4b1. The note revealed the resident was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The note revealed the resident had a history of exhibiting NJ Exec Order 26.4b1, and they received NJ Exec Order 26.4b1 daily. The note revealed the provider recommended increasing NJ Exec Order 26.4b1 daily and indicated a message was left for the family regarding the recommendation.</p> <p>Resident #1's "[Facility name] Service Plan" effective NJ Exec Order 26.4b1, revealed a service area that included a NJ Exec Order 26.4b1 plan that was revised on NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 in commons areas, and follow up with NJ Exec Order 26.4b1 services regarding NJ Exec Order 26.4b1.</p> <p>During an interview on 11/17/2025 at 2:00 PM, Resident #4 revealed they recalled the incident on NJ Exec Order 26.4b1 when their NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1 by Resident #1. Resident #4 stated that the NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1, and that was the only time it occurred. Resident #4 stated they spoke to a NJ Exec Order 26.4b1 about it, but that they were NJ Exec Order 26.4b1. Resident #4 indicated staff NJ Exec Order 26.4b1 Resident #1, and kept the residents NJ Exec Order 26.4b1.</p> <p>During an interview on 11/17/2025 at 12:02 PM, the MSD revealed she was aware of the NJ Exec Order 26.4b1 that occurred on NJ Exec Order 26.4b1 between Resident #1 and</p> | A 389 | | |

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| A 389 | <p>Continued From page 8</p> <p>Resident #4, but she did not recall who informed her of the incident. The MSD stated that when she was notified, she spoke to Resident #4 about it. The MSD stated Resident #4 stated that when Resident #1 and Resident #4 were seated next to each other on the couch in the common area, Resident #1 reached over and [redacted] their [redacted] and the resident [redacted] the [redacted] of Resident #1 [redacted]. The MSD stated that she watched CCTV footage to confirm what Resident #4 told her, and it was clear on the CCTV footage what occurred as reported by Resident #4. The MSD stated that she immediately notified the family and ED #1.</p> <p>During an interview on 11/19/2025 at 2:22 PM, the ADON revealed she was not on the [redacted] unit when Resident #1 [redacted] the [redacted] of Resident #4, but she was informed when it occurred. The ADON stated that after the [redacted] incident, both residents were referred to the ANP [redacted] who recommended an increase in [redacted] from [redacted] for Resident #1. The ADON further stated that a family member of Resident #1 agreed to the increase in [redacted] and the medication was [redacted] but then [redacted] back to [redacted] at the request of another family member. The ADON also stated that to keep [redacted] from reoccurring, she expected the staff on the [redacted] unit to keep Resident #1 separate from residents of the [redacted] and a staff member should be present for monitoring to prevent that from occurring.</p> <p>During an interview on 11/20/2025 at 10:03 AM, DON/DHW #2 revealed she recalled being notified of the [redacted] that occurred on [redacted] between Resident #1 and Resident #4. DON/DHW #2 further stated</p> | A 389 | | |

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| A 389 | <p>Continued From page 9</p> <p>that the ROS, who was the acting ED at the time, was immediately notified. DON/DHW #2 stated that both residents were separated, assessed, and referred for NJ Exec Order 26.4b1 services.</p> <p>During a telephone interview on 11/24/2025 at 7:32 AM, the ROS revealed he was the acting ED at the time when the NJ Exec Order 26.4b1 occurred on NJ Exec Order 26.4b1 between Resident #1 and Resident #4. The ROS stated that staff notified him immediately. He stated that once he was notified, he completed the Reportable Event Record/Report and called the State Agency on the same day the incident occurred. He stated that he did recall the incident, but he did not know any more about what occurred than what he recorded on the Reportable Event Record/Report. He stated that to prevent a recurrence of NJ Exec Order 26.4b1 he could not recall specifically, but he thought he would have instructed staff to keep the residents apart and monitor the activity of Resident #1. The ROS further stated that while he was the acting ED at the facility, there were no other incidents of NJ Exec Order 26.4b1.</p> <p>During an interview on 11/19/2025 at 12:18 PM, ED #1 revealed he was not the ED at the time of the NJ Exec Order 26.4b1 that occurred on NJ Exec Order 26.4b1 between Resident #1 and Resident #4 and did not know any details of the incident.</p> <p>A "Face Sheet" indicated the facility admitted Resident #5 on NJ Exec Order 26.4b1. According to the Face Sheet, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.</p> <p>A "Reportable Event Record/Report," dated NJ Exec Order 26.4b1 revealed the facility submitted a report to the State Agency regarding an NJ Exec Order 26.4b1</p> | A 389 | | |

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| (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 |
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| A 389 | <p>Continued From page 10</p> <p>of NJ Exec Order 26.4b1 that occurred on NJ Exec Order 26.4b1 at approximately 9:45 AM. The Reportable Event Record/Report revealed the NJ Exec Order 26.4b1 witnessed Resident #1 touch Resident #5's NJ Exec Order 26.4b1 then Resident #1 NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 of the NJ Exec. According to the Reportable Event Record/Report, staff intervened immediately, NJ Exec Order 26.4b1 both residents, and ensured the safety of all involved.</p> <p>Resident #1's "NJ Exec Order 26.4b1 Progress Note," dated NJ Exec Order 26.4b1 written by the APN NJ Exec Order 26.4b1 indicated Resident #1 continued to exhibit NJ Exec Order 26.4b1. The note revealed the resident continued to NJ Exec Order 26.4b1 staff NJ Exec Order 26.4b1 and there had been multiple incidents where the resident NJ Exec Order 26.4b1 a staff member on her NJ Exec Order 26.4b1 and made NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 toward residents and staff. The note revealed the provider made a recommendation to NJ Exec Order 26.4b1 the resident's NJ Exec Order 26.4b1 but the family declined. The note revealed that the family felt the staff should NJ Exec Order 26.4b1 rather than address it. The note revealed staff should continue NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 such as NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1</p> <p>Resident #1's "[Facility name] Service Plan," effective NJ Exec Order 26.4b1 revealed a service area for a NJ Exec Order 26.4b1 management plan dated NJ Exec Order 26.4b1 that indicated the resident had frequent NJ Exec Order 26.4b1. The service area indicated that staff were to provide NJ Ex Order NJ Ex Order 26.4b1 in communal areas, promptly NJ Ex Order 26.4b1 the resident when NJ Exec Order 26.4b1 occur, document all incidents in the NJ Exec Order 26.4b1 log, and notify the nurse and supervisor immediately if NJ Exec Order 26.4b1. Further review revealed unlicensed assistive personnel were to provide support to the resident through interventions such as NJ Ex Order 26.4(b)(1)</p> | A 389 | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 082462 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 11/21/2025 |
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| A 389 | <p>Continued From page 11</p> <p>NJ Exec Order 26.4b1 use of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, and establish and NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. Further review revealed there were no interventions in place that directed staff to keep Resident #1 NJ Exec Order 26.4b1 from residents of the NJ Exec Order 26.4b1.</p> <p>An attempted interview on 11/17/2025 at 10:40 AM revealed Resident #5 was NJ Exec Order 26.4b1.</p> <p>During an interview on 11/19/2025 at 9:02 AM, the ST revealed that on NJ Exec Order 26.4b1, she and Resident #5 were in the NJ Exec Order 26.4b1 unit dining room for the breakfast meal while she assessed Resident #5. The NJ Exec stated that Resident #1 was seated at the dining room table, and as they walked by to leave the dining room, Resident #1 NJ Exec Order 26.4b1 of Resident #5. The NJ Exec stated that Resident #5 NJ Exec Order 26.4b1 and said to Resident #1, "NJ Exec Order 26.4b1." The NJ Exec stated that she encouraged Resident #5 to keep walking to NJ Exec Order 26.4b1, and then Resident #1 also NJ Exec Order 26.4b1. The NJ Exec further stated that Care Partner (CP) #7 was also present in the dining room and told Resident #1 not to do that, got up, and stood between Resident #1 and the NJ Exec. The NJ Exec further stated that she had not witnessed that NJ Exec Order 26.4b1 of Resident #1 before, but got the impression based on staff's response that Resident #1 may have done it before. The NJ Exec stated that after a couple of minutes, Resident #5 NJ Exec Order 26.4b1 and completed the NJ Exec Order 26.4b1 session in the common area. The NJ Exec stated that she completed a statement about what occurred.</p> <p>During a telephone interview on 11/20/2025 at 3:15 PM, CP #7 revealed she was in the dining room on NJ Exec Order 26.4b1 assisting residents with</p> | A 389 | | |
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| A 389 | <p>Continued From page 12</p> <p>breakfast when she saw the [redacted] and Resident #5 get up from the dining room table. She stated that as they passed by, Resident #1, who was seated at the dining room table, reached out and [redacted] of Resident #5. CP #7 stated that Resident #5 [redacted] Resident #1, but the [redacted] encouraged Resident #5 to [redacted] and [redacted]. CP #7 stated she told Resident #1 [redacted] and got up to intervene, but the [redacted] got between the two residents, and that was when Resident #1 [redacted]. CP #7 said she told Resident #1 [redacted], and Resident #5 and the [redacted] moved to the common area away from Resident #1. CP #7 stated that was the only time she witnessed Resident #1 [redacted] another resident. CP #7 further stated that she and the [redacted] wrote a statement about what occurred, and she immediately told her supervisor, the MSD, and gave her supervisor the written statements. CP #7 stated that staff [redacted] Resident #1 [redacted] from residents of the [redacted], did not allow Resident #1 to be seated next to them, and [redacted].</p> <p>During an interview on 11/17/2025 at 12:02 PM, the MSD revealed staff notified her on [redacted] of [redacted] when Resident #1 [redacted] of Resident #5. The MSD stated she was told that Resident #1 [redacted] the [redacted] of Resident #5 as the resident walked by while they were both in the dining room. The MSD stated that Resident #5 was working with the [redacted] in the dining room when the resident got up to walk out of the dining room. She further stated that as Resident #5 and the [redacted] walked out of the dining room, Resident #1 [redacted] of Resident #5 and the [redacted]. The MSD stated that CP #7 also witnessed it and told Resident #1 not to do that. The MSD also stated</p> | A 389 | | |
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| A 389 | <p>Continued From page 13</p> <p>that staff immediately ^{NJ Ex Order 26.4(b)(1)} both residents, ^{NJ Ex Order 26.4(b)(1)}, and reported the incident to her. The MSD stated that she immediately notified ED #1.</p> <p>During a telephone interview on 11/26/2025 at 10:22 AM, ANP ^{NJ Exec Order 26.4} revealed Resident #1 was referred for a ^{NJ Exec Order 26.4b1} evaluation after the resident ^{NJ Exec Order 26.4} the ^{NJ Exec Order 26.4} of Resident #2 in ^{NJ Exec Order 26.4b1}. The ANP ^{NJ Exec Order 26.4} stated she assessed the resident and recommended increasing ^{NJ Exec Or} from ^{NJ Exec Order 26.4b1}, but the family was not in agreement. The ANP ^{NJ Exec Order 26.4} stated another incident occurred in ^{NJ Exec Order 26.4b1} when Resident #1 ^{NJ Exec Order 26.4b1} of Resident #4, and she recommended increasing the ^{NJ Exec Or} again, but the family was concerned the increase would make the resident ^{NJ Ex Order 26.4(b)(1)}. The ANP ^{NJ Exec Order 26.4} stated she then recommended providing ^{NJ Exec Or} at 5:00 PM before bedtime or trying a different ^{NJ Exec Order 26.4b1} to address the family's concern with Resident #1's ^{NJ Exec Order 26.4b1} and the ^{NJ Exec Order 26.4b1} but the family did not agree to the recommendation. The ANP ^{NJ Exec Order 26.4} then said that in ^{NJ Exec Order 26.4b1} Resident #1 ^{NJ Ex Order 26.4(b)} Resident #5, and one family member agreed to increase the ^{NJ Exec Or} so it was ^{NJ Exec Order 26.4b1} but then another family member disagreed and requested to ^{NJ Exec Order 26.4b1}, so it was changed back. The ANP ^{NJ Exec Order 26.4} also stated that the facility met with the family or ^{NJ Exec Order 26.4b1} discussed the seriousness of Resident #1's ^{NJ Exec Order 26.4b1} but the family expressed that staff should keep residents of the ^{NJ Exec Order 26.4b1} Resident #1. The ANP ^{NJ Exec Order 26.4} stated the family was advised that ^{NJ Exec Order 26.4b1} could not continue to happen and reiterated the recommendation to increase ^{NJ Exec Order 26.4b1}, but the family did not agree to the recommendation.</p> | A 389 | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 082462 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 11/21/2025 |
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| A 389 | <p>Continued From page 14</p> <p>During a telephone interview on 11/20/2025 at 9:15 AM, the Medical Doctor (MD) revealed he was aware of Resident #1's NJ Exec Order 26.4b1, but he treated the clinical issues and left the NJ Exec Order 26.4b1 issues to NJ Exec Order 26.4b1 services. The MD stated that when the facility made him aware of the NJ Exec Order 26.4b1 of Resident #1, he ordered labs for the resident to identify any clinical changes that needed to be addressed. The MD stated that Resident #1 was treated for a NJ Exec Order 26.4b1 and again on NJ Exec Order 26.4b1. The MD described Resident #1 as NJ Exec Order 26.4b1 because of the progression of the diagnosis of NJ Exec Order 26.4b1. The MD further stated that the ANP NJ Exec Order 26.4b1 increased NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 family agreement, but then the family requested NJ Exec Order 26.4b1 be NJ Exec Order 26.4b1 due to a concern that the NJ Exec Order 26.4b1 would make Resident #1 NJ Exec Order 26.4b1. The MD stated that was the last recommendation for Resident #1 that he was aware of. He stated that he expected the facility to ensure the safety of all residents.</p> <p>During an interview on 11/20/2025 at 10:03 AM, DON/DHW #2 revealed she was employed at the facility on NJ Ex Order 26.4(b)(1) and first became aware of Resident #1's NJ Exec Order 26.4b1 when Resident #1 NJ Exec Order 26.4b1 of Resident #4. DON/DHW #2 stated she was also notified on NJ Exec Order 26.4b1 when Resident #1 NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 of both Resident #5 and the NJ Exec Order 26.4b1. DON/DHW #2 stated that it was her understanding that Resident #1's NJ Exec Order 26.4b1 seemed to be triggered when the resident did not NJ Exec Order 26.4b1. DON/DHW #2 further stated that she was informed that the family of Resident #1 was aware of the NJ Exec Order 26.4b1 but did not want NJ Exec Order 26.4b1 for Resident #1 for NJ Exec Order 26.4b1 management. DON/DHW #2 stated that with each incident, staff were told to keep the</p> | A 389 | | |

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| A 389 | <p>Continued From page 15</p> <p>residents [redacted] staff were re-educated on [redacted] the residents were referred to [redacted] services, and their Service Plans were updated to make sure staff monitored Resident #1's [redacted] DON/DHW #2 stated that she expected staff to monitor residents for safety on the [redacted] in the common area. DON/DHW #2 stated that the facility met with Resident #1's family on [redacted] and notified the family that Resident #1's [redacted] could not continue. DON/DHW #2 stated that during the meeting, the ANP [redacted] reiterated the recommendation to increase [redacted], but the family was concerned the resident would not be [redacted] and declined the recommendation but agreed to visit Resident #1 daily to assist with [redacted]</p> <p>During a follow-up interview on 11/19/2025 at 12:51 PM, ED #1 stated that he was the ED for the facility when the [redacted] occurred between Resident #1 and Resident #5 on [redacted]. ED #1 stated he was currently aware of the [redacted] of Resident #1, and he expected the staff to be available to prevent the reoccurrence by keeping Resident #1 [redacted] from residents of the [redacted].</p> | A 389 | | |
| A 565 | <p>8:36-5.10(a)(3) General Requirements</p> <p>(a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following:</p> <p>3. Any suspected cases of resident abuse or</p> | A 565 | | |

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| A 565 | <p>Continued From page 16</p> <p>exploitation which have been reported to the State Long-Term Care Ombudsman.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility document and policy review, the facility failed to notify the State Agency immediately of suspected cases of resident [redacted] for 4 (Residents #1, #2, #5, and #3) of 5 residents reviewed for [redacted] and/or NJ Exec Order 26.4b1.</p> <p>Findings included:</p> <p>A facility policy titled, "Elder Abuse/Neglect," revised 05/2025, revealed the section titled, "Definitions," included, "Elder abuse includes physical, emotional or sexual harm inflicted upon an older adult, financial exploitation, or neglect of their welfare by people who are directly responsible for their care." Further review revealed "- Neglect: Failure to meet an older adult's basic needs including food, water, shelter, clothing hygiene and essential medical care. - Sexual Abuse: Sexual contact with an elderly person without their consent including inappropriate touching or coercion." The policy revealed, "If any resident experiences abuse (by staff, residents, family, or others) or when abuse is suspected, as mandated reporters, staff is required to report this to the appropriate State agency." The section titled, "Procedure," included, "6) Reporting of any suspected, alleged, or</p> | A 565 | | |

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| A 565 | <p>Continued From page 17</p> <p>witnessed abuse or neglect will be completed according to state reporting requirements."</p> <p>1. A "Reportable Event Record/Report," dated [redacted], revealed that on [redacted] at 3:15 PM, a significant event occurred in the facility regarding an [redacted]. According to the Reportable Event Record/Report, the MSD witnessed Resident #1 [redacted] Resident #2's [redacted] while both residents were seated next to each other in the common area of the [redacted] unit. According to the Reportable Event Record/Report, the MSD intervened, removed Resident #1 from the common area, and staff kept Resident #1 and Resident #2 separated. According to the Reportable Event Record/Report, Executive Director (ED) #3 contacted the State Agency by phone on [redacted] at 11:09 AM to report the [redacted].</p> <p>An interview on 11/17/2025 at 12:12 PM with the MSD revealed that if a problem occurred on the MCU, she would report the problem to the Assistant Director of Nursing (ADON) or the Director of Nursing (DON)/Director of Health and Wellness (DHW). The MSD reviewed the Reportable Event Record/Report regarding Resident #1 and Resident #2 and stated that there was an incident of [redacted] that occurred in the [redacted] when Resident #1 [redacted] the [redacted] of Resident #2. The MSD stated that she could not recall if Resident #2 reported the incident to her or if a staff member told her, but she did not recall if she witnessed the incident because it had been so long ago.</p> <p>A telephone interview on 11/20/2025 at 8:41 AM with DON/DHW #4 revealed she was the DON/DHW at the time when Resident #1 was</p> | A 565 | | |

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| A 565 | <p>Continued From page 18</p> <p>witnessed by staff to [redacted] the [redacted] of Resident #2. DON #4 stated she was notified of the incident the next day [redacted] (NJ Exec Order 26.4b1). DON/DHW #4 stated that when she was notified, she told ED #3 immediately. DON/DHW #4 stated that she expected staff to notify her immediately (of an NJ Exec Order 26.4b1) so that she could report the incident immediately to the ED and put a plan in place to keep residents safe. DON/DHW #4 stated that she reported the incidents to the ED, and the ED was responsible for reporting to the State Agency.</p> <p>2. A "Reportable Event Record/Report," dated 09/11/2025, revealed on [redacted] at 9:45 AM an [redacted] occurred in the facility. The Reportable Event Record/Report indicated it was not a significant event. The Reportable Event Record/Report revealed no documentation that the event was called into the State Agency. According to the Reportable Event Record/Report, staff witnessed Resident #1 [redacted] Resident #5's [redacted]</p> <p>An electronic mail (email) revealed Executive Director (ED) #1 contacted the State Agency on [redacted] at 3:54 PM to report an [redacted] of [redacted] NJ Exec Order 26.4b1.</p> <p>An undated "Resident Incident/Accident Report" revealed that on [redacted] at 9:40 AM, staff witnessed Resident #1 [redacted] of Resident #5 and reported the incident to the [redacted] Director [redacted] at 9:45 AM.</p> <p>During an interview on 11/17/2025 at 12:02 PM, the MSD stated that staff told her about the incident (on [redacted]). She stated that staff reported it to her, and she immediately notified the ED.</p> | A 565 | | |
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| A 565 | <p>Continued From page 19</p> <p>During an interview on 11/19/2025 at 1:18 PM, ED #1 stated the incident (on NJ Exec Order 26.4b1) was reported to him immediately by staff. ED #1 stated that he was aware of the requirement to immediately notify the state agency of significant events, but at the time he did not see the NJ Exec Order 26.4b1 as a significant event that required immediate reporting to the State Agency. ED #1 stated that in his experience of reporting events to the State Agency, he had never received a response from the State Agency that he was incorrect in his assumption of what qualified as a significant event. ED #1 further stated that he now realized the incident was a significant event that required immediate reporting to the State Agency.</p> <p>3. A "Reportable Event Record/Report," Dated NJ Exec Order 26.4b1 revealed that on NJ Exec Order 26.4b1 at 12:35 PM a significant event occurred in the facility regarding an unwitnessed injury. According to the Reportable Event Record/Report, Resident #3 was found on the floor in the resident's room NJ Exec Order 26.4b1 after an NJ Exec Order 26.4b1. The Reportable Event Record/Report revealed Care Partner (CP) #5 and CP #6 were NJ Exec Order 26.4b1 pending the outcome of the investigation. According to the Reportable Event Record/Report, Executive Director (ED) #1 contacted the State Agency by phone on NJ Exec Order 26.4b1 at 12:35 PM to report the NJ Exec Order 26.4b1 of an NJ Exec Order 26.4b1.</p> <p>An "Resident Incident Report" dated NJ Exec Order 26.4b1 revealed on NJ Exec Order 26.4b1 at 1:05 PM, Resident #3 was NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 of their NJ Exec Order 26.4b1 and was transported to the emergency department for further evaluation.</p> | A 565 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 082462 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 11/21/2025 |
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| NAME OF PROVIDER OR SUPPLIER MIRA VIE AT FORSGATE | STREET ADDRESS, CITY, STATE, ZIP CODE 319 FORSGATE DRIVE JAMESBURG, NJ 08831 |
|---|--|

| (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 565 | <p>Continued From page 20</p> <p>A hospital "Discharge Summary" dated [redacted] revealed Resident #3 was admitted to the hospital on [redacted] and a discharge on [redacted]. The Discharge Summary indicated Resident #3 presented on admission with a [redacted]. The Discharge Summary revealed the section titled, "Hospital Course," indicated that the resident also had a [redacted].</p> <p>During an interview on 11/17/2025 at 10:15 AM, ED #1 stated the resident's [redacted] on [redacted] was [redacted] so he submitted a "reportable" regarding the [redacted] because it was significant and staff did not see how the [redacted] to the resident's [redacted] occurred. ED #1 stated he should have notified the State Agency immediately.</p> | A 565 | | |

POC #2 received 1/14/26
Accepted 1/14/26



A389 – Resident Rights 8:36-4.1(a)(16)

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The community immediately ensured the safety and well-being of the identified residents. Protective interventions were implemented on the day of the reportable event, September 8, 2025, including increased supervision and separation of involved individuals as appropriate. The affected residents were provided with reassurance, support, and monitoring to ensure continued safety and dignity.

- Resident #1 POA was issued an immediate discharge notice on **NJ Exec Order 26.4b1** stating the need to find Resident #1 a more suitable facility/community to **NJ Exec Order 26.4b1** Resident #1 was relocated to a skilled nursing facility on **NJ Exec Order 26.4b1** and is no longer a resident at Mira Vie Forsgate. Resident's #2,4 and 5 remain in the community.

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 by the same deficient practice.

Any identified risks were addressed on September 9, 2025, through care plan updates, supervision adjustments, and environmental modifications as needed.



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

The Executive Director and Director of Health and Wellness conducted a facility-wide assessment on September 9, 2025, to identify any other residents who may be at risk for sexual abuse. This assessment included:

- Review of resident cognitive status and supervision needs
- Review of room assignments and common area supervision
- Review of incident reports

The community reinforced its **Elder Abuse/Neglect Prevention, Sexual Abuse, and Resident Rights policies**, emphasizing a zero-tolerance approach. All staff received mandatory re-education on November 20, 2025.

- Resident rights and protection from abuse
- Recognition and prevention of sexual abuse in an assisted living setting
- Mandatory reporting requirements

Education was documented and incorporated into new staff orientation. Staffing patterns, supervision in common areas, and overnight monitoring practices were reviewed and adjusted as necessary to enhance resident safety.



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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.

The Executive Director and Director of Health and Wellness will conduct weekly monitoring for four (4) weeks, then monthly for three (3) months, including:

- Observation of resident interactions in common areas
- Review of incident reports and supervision logs
- Verification that care plans reflect identified risks and interventions.

Results will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) process. Any concerns identified will be addressed immediately with corrective action and additional staff education.

Next QAPI Meeting Date: January 21, 2026

Completion date: November 22, 2025

Completed by: Director of Health and Wellness

NJ Exec Order 260



approved
1/14/26



A565 – General Requirements 8:36-5.10(a)(3)

- 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

Resident #1 POA was issued an immediate discharge notice on NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 stating the need to find Resident #1 a more suitable facility/community to NJ Exec Order 26.4b1 Resident #1 was relocated to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) on NJ Exec Order 26.4b1 and is no longer a resident at Mira Vie Forsgate. Resident's #2,3 and 5 remain in the community.

On September 10, 2025, the Executive Director and Director of Health and Wellness reviewed all incident reports, injury reports, and allegations for the previous 60 days to ensure all reportable events were reported in accordance with N.J.A.C. 8:36-5.10(a).

No additional unreported incidents were identified.

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- 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 by the same deficient practice.

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



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The facility's Reportable Events/Abuse Prevention Policy was reviewed on November 20, 2025, by the Executive Director and Director of Health and Wellness to clearly define:

- Suspected abuse
- Immediate reporting requirements
- Designated responsible staff
- Required documentation and timelines.

The Director of Health and Wellness and Assistant Director of Health and Wellness re-educated all administrative and direct care staff on:

- Identification of suspected abuse
 - Mandatory reporting requirements
 - Immediate notification procedures.
- Training completed on November 20, 2025

Beginning September 10, 2025, the Executive Director or Director of Health and Wellness reviewed all incident reports involving injuries, allegations, or unexplained findings daily to ensure timely reporting.

A Reportable Events Log was implemented on November 20, 2025, and will be maintained and reviewed weekly for 90 days, then monthly thereafter.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

The Executive Director will follow the Community Policy and Procedure of State Reporting and ensure that all events reported to the Department of



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Health is called into the State Long-Term Care Ombudsman in a timely matter. This will be effective immediately.

The facility shall notify the Department of Health immediately by telephone at (609) 633-9034 or (609) 392-2020 after business hours, followed within 72 hours by written confirmation.

The Director of Health and Wellness and Executive Director will identify residents that have the potential to be affected by the same deficient practices. Incident reports will be completed and investigated by the Executive Director and Director of Health and Wellness.

- Following community policies on Abuse & Neglect, Incident Reports and Reporting.
- Completing all Incident Reports with Investigation within 72 hours and notifying DOH and Ombudsman for any suspected cases of resident abuse.

Completion Date: November 22, 2025

NJ Exec Order 26.4b1
[Redacted Signature]

*approved
1/14/26*

STATE FORM: REVISIT REPORT

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|--|--|------------------------------|
| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 082462 | MULTIPLE CONSTRUCTION A. Building B. Wing | DATE OF REVISIT 1/14/2026 |
| NAME OF FACILITY MIRA VIE AT FORSGATE | STREET ADDRESS, CITY, STATE, ZIP CODE 319 FORSGATE DRIVE JAMESBURG, NJ 08831 | |

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 | Correction | ID Prefix A0565 | Correction | ID Prefix | Correction |
| Reg. # 8:36-4.1(a)(16) | Completed | Reg. # 8:36-5.10(a)(3) | Completed | Reg. # | Completed |
| LSC | 11/22/2025 | LSC | 11/22/2025 | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
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| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
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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 11/21/2025 | | <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 | | |

STATE FORM: REVISIT REPORT

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|--|--|------------------------------|
| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 082462 | MULTIPLE CONSTRUCTION A. Building B. Wing | DATE OF REVISIT 1/14/2026 |
| NAME OF FACILITY MIRA VIE AT FORSGATE | STREET ADDRESS, CITY, STATE, ZIP CODE 319 FORSGATE DRIVE JAMESBURG, NJ 08831 | |

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| LSC | 11/22/2025 | LSC | 11/22/2025 | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
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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 11/21/2025 | | <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 | | |