New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031446	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT MONTVILLE	165 CHANGEBRIDGE ROAD MONTVILLE, NJ 07045

(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 #: NJ00178675 CENSUS: 104 SAMPLE SIZE: 4 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/21/25

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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Complaint #: NJ00178675

Based on observation, interview and review of records, it was determined that the Administrator failed to ensure the implementation of a facility policy related to assessments, to ensure that a resident was assessed following hospitalization, for 1 of 4 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On 2/13/25 at 12:15 p.m., the surveyor reviewed Resident #2's medical record (MR), which revealed an admission date of [NJ Ex Order 26.4], and a diagnosis of [NJ Ex Order 26.4(b)(1)].

The surveyor reviewed a progress note (PN) dated [NJ Ex Order 26.4(b)] at 8:55 a.m., written by the Director of Health and Wellness (DHW), which documented that Resident #2 was [NJ Ex Order 26.4(b)(1)] [redacted], and was sent to the hospital via 911. The surveyor reviewed an additional PN dated [NJ Ex Order 26.4(] at 11:20 a.m., written by a facility Licensed Practical Nurse (LPN #1), which revealed that Resident #2 returned to the facility at [NJ Ex Order 26.4(b)] at 9:15 p.m.

The surveyor reviewed the MR and observed that there was no documentation to reflect that an assessment by a Registered Nurse (RN), was completed upon Resident #2's return from the hospital.

At 12:20 p.m., the surveyor reviewed an additional PN dated [NJ Ex Order 26.4(] at 3:21 p.m., written

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A 310	Continued From page 2	A 310		

by LPN #1, which indicated Resident #2 arrived to the facility on a stretcher. The PN also indicated that Resident #2 was NJ Ex Order 26.4(b)(1) and, had NJ Ex Order 26.4(b)(1) to his/her NJ Ex Order . There was no documentation observed by the surveyor, prior to this PN, that indicated why or when the resident was sent out to the hospital.

The surveyor reviewed the MR and observed that there was no documentation to reflect that an assessment by a RN was completed upon Resident #2's return from the hospital on NJ Ex Order 26.4(b)

At 12:30 p.m., the surveyor reviewed a PN dated NJ Ex Order 26.4(b) at 11:19 a.m., written by a facility RN, which revealed that Resident #2 was sent to the emergency room for evaluation.

The surveyor reviewed a PN dated NJ Ex Order 26.4(at 1:00 p.m., written by a facility LPN, (LPN #2), which indicated that Resident #2 returned from the hospital on NJ Ex Order 26.4(at 8:30 p.m.

The surveyor reviewed the MR and observed that there was no documentation to reflect that an assessment was completed by the RN upon Resident #2's return from the hospital after the date of NJ Ex Order 26.4(b)

The surveyor reviewed a PN dated NJ Ex Order 26.4(b) at 1:02 p.m., written by a Certified Medication Aide (CMA #1), which revealed that Resident #2 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) breakfast or lunch. An additional PN dated NJ Ex Order 26.4(at 1:38 p.m., written by a CMA, (CMA #2), revealed that Resident #2 was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)

The surveyor reviewed an additional PN dated

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A 310	Continued From page 3 NJ Ex Order 26.4(b), at 5:34 p.m., written by LPN #2, which revealed that Resident #2 NJ Exec Order 26.4 to take his/her medications, appeared NJ Ex Order 26.4(b)(1), and was sent to the hospital for further evaluation. The surveyor reviewed a PN dated NJ Ex Order 26 at 9:14 a.m., written by a facility RN, which revealed that Resident #2 NJ Ex Order 26.4(b)(1) the hospital at 7:50 a.m. On 2/13/25 at 1:45 p.m. the surveyor reviewed a facility policy dated 4/2021, titled, "Assessments" which revealed the following ... "Policy All assessments will be completed per state regulation. Procedure ... 4) All residents will be reassessed upon return from the hospital or other higher level of care such as skilled care services ..."	A 310		
A 765	8:36-7.4(c)(1) Resident Assessments and Care Plans (c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following: 1. Assessment of all residents with a general service plan at least semi-annually, and those residents who have a health service plan shall be reassessed at least quarterly and more often on an as needed basis, including and upon the resident's return to the facility from the hospital;	A 765		

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A 765	Continued From page 4 This REQUIREMENT is not met as evidenced by: Complaint #: NJ00178675 Based on observation, interview and review of records, it was determined that the facility failed to ensure that an assessment was completed after a resident's return from the hospital, to determine the needs of the resident, for 1 of 4 residents reveiwed, Resident #2. This deficient practice was evidenced by the following: On 2/13/25 at 12:15 p.m., the surveyor reviewed Resident #2's medical record (MR), which revealed an admission date of NJ Ex Order 26.4 and a diagnosis of NJ Ex Order 26.4(b)(1). The surveyor reviewed a progress note (PN) dated 8/13/24 at 8:55 a.m., written by the Director of Health and Wellness (DHW), which documented that Resident #2 was complaining of NJ Ex Order 26.4(b)(1) his/her NJ Ex Order 26.4(b)(1), and was sent to the hospital via NJ Exec O The surveyor reviewed an additional PN dated NJ Ex Order 26.4(b) at 11:20 a.m., written by a facility Licensed Practical Nurse (LPN #1), which revealed that Resident #2 returned to the facility at NJ Ex Order 26.4(at 9:15 p.m. The surveyor reviewed the MR and observed that there was no documentation to reflect that an assessment by a Registered Nurse (RN) was completed upon Resident #2's return from the hospital. At 12:20 p.m., the surveyor reviewed an additional PN dated NJ Ex Order 26.4(at 3:21 p.m., written by LPN #1, which indicated Resident #2 arrived to	A 765		

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A 765	Continued From page 5	A 765		

the facility on a stretcher. The PN also indicated that Resident #2 was NJ Ex Order 26.4(b)(1) ; and, NJ Ex Order 26.4(b)(1) his/her NJ Ex Order . There was no documentation observed by the surveyor prior to this PN that indicated why or when the resident was sent out to the hospital.

The surveyor reviewed the MR and observed that there was no documentation to reflect that an assessment by a RN was completed upon Resident #2's return from the hospital on NJ Ex Order 26.4(.

At 12:30 p.m., the surveyor reviewed a PN dated NJ Ex Order 26.4(b) at 11:19 a.m., written by a facility RN, which revealed that Resident #2 was sent to the emergency room for evaluation.

The surveyor reviewed a PN dated NJ Ex Order 26.4(b) at 1:00 p.m., written by a facility LPN (LPN #2), which indicated that Resident #2 returned from the hospital on NJ Ex Order 26.4(at 8:30 p.m.

The surveyor reviewed the MR and observed that there was no documentation to reflect that an assessment was completed by the RN upon Resident #2's return from the hospital after the date of NJ Ex Order 26.4(b)

The surveyor reviewed a PN dated NJ Ex Order 26.4(at 1:02 p.m., written by a Certified Medication Aide (CMA #1), which revealed that Resident #2 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) breakfast or lunch. An additional PN dated NJ Ex Order 26.4(at 1:38 p.m., written by a CMA, CMA #2, revealed that Resident #2 was in NJ Ex Order 26.4(b)(1)

The surveyor reviewed an additional PN dated NJ Ex Order 26.4(, at 5:34 p.m., written by LPN #2, which

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A 765	Continued From page 6 revealed that Resident #2 refused to take his/her medications, appeared NJ Ex Order 26.4(b)(1), and was sent to the hospital for further evaluation. The surveyor reviewed a PN dated [redacted] at 9:14 a.m., written by a facility RN, which revealed that Resident #2 [redacted] in the hospital at 7:50 a.m. On 2/13/25 at 1:45 p.m. the surveyor reviewed a facility policy dated 4/2021, titled "Assessments" which revealed the following ... "Policy All assessments will be completed per state regulation. Procedure ... 4) All residents will be reassessed upon return from the hospital or other higher level of care such as skilled care services ..."	A 765		

MIRA VIE

AT MONTVILLE

ASSISTED LIVING | MEMORY CARE

Plan of Correction for Complain Survey to Mira Vie Montville on 2-13-25

A 310

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

   The corrective Action cannot be taken as this is closed record due to the resident [NJ Exec Order 26.461] prior to the DOH visit. (To be completed by 4-1-25)

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

   The Administrator or their designee will identify residents potentially being affected by the lack of a readmission assessment by reviewing the list of residents out of the community and identifying those who have returned during the managers' daily stand-up meeting.

   The Front-line staff will also utilize the 24-hour report in the EMAR to identify residents who leave, return or show a change of condition.

   Front line staff will also communicate admissions and hospital admissions during the dept stand up and stand down meetings. In the event the Stand up/down meetings do not occur, the staff will be made aware to notify the DON of any information that would have been shared in said meeting. (To be completed by 4-1-25)

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

   The following measures have been put in place to ensure that this deficiency does not occur: the Administrator or their designee will complete the Stand-up sheet after discussing the readmission list in stand-up.

   A checklist will be developed to ensure that all readmission steps are completed when a resident is readmitted.

   The DON will utilize her qualified team members to assist in completing assessments within the time frame required by the regulation. (To be completed by 4-1-25)

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

In order to monitor the effectiveness of the POC, the Administrator or their designee will spot check the list of readmissions quarterly as part of the communities QAPI. (To be completed by 4-1-25)

A 765

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

   The corrective Action cannot be taken as this is closed record due to the resident [redacted] NJ Exec Order 26.4b] prior to the DOH visit. (To be completed by 4-1-25)

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

   The Administrator or their designee will identify residents potentially being affected by the lack of an updated GSP/HSP by reviewing the list of residents out of the community and identifying those who have returned or had a COC during the managers' daily stand-up meeting.

   The Front-line staff will also utilize the 24-hour report in the EMAR to identify residents who leave, return or show a change of condition.

   Front line staff will also communicate admissions and hospital admissions and COC during the dept stand up and stand down meetings. In the event the Stand up/down meetings do not occur, the staff will be made aware to notify the DON of any information that would have been shared in said meeting. (To be completed by 4-1-25)

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

   The following measures have been put in place to ensure that this deficiency does not occur: the Administrator or their designee will complete the Stand-up sheet after discussing the readmission list in stand-up. COC will also be discussed.

   A checklist will be developed to ensure that all readmission steps are completed when a resident is readmitted.

   The DON will utilize her qualified team members to assist in completing GSP/HSP within the time frame required by the regulation. (To be completed by 4-1-25)

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

MIRA VIE

AT MONTVILLE

ASSISTED LIVING | MEMORY CARE

In order to monitor the effectiveness of the POC, the Administrator or their designee will spot check the list of COC residents quarterly as part of the communities QAPI. (To be completed by 4-1-25)

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
031446	A. Building B. Wing	4/29/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT MONTVILLE	165 CHANGEBRIDGE ROAD MONTVILLE, NJ 07045

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 04/01/2025	ID Prefix A0765 Reg. # 8:36-7.4(c)(1) LSC	Correction Completed 04/01/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/13/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			