STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A114	A. BUILDING: _____ B. WING _____	C 12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT TOMS RIVER	1657 SILVERTON ROAD TOMS RIVER, NJ 08753

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ0018870, NJ00183247, NJ00181274, NJ00168436, and NJ00159303 CENSUS: 109 SAMPLE SIZE: 16 SURVEY DATE: 11/06/2025 - 12/08/2025 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. 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 01/06/26

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This REQUIREMENT is not met as evidenced by:
Complaint #NJ0088870

Based on facility policy review, record review, facility document review, and interview, the facility failed to implement their "Elder Abuse/Neglect" policy, "Internal Incident Reports and State Reports" policy, and "Service Plans and Assessments" policy when they failed to report incidents of abuse to the state survey agency, failed to investigate incidents, and failed to develop and implement interventions to protect residents from NJ Exec Order following NJ Exec Order incidents. The deficiencies affected 4 (Resident #1, #14, #15, and #16) of 11 residents reviewed for NJ Exec Order 2 The failures caused residents to be subject to continued NJ Exec Order from Resident #2 and subsequently, on NJ Exec Order 26.4b1, Resident #2 NJ Exec Order 26. Resident #1 after a NJ Exec Order 26.4b1, causing Resident #1 to NJ Exe and NJ Exec Order 26 a NJ Exec O NJ Exec Order 26.4b1.

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.

On 12/08/2025 at 6:14 PM, the facility's Executive Director (ED) was verbally informed of the immediacy of the situation involving the facility's failure to implement their NJ Exec Order prohibition policy, which lead to multiple incidents of NJ Exec Order involving Resident #2.

Findings included:

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A 310	Continued From page 2 A facility policy titled, "Elder Abuse/Neglect New Jersey," dated 04/2021, indicated, "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. Staff are to immediately notify the Director of Health and Wellness or Executive Director. Staff will not be terminated nor reprimanded for reporting suspected or actual cases of resident abuse. Staff do not require permission from their supervisor, Director of Health and Wellness, Executive Director or any other person to report actual or suspected elder abuse." The policy further specified, "4) Upon the notice of reported observed, suspected, or at imminent risk of abuse or exploitation: a) Immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is being conducted. b) A thorough investigation will be conducted by the Director of Health and Wellness or Executive Director." The policy revealed, "6) Reporting of any suspected, alleged, or witnessed abuse or neglect will be completed according to state reporting requirements." The policy revealed, "7) An investigation will take place surrounding the cause of the abuse." The abuse policy revealed that it did not include the definition of abuse or the types of abuse. The abuse policy revealed that it did not include how residents' rights would be protected following the investigation of abuse if resident-to-resident abuse was in fact substantiated. A facility policy titled, "Internal Incident Reports and State Reports," revised 01/2025, revealed, "1) The Internal Incident Report is to be completed for all unusual occurrences, injury, and	A 310		

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incidents. The staff member involved in or witnessing the incident will complete the Internal Incident Report. If the witness is a Care Partner who does not have access to the electronic Incident report, they will complete it on paper." The policy revealed, "3) Director of Health and Wellness will evaluate the resident and document a note in the resident record." The policy continued, "a) Verify that ancillary assessment is completed including resident specific interventions are updated." The policy revealed, "8) All incidents related to physical abuse, neglect, sexual assault, or exploitation are reported to the ombudsman, state licensing agency, and in the cause of assault (physical or sexual), to law enforcement per state regulations."

A facility policy titled, "Service Plans and Assessments," revised 12/01/2025, revealed, "Individualized service plans are used to plan for and meet resident needs using an interdisciplinary approach." The policy revealed, "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 the care provided and any changes in the resident's physical or cognitive status." The policy continued, "9. The resident health service plan shall be reviewed, and if necessary, revised quarterly, and as needed, based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status."

A "Face Sheet" revealed the facility admitted Resident #2 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

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NJ Exec Order 26.4b1 .

Resident #2's "DL [Distinct Living] Master Assessment," initiated NJ Exec Order 26.4b1 revealed Resident #2 was oriented to NJ Exec Order 26.4b1 .

Resident #2's "Service Plan," initiated on NJ Exec Order 26.4b1 indicated Resident #2 had NJ Exec Order 26.4b1 interventions in place directing staff to document any NJ Exec Order 26.4b1 including NJ Exec Order or NJ Exec Order 26 at residents. The Service Plan indicated that the resident NJ Exec Order at another resident on NJ Exec Order 26.4b1 ; NJ Exec Order at staff and residents on NJ Exec Order 26.4b1; and had an NJ Exec Order 26.4b1 with a resident on NJ Exec Order 26.4b1.

Resident #2's "[The Facility's Name] Service Agreement," dated NJ Exec Order 26.4b1, included a "Behavioral Management Plan," with an effective date of NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 Management Plan directed staff to document any NJ Exec Order 26.4b1 including NJ Exec Order or NJ Exec Order 26 at other residents. Per the NJ Exec Order 26.4b1 Management Plan, interventions included redirection, use of NJ Exec Order 26.4b1 and collaborating with NJ Exec Order 26.4b1 health services as needed to ensure resident safety and well-being. The NJ Exec Order 26.4b1 Management Plan indicated that the resident NJ Exec Order at other residents on NJ Exec Order 26.4b1 ; NJ Exec Order at staff and residents on NJ Exec Order 26.4b1; and had an NJ Exec Order 26.4b1 with a resident on NJ Exec Order 26.4b1.

Resident #14's "Face Sheet" revealed the facility admitted the resident on NJ Exec Order 26.4b1

Resident #14's "NJ Exec Order 26.4b1 " dated NJ Exec Order 26.4b1, revealed the

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resident had a score of [redacted] and indicated the resident had a [redacted].

"Progress Notes for [Resident #2]" revealed a note, dated [redacted] at 6:02 PM and authored by the ED, that revealed Resident #2 was waiting outside the ED's office to report that another resident (Resident #14) [redacted] on the floor in the theater. The note indicated that the ED asked the other resident if they had [redacted] on the floor, and they [redacted] having done so. The note indicated that Resident #2 started '[redacted] "You did [redacted] on the floor. you're [sic] [redacted] The note indicated that the residents began [redacted] at each other. Per the note, The ED stepped between the two residents and told Resident #2 that they could not [redacted] and [redacted] at people, as it could be considered [redacted]

The facility staff were unable to provide evidence that the [redacted] incident was reported to the state survey agency, evidence that the incident was investigated, or evidence that interventions were developed and implemented to prevent further [redacted] from Resident #2 following the incident.

Resident #16's "Face Sheet" revealed the facility admitted the resident on [redacted]

Resident #16's '[redacted]" dated [redacted] revealed the resident had a score of [redacted] which indicated the resident had a [redacted] of [redacted]

"Progress Notes for [Resident #2]" revealed a note, dated [redacted] at 2:38 PM and authored by the Director of Memory Support (DMS), that

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revealed that at 1:20 PM, Resident #2 and Resident #16 NJ Exec Order 26.4b1 as they were both trying to enter the activity room. The note indicated that Resident #2 and Resident #16 got in to a NJ Exec Order 26.4b1" and the DMS NJ Exec Order 26.4b1 The note indicated that Resident #2 went into the activity room and proceeded to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Per the note, when Resident #16 entered the room, Resident #2 stated that if Resident #16 made them NJ Exec Order 26.4b1, they were going to NJ Exec O Resident #16. The note indicated the DMS "NJ Exec Order [Resident #2] NJ Exec Order 2 and the resident was NJ Exec Ord The note indicated the DMS asked the Director of Lifestyle and Leisure to stay in the activity room to supervise, as she did not want another situation to occur if Resident #2 and Resident #16 were NJ Exec Order 26.4b1 in the room NJ Exec Order 26.4b1

Resident #2's "Service Agreement" revealed that a "NJ Exec Order 26.4b1 Management Plan" was added on NJ Exec Order 26.4b1 with interventions that included NJ Exec Order 26.4b1 use of NJ Exec Order 26.4b1, and collaborating with NJ Exec Order 26.4b1 services as needed to ensure resident safety and well-being. However, the facility staff were unable to provide evidence that the NJ Exec Order 26.4b1 incident was reported to the state survey agency or evidence that the incident was investigated.

During an interview on 12/05/2025 at 1:04 PM, the DMS stated she did not see the incident on NJ Exec Order 26.4b1 with Resident #2 and Resident #16 as NJ Exec Order 26.4b1; she saw it as two residents having a NJ Exec Order 26.4b1 She stated the residents were easily NJ Exec Order 26.4b1 She revealed that she stayed in the activity room during the activity to make sure NJ Exec Order 26.4b1 between Resident #2 and Resident #16.

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A 310	Continued From page 7 Resident #15's "Face Sheet" revealed the facility admitted the resident on NJ Exec Order 26.4b1 and indicated that the resident NJ Exec Order 26 on NJ Exec Order 26.4b1. Resident #15's NJ Exec Order 26.4b1 " dated NJ Exec Order 26.4b1 revealed the resident had a score of NJ Exec and indicated the resident had a NJ Exec Order 26.4b1. "Progress Notes for [Resident #2]" revealed a note, dated NJ Exec Order 26.4b1 at 1:30 PM and authored by the Director of Health and Wellness (DHW), that revealed that Resident #2 was observed "NJ Exec Order 26.4b1 " (Resident #15) in the dining hall. The note indicated that the DHW and another staff member approached the table to NJ Exec Order 26.4b1 the situation. Per the note, Resident #2 NJ Exec Order 26 and was NJ Exec Order 26.4b1 appropriately "to ensure a safe and respectful environment for all residents." The facility staff were unable to provide evidence that the NJ Exec Order 26.4b1 incident was reported to the state survey agency, evidence that the incident was investigated, or evidence that interventions were developed and implemented to prevent further NJ Exec Order from Resident #2 following the incident. During an interview on 12/08/2025 at 11:09 AM, the DHW stated that the incident on 04/21/2025 was NJ Exec Order 26.4b1 and she did not consider it NJ Exec Order 26.4b1. The DHW stated that it was a NJ Exec Order 26.4b1 between Resident #2 and Resident #15. "Progress Notes for [Resident #2]" revealed a note, dated NJ Exec Order 26.4b1 at 2:10 PM and authored by the DHW, that indicated that an "NJ Exec Order 26.4b1	A 310		

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occurred between Resident #2 and another resident (Resident #16) on the facility's [NJ Exec] on [NJ Exec Order 26.4b1]. The note indicated that Resident #2 was "[NJ Exec Order 26.4b1] The note indicated that staff intervened promptly to [NJ Exec Order 26.4b1] the situation "best as possible." The note indicated the incident had been documented and would be reviewed for any necessary follow-up or support.

The facility staff were unable to provide evidence that the [NJ Exec Order 26.4b1] incident was reported to the state survey agency, evidence that the incident was investigated, or evidence that interventions were developed and implemented to prevent further [NJ Exec Order] from Resident #2 following the incident.

During an interview on 12/05/2025 at 3:27 PM, Resident #16 stated that months prior, when they went on a [NJ Exec Order 26.] , Resident #2 said Resident #16 was [NJ Exec Order] in Resident #2's [NJ Exec O] and called Resident #16 a [NJ Exec Order 26.4b1] and was [NJ Exec Order 26.4]

During an interview on 12/05/2025 at 1:26 PM, Lifestyle and Leisure Assistant (LLA) #3 revealed that at the time of the incident on [NJ Exec Order 26.4b1] at 12:30 PM, she was outside assisting residents on the facility [NJ Exec] to go on an outing. She stated that Resident #2 and Resident #16 were on the [NJ Exec] first, and she heard Resident #2 call Resident #16 a [NJ Exec Order 26.4b1]. She stated that Resident #16 told Resident #2 not to [NJ Exec Order 26.4b1] that way and stated that they [NJ Exec Order 26.4b1] Resident #2, after which Resident #2 [NJ Exec] Resident #16 to [NJ Exec] She stated that the residents began [NJ Exec Order] at [NJ Exec Order 26.4b1], and she (LLA #3) got on the [NJ Exec] and told them to stop and that if they did not stop, they

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would not be going on the [redacted] She stated that she did not consider the incident to be [redacted] just two residents having a [redacted]

Resident #1's "Face Sheet" revealed the facility admitted the resident on [redacted]. According to the Face Sheet, Resident #1 had a medical history that included a diagnosis of [redacted]

Resident #1's [redacted] revealed the resident had a score of [redacted] which indicated the resident had a [redacted].

"Progress Notes for [Resident #2]" revealed a note, dated [redacted] at 9:26 PM, that revealed Resident #1 approached Resident #2 regarding [redacted] Resident #1 believed they were [redacted] The note indicated that an [redacted] occurred between the residents and Resident #2 [redacted] Resident #1 by the [redacted] and [redacted], resulting in Resident #1 [redacted]

A "New Jersey Department of Health Division of Health Facility Survey and Field Operations Long Term Care Assessment and Survey Program/Complaint Unit" "Reportable Event Record/Report," dated [redacted], revealed that at 3:00 PM, Resident #1 approached Resident #2 after a Bingo activity was over and requested [redacted] Resident #2 [redacted] them. The report indicated that when Resident #2 [redacted] to [redacted] Resident #1 [redacted] that was sitting on a table. Per the report, Resident #2 then [redacted] Resident #1's [redacted] and was witnessed [redacted] on the table. The report indicated that Resident #1 then [redacted] Resident #2 by the [redacted] then Resident #2 [redacted] Resident #1, resulting in Resident #1

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NJ Exec Order to the floor. The report revealed Resident #1 NJ Exec Order 26.4b1 .

A typed facility document, dated NJ Exec Order 26.4b1 indicated that the facility's investigation related to the incident involving Resident #1 and Resident #2 was concluded. Per the document, Resident #1 NJ Exec Order 26.4b1 Resident #2 NJ Exec Order 26.4b Resident #1's NJ Exec Ord and NJ Exec Order 26.4b1. Per the document, Resident #2 NJ Exec Order 26.4b Resident #1 by their NJ Exec O to get NJ Exec Order 26.4b1, then Resident #2 NJ Exec Order 26. Resident #1 with NJ Exec Order 26.4b1 on the resident's NJ Exec Orde resulting in Resident #1 NJ Exec Order 26.4b1. The document indicated that Resident #1 was taken to the hospital and found to have a NJ Exec Order 26.4b1 .

Resident #1's hospital discharge summary, dated NJ Exec Order 26.4b1 indicated that the resident was admitted to the hospital on NJ Exec Order 26.4b1 and discharged on NJ Exec Order 26.4b1 with diagnoses that included a NJ Exec Order 26.4b1, with orders for NJ Exec Order 26.4b1.

During an interview on 12/05/2025 at 2:13 PM, Resident #1 stated that NJ Exec felt like the incident between them and Resident #2 was NJ Exec Order 2 Resident #1 stated that they told Resident #2 to pay NJ Exec Order 26.4b1 (Resident #1) after Resident #2 won two games of Bingo. Resident #1 stated Resident #2 put their NJ Exec Ord on Resident #1's NJ Exec O and NJ Exec Order 26.4 causing the resident to NJ Exec Resident #1 stated their NJ Exec Order 26.4b1 was NJ Exec Order 2 and that there was a NJ Exec O on their NJ Exec Ord after the NJ Exec

During an interview on 11/08/2025 at 8:28 AM, the DHW stated that Resident #2's service plan should have been updated after each of the incidents, with effective interventions.

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A 310	Continued From page 11 During an interview on 12/06/2025 at 11:00 AM, the ED revealed that she did not report the incidents on NJ Exec Order 26.4b1 to the state survey agency. The ED stated that she saw the incidents as two residents NJ Exec Order 26.4b1 and stated that the residents were separated, and the situations were NJ Exec Order 26.4b1. During an interview on 12/08/2025 at 11:12 AM, the ED stated that she witnessed the incident on NJ Exec Order 26.4b1. The ED stated that she was not aware of the incident on NJ Exec Order 26.4b1. She stated that she would have expected the DMS to notify her of the incident. The ED stated that she was aware of Resident #2 and Resident #15's NJ Exec Order 26.4b1 in the dining hall on NJ Exec Order 26.4b1. The ED stated that the incident was NJ Exec Order 26.4b1. The ED stated that she was aware of the incident documented on NJ Exec Order 26.4b1 involving Resident #2 and Resident #16. The ED stated that the incident was NJ Exec Order 26.4b1. The ED stated that she expected staff to report all forms of NJ Exec Order 2[illegible]. The ED stated that she did not typically report NJ Exec Order 26.4b1 to the state survey agency if it was successfully NJ Exec Order 26.4b1. During an interview on 12/08/2025 at 5:08 PM, the ED revealed that she was not aware she had to report NJ Exec Order 26.4b1 to the state survey agency. The ED further stated that going forward, all NJ Exec Order 26.4b1 would be reported and investigated. The ED stated that it was her expectation that interventions be implemented on a resident's service plan after each incident. The ED stated that she thought Resident #2's service plan was updated with interventions.	A 310		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT TOMS RIVER	1657 SILVERTON ROAD TOMS RIVER, NJ 08753

(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 389	Continued From page 12	A 389		
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; This REQUIREMENT is not met as evidenced by: Complaint #NJ0088870 Based on facility policy review, record review, facility document review, and interview, the facility failed to protect the residents' right to be [NJ Exec O] from [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1], which affected 4 (Residents #1, #14, #15, and #16) of 11 residents reviewed for [NJ Exec Order 2] Following an incident on [NJ Exec Order 26.4b1] involving Resident #1 and Resident #14, the facility failed to report the [NJ Exec Order] to the state survey agency, failed to investigate the incident, and failed to implement interventions to protect residents from further [NJ Exec Order] following the [NJ Exec Order] incident. Subsequently, Resident #2 continued to be [NJ Exec Order 26.4b1] towards other residents on [NJ Exec Order 26.4b1], Resident #2 had a [NJ Exec Order 26.4b1] with Resident #1, then [NJ Exec Order 26] Resident #1, causing Resident #1 to [NJ Exe] and [NJ Exec Order 26] a right [NJ Exec Order 26.4b1].	A 389		

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A 389	Continued From page 13 It was determined that the facility's non-compliance with one or more requirements had caused, or was likely to cause serious injury, harm, impairment, or death to residents. On 12/08/2025 at 6:14 PM, the facility's Executive Director (ED) was verbally informed of the immediacy of the situation involving Resident #2's NJ Exec Order 26.4b1. Findings included: A facility policy titled, "Elder Abuse/Neglect New Jersey," dated 04/2021, indicated, "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. Staff are to immediately notify the Director of Health and Wellness or Executive Director. Staff will not be terminated nor reprimanded for reporting suspected or actual cases of resident abuse. Staff do not require permission from their supervisor, Director of Health and Wellness, Executive Director or any other person to report actual or suspected elder abuse." The policy further specified, "4) Upon the notice of reported observed, suspected, or at imminent risk of abuse or exploitation: a) Immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is being conducted. b) A thorough investigation will be conducted by the Director of Health and Wellness or Executive Director." The policy revealed, "6) Reporting of any suspected, alleged, or witnessed abuse or neglect will be completed according to state reporting requirements." The policy revealed, "7) An investigation will take place surrounding the cause of the abuse." The abuse policy revealed	A 389		

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A 389	Continued From page 14	A 389		

that it did not include the definition of abuse or the types of abuse. The abuse policy revealed that it did not include how residents' rights would be protected following the investigation of abuse if resident-to-resident abuse was in fact substantiated.

A "Face Sheet" revealed the facility admitted Resident #2 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 .

Resident #2's "DL [Distinct Living] Master Assessment," initiated NJ Exec Order 26.4b1, revealed Resident #2 was NJ Exec Order 26.4b1

Resident #2's "Service Plan," initiated on NJ Exec Order 26.4b1 indicated Resident #2 had NJ Exec Order 26.4b1 interventions in place directing staff to document any NJ Exec Order 26.4b1 including NJ Exec Order 2 or NJ Exec Order 26 at residents. The Service Plan indicated that the resident NJ Exec Order at another resident on NJ Exec Order 26.4b1 ; NJ Exec Order at staff and residents on NJ Exec Order 26.4b1; and had an NJ Exec Order 26.4b1 with a resident on NJ Exec Order 26.4b1.

Resident #2's "[The Facility's Name] Service Agreement," dated NJ Exec Order 26.4b1, included a "NJ Exec Order 26.4b1 Management Plan," with an effective date of NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 Management Plan directed staff to document any NJ Exec Order 26.4b1 including NJ Exec Order 2 or NJ Exec Order 26 at other residents. Per the NJ Exec Order 26.4b1 Management Plan, interventions included NJ Exec Order 26.4b1 use of NJ Exec Order 26.4b1 , and collaborating with NJ Exec Order 26.4b1 health services as needed to ensure resident safety and well-being. The NJ Exec Order 26.4b1

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A 389	Continued From page 15 Management Plan indicated that the resident NJ Exec Order at other residents on NJ Exec Order 26.4b1 ; NJ Exec Order at staff and residents on NJ Exec Order 26.4b1 and had an NJ Exec Order 26.4b1 with a resident on NJ Exec Order 26.4b1. Resident #14's "Face Sheet" revealed the facility admitted the resident on NJ Exec Order 26.4b1. Resident #14's "NJ Exec Order 26.4b1 " dated NJ Exec Order 26.4b1 revealed the resident had a score of NJ Exec and indicated the resident had a NJ Exec Order 26.4b1. "Progress Notes for [Resident #2]" revealed a note, dated NJ Exec Order 26.4b1 at 6:02 PM and authored by the ED, that revealed Resident #2 was waiting outside the ED's office to report that another resident (Resident #14) NJ Exec on the floor in the theater. The note indicated that the ED asked the other resident if they had NJ Exec on the floor, and they NJ Exec Order 2 having done so. The note indicated that Resident #2 started "NJ Exec Order 26.4b1 " NJ Exec Order 26. " The note indicated that the residents began NJ Exec Order at NJ Exec Order 26.4b1. Per the note, The ED stepped between the two residents and told Resident #2 that they could not NJ Exec Order 26. and NJ Exec Orde at people, as it could be considered NJ Exec Order 2. The facility staff were unable to provide evidence that the NJ Exec Order 26.4b1 incident was reported to the state survey agency, evidence that the incident was investigated, or evidence that interventions were developed and implemented to prevent further NJ Exec Order from Resident #2 following the incident. Resident #16's "Face Sheet" revealed the facility	A 389		

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A 389	Continued From page 16 admitted the resident on NJ Exec Order 26.4b1. Resident #16's NJ Exec Order 26.4b1 " dated NJ Exec Order 26.4b1, revealed the resident had a score of NJ Exec which indicated the resident had a NJ Exec Order 26.4b1 "Progress Notes for [Resident #2]" revealed a note, dated NJ Exec Order 26.4b1 at 2:38 PM and authored by the Director of Memory Support (DMS), that revealed that at 1:20 PM, Resident #2 and Resident #16 NJ Exec Order 26.4b1 as they were both trying to enter the activity room. The note indicated that Resident #2 and Resident #16 got in to a 'NJ Exec Order 26.4b1" and the DMS NJ Exec Order 26.4b1. The note indicated that Resident #2 went into the activity room and proceeded to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Per the note, when Resident #16 entered the room, Resident #2 stated that if Resident #16 made them NJ Exec Order 26.4b1, they were going to NJ Exec Resident #16. The note indicated the DMS 'NJ Exec Order [Resident #2] NJ Exec Order 2 and the resident was NJ Exec Ord The note indicated the DMS asked the Director of Lifestyle and Leisure to stay in the activity room to NJ Exec Order 26.4b1 as she did not want another situation to occur if Resident #2 and Resident #16 were NJ Exec Order 26.4b1 in the room NJ Exec Order 26.4b1 Resident #2's "Service Agreement" revealed that a 'NJ Exec Order 26.4b1 Management Plan" was added on NJ Exec Order 26.4b1. Interventions included NJ Exec Order 26.4b1 use of NJ Exec Order 26.4b1, and collaborating with NJ Exec Order 26.4b1 health services as needed to ensure resident safety and well-being. However, the facility staff were unable to provide evidence that the incident was investigated.	A 389		

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During an interview on 12/05/2025 at 1:04 PM, the DMS stated she did not see the incident on NJ Exec Order 26.4b1 with Resident #2 and Resident #16 as NJ Exec Order 26.4b1; she saw it as two residents having a NJ Exec Order 26.4b1. She stated that the residents were easily NJ Exec Order 26.4b1. She revealed that she stayed in the activity room during the activity to make sure everything was NJ Exec Or between Resident #2 and Resident #16.

Resident #15's "Face Sheet" revealed the facility admitted the resident on NJ Exec Order 26.4b1 and indicated that the resident NJ Exec Order 26. on NJ Exec Order 26.4b1.

Resident #15's "NJ Exec Order 26.4b1 " dated NJ Exec Order 26.4b1 revealed the resident had a score of NJ Exec and indicated the resident had a NJ Exec Order 26.4b1.

"Progress Notes for [Resident #2]" revealed a note, dated NJ Exec Order 26.4b1 at 1:30 PM and authored by the Director of Health and Wellness (DHW), that revealed that Resident #2 was observed "NJ Exec Order 26.4b1 " (Resident #15) in the dining hall. The note indicated that the DHW and another staff member approached the table to NJ Exec Order 26.4b1 the situation. Per the note, Resident #2 NJ Exec Order 26. and was NJ Exec Order 26.4b1 appropriately "to ensure a safe and respectful environment for all residents."

The facility staff were unable to provide evidence that interventions were developed and implemented to prevent further NJ Exec Order from Resident #2 following the incident.

During an interview on 12/08/2025 at 11:09 AM, the DHW stated that the incident on NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1, and she did not consider it NJ Exec Order 26.4b1. The DHW stated that it was a

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NJ Exec Order 26.4b1 between Resident #2 and Resident #15.

"Progress Notes for [Resident #2]" revealed a note, dated NJ Exec Order 26.4b1 at 2:10 PM and authored by the DHW, that indicated that an 'NJ Exec Order 26.4b1 occurred between Resident #2 and another resident (Resident #16) on the facility's bus on NJ Exec Order 26.4b1. The note indicated that Resident #2 was 'NJ Exec Order 26.4b1 The note indicated that staff intervened promptly to NJ Exec Order 26.4b1 the situation NJ Exec Order 26.4b1." The note indicated the incident had been documented and would be reviewed for any necessary follow-up or support.

The facility staff were unable to provide evidence that interventions were developed and implemented to prevent further NJ Exec Order from Resident #2 following the incident.

During an interview on 12/05/2025 at 3:27 PM, Resident #16 stated that NJ Exec Order 26 prior, when they went on a NJ Exec Order 26, Resident #2 said Resident #16 was NJ Exec Orde in Resident #2's NJ Exec O and called Resident #16 a NJ Exec Order 26.4b1 and was NJ Exec Order 26.4

During an interview on 12/05/2025 at 1:26 PM, Lifestyle and Leisure Assistant (LLA) #3 revealed that at the time of the incident on NJ Exec Order 26.4b1 at 12:30 PM, she was outside assisting residents on the NJ Exec Order 26.4b1 to go on an NJ Exec Order 2 She stated that Resident #2 and Resident #16 were on the NJ Exec first, and she heard Resident #2 NJ Exec Resident #16 a NJ Exec Order 26.4b1. She stated that Resident #16 told Resident #2 not to NJ Exec Order 26.4b1 that way and stated that they would NJ Exec Order Resident #2, after which Resident #2 told Resident #16 to NJ Exec

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She stated that the residents began NJ Exec Order at NJ Exec Order 26.4b1, and she (LLA #3) got on the NJ Exec and told them to stop and that if they did not stop, they would not be going on the NJ Exec. She stated that she did not consider the incident to be NJ Exec Order, just two residents having a NJ Exec Order 26.4b1.

Resident #1's "Face Sheet" revealed the facility admitted the resident on NJ Exec Order 26.4b1. According to the Face Sheet, Resident #1 had a medical history that included a diagnosis of NJ Exec Order 26.4b1.

Resident #1's 'NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b1, revealed the resident had a score of NJ Exec which indicated the resident had a NJ Exec Order 26.4b1.

"Progress Notes for [Resident #2]" revealed a note, dated NJ Exec Order 26.4b1 at 9:26 PM, that revealed Resident #1 approached Resident #2 regarding NJ Exec Order 26.4b. Resident #1 believed they were NJ Exec Order. The note indicated that an NJ Exec Order 26.4b1 occurred between the residents and Resident #2 NJ Exec Order 26.4b Resident #1 by the NJ Exec C and NJ Exec Order 26.4b1, resulting in Resident #1 NJ Exec Order 26.4b1.

A "New Jersey Department of Health Division of Health Facility Survey and Field Operations Long Term Care Assessment and Survey Program/Complaint Unit" "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, revealed that at 3:00 PM, Resident #1 approached Resident #2 after a Bingo activity was over and requested NJ Ex Resident #2 NJ Exec Orde them. The report indicated that when Resident #2 NJ Exec Order 26.4 to NJ Exec the NJ Exec Order 26 Resident #1 NJ Exec Order 26.4b1 that was sitting on a table. Per the report, Resident #2 then NJ Exec Order 26.4b Resident #1's NJ Exec and was witnessed 'NJ Exec Order 26.4b1. The

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report indicated that Resident #1 then NJ Exec Order 26.4b Resident #2 by the NJ Exec Or then Resident #2 NJ Exec Order 26 Resident #1, resulting in Resident #1 NJ Exec Order to the floor. The report revealed Resident #1 NJ Exec Order 26.4b1 a NJ Exec Order 26.4b1.

A typed facility document, dated NJ Exec Order 26.4b1, indicated that the facility's investigation related to the incident involving Resident #1 and Resident #2 was concluded. Per the document, Resident #1 NJ Exec Order 26.4b1 at the end of a Bingo activity, Resident #2 NJ Exec Order 26.4b Resident #1's NJ Exec Or and NJ Exec Order 26.4b1. Per the document, Resident #2 NJ Exec Order 26.4b Resident #1 by their NJ Exec O to NJ Exec Order 26.4b1, then Resident #2 NJ Exec Order 26 Resident #1 with NJ Exec Order 26.4b1 on the resident's NJ Exec Order NJ Exec Order 26.4b in Resident #1 NJ Exec Order 26.4b1. The document indicated that Resident #1 was taken to the hospital and found to have a NJ Exec Order 26.4b1.

Resident #1's hospital discharge summary, dated NJ Exec Order 26.4b1, indicated that the resident was admitted to the hospital on NJ Exec Order 26.4b1 and discharged on NJ Exec Order 26.4b1 with diagnoses that included a NJ Exec Order 26.4b1, with orders for NJ Exec Order 26.4b1.

During an interview on 12/05/2025 at 2:13 PM, Resident #1 stated that NJ Exec felt like the incident between them and Resident #2 was NJ Exec Order 2 Resident #1 stated that they told Resident #2 to pay $NJ Exec Order 26.4b1 (Resident #1) after Resident #2 won two games of Bingo. Resident #1 stated Resident #2 NJ Exec Order 26.4b1 on Resident #1's NJ Exec O and NJ Exec Order 26.4 causing the resident to NJ Exec Resident #1 stated their NJ Exec Order 26.4b was NJ Exec Order 2 and that there was a NJ Exec O on their NJ Exec Or after the NJ Exec

During an interview on 11/07/2025 at 9:41 AM,

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the DMS stated that Resident #2 was NJ Exec Order 26.4 [redacted] to everyone.

During an interview on 11/07/2025 at 11:47 AM, Lifestyle and Leisure Assistant (LLA) #2 stated that Resident #2 often NJ Exec Order [redacted] at and NJ Exec Order 26 residents' NJ Exec Order [redacted]

During an interview on 11/08/2025 at 8:28 AM, the DHW stated that if staff witnessed any form of NJ Exec Order 2 [redacted] she expected them to make sure residents were safe, notify the supervisor, and document what they observed. The DHW stated that the ED investigated incidents of NJ Exec Order [redacted] and provided a conclusion.

During an interview on 11/08/2025 at 10:31 AM, the ED stated that all incidents were discussed during morning meetings, and the DHW updated the service plans with interventions. Regarding her expectations of staff when NJ Exec Order [redacted] had been witnessed or reported, she stated she expected staff to ensure residents were safe and to notify the nurse or herself immediately. She stated that she expected all NJ Exec Order 26.4b1 to be addressed so that residents resided in a safe environment.

During an interview on 12/08/2025 at 11:12 AM, the ED stated that she witnessed the incident on NJ Exec Order 26.4b1 [redacted]. The ED stated that she was not aware of the incident on NJ Exec Order 26.4b1 [redacted] She stated that she would have expected the DMS to notify her of the incident. The ED stated that she was aware of Resident #2 and Resident #15's NJ Exec Order 26.4b1 [redacted] in the dining hall on NJ Exec Order 26.4b1 [redacted]. The ED stated that the incident was NJ Exec Order 26.4b1 [redacted] The ED stated that she was aware of the incident documented on NJ Exec Order 26.4b1 [redacted] involving Resident #2 and Resident #16. The ED stated that the

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A 389	Continued From page 22 incident was[NJ Exec Order 26.4b1]. The ED stated that she expected staff to report all forms of [NJ Exec Order 2] During an interview on 12/08/2025 at 5:08 PM, the ED stated that it was her expectation that interventions be implemented on a resident's service plan after each incident. The ED stated that she thought Resident #2's service plan was updated with interventions.	A 389		
A1057	8:36-15.4 Resident Records All records shall be maintained for a period of 10 years after the discharge of a resident from the assisted living residence, comprehensive personal care home or assisted living program. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00159303 and #NJ00168436 Based on facility policy review and interview, the facility failed to ensure medical records were maintained for 10 years after a resident was discharged from the facility for 3 (Residents #4, #5, and #6) of 3 residents reviewed who had discharged prior to the facility's change in ownership in April 2024. Findings included: A facility policy titled, "Resident Medical Record," dated 04/2021, indicated, "An accurate and properly updated Resident Record will assist us in managing the health care of our residents." The policy revealed the "Procedure" included, "4.	A1057		

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Keep the Resident Record on file after the resident has left in accordance with state regulations."

During an interview on 11/06/2025 at 1:18 PM, the Director of Health and Wellness (DHW) stated that if the residents were already discharged from the facility prior to the ownership change, the facility did not have any of those records. The DHW stated that they did not have any records for Residents #4, #5, or #6. The DHW stated that those residents must have been discharged prior to the change in ownership because they were not in the facility's computer system.

During an interview on 11/06/2025 at 10:21 AM, the Director of Nursing Clinical Area Supervisor (DNCAS) stated that they did not have access to any medical records prior to [redacted]. The DNCAS stated that the facility had no grievances or any record types from the previous facility owner from [redacted] through [redacted]

During an interview on 11/06/2025 at 1:15 PM, the DNCAS stated that the facility did not have records for any residents prior to the change in ownership.

During an interview on 11/08/2025 at 12:53 PM, the Director of Memory Support (DMS) stated that she barely remembered Resident #6.

During an interview on 11/08/2025 at 8:27 AM, the DHW stated that she was not aware of the medical records process. The DHW stated that it made sense that the facility needed to retain resident records after a change in ownership.

During an interview on 11/08/2025 at 11:01 AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65A114	A. BUILDING: _____ B. WING _____	C 12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT TOMS RIVER	1657 SILVERTON ROAD TOMS RIVER, NJ 08753

(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
A1057	Continued From page 24 the Executive Director (ED), who had been working at the facility since November 2022, stated that medical records must be available, even if a resident moved out of the facility. The ED stated that if the state survey agency needed medical records from the previous facility owner, then the facility needed to obtain those medical records. The ED stated that she expected the facility to maintain resident records for 10 years. She stated that she did remember Resident #4 and Resident #5. The ED stated the facility should have had access to the facility reported event that occurred between Resident #4 and Resident #5.	A1057		

POC #3 received 1/13/26.
Accepted 1/13/26

MIRA VIE
AT TOMS RIVER
ASSISTED LIVING · MEMORY SUPPORT
A DISTINCTIVE LIVING COMMUNITY

12/29/2025

To Whom It May Concern,
Please find the Plan of Correction related to the complaint survey conducted on 12/8/2025.
A310 8:36- 3.4(a)(1) Administrator's Responsibilities

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
   - Resident #2 no longer resides at the community; NJ Exec Order 26.4b1 Resident #1, 14, 15, 16 are no longer affected; Resident #1 returned to community on NJ Exec Order 26.4b1
   - Elder Abuse/Neglect policy continues to be followed. All incidents of resident abuse will be reported to NJ Department of Health.
   - All staff in-serviced by Executive Director(ED) or Designee, related to Elder Abuse/Neglect policy. Completed 12/09/2025.
   - Late entry Incident Reports completed for NJ Exec Order 26.4b1 or residents #14, #15, #16 for dates NJ Exec Order 26.4b1 by Director of Health and Wellness.

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

3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.
   - Executive Director or designee to ensure all staff are trained to respond to all potential cases of resident abuse, including verbal abuse. Completed 12/09/2025.
   - Executive Director educated Leadership Team on 12/09/2025 on policies and procedures: Elder Abuse and Neglect, Internal Incident Reports and State Reports.
   - Director of Health and Wellness(DHW)and Executive Director reviewed Service Plan and Assessment policy with Vice President of Health and Wellness (VPHW). Completed on 12/9/25.

- Community to follow policies and procedures as it relates to Elder Abuse/Neglect, Internal Incident Reports and State Reports, and Service Plans and Assessments up to and including education on completing incident reports on verbal altercation between residents. Effective 12/29/2025.
- Audit completed by Director of Health and Wellness of resident records over the last 6 months to ensure that all verbal altercations between residents have an incident report per policy. Completed on 12/9/2025.
- Department managers, including Director of Health & Wellness, Director of Business and People, Director of Sales & Marketing, Director of Resident Experience, Director of Memory Support, Director of Plant Operations, and Director of Restaurant & Hospitality educated by Executive Director on policies related to Elder Abuse/Neglect 12/09/2025.
- Licensed staff educated on Internal Incident Reports and State Reports policy. Completed 12/09/2025.
- Executive Director provided education to residents on Resident Rights and reporting abuse/neglect. Completed 12/30/2025.
- Resident service plans updated per policy. Completed 12/30/2025.
- Staff education on Resident-to-Resident Mistreatment completed by Executive Director on 12/9/2025.
- Effective 12/30/2025 and ongoing.

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.

- Review of Grievances by Executive Director, as part of QAPI to ensure compliance. Next QAPI Date: 1/30/2025.
- Review of Incident Reports by Executive Director at least once per week. Effective 12/30/2025.
- Review of all staff training regarding policies stated above audited quarterly and presented during quarterly QAPI meeting by Director of Health and Wellness. Next QAPI Date: 1/30/2026.
- Resident Incidents Reviewed by Director of Health and Wellness as part of Quarterly QAPI to ensure interventions are currently in place. Next QAPI Date: 1/30/2026
- Completion date: 12/30/2025. KF approved 1/13/26

A355 8:36-4.1(a)(1) Resident Rights

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
   - Resident #2 no longer resides at facility. NJ Exec Order 26.4b1
   - Resident #1 resides in the community. Service plan updated post incident/upon return to facility or NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Resident #2 discharged or NJ Exec Order 26.4b1
   - Resident #14 service plan updated NJ Exec Order 26.4b1 (Resident #2 discharged on NJ Exec Order 26.4b1
   - Resident #15 is NJ Exec Order 26.4b1
   - Resident #16 has service plan updated NJ Exec Order 26.4b1 including NJ Exec Order 26.4b1 interventions. (Resident #2 discharged on NJ Exec Order 26.4b1.

- Staff education upon hire, annually, and on-going regarding Resident Abuse/Neglect and Resident Rights.
- Executive Director to continue to report all allegations of resident abuse, to include New Jersey Department of Health and Office of the Long-Term Care Ombudsman. Report to include investigation, interventions, and summary for all incidents.

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

3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.
   - Immediate re-education of all staff regarding Resident Abuse/Neglect policies and reporting expectations. Completed 12/9/2025.
   - Continued staff education regarding Resident Abuse/Neglect during staff meetings by Executive Director or designee and through on-line training portal as assigned. Completed 12/9/2025 and on-going.
   - DHW updated all service plans to include dated interventions. Completed 12/9/2025.
   - Ongoing staff education regarding Resident Abuse/Neglect, Resident Rights.
   - Ongoing resident education as part of Monthly Resident Council Meeting on expectations and resident rights. Completed 12/30/2025 and on-going.
   - Effective 12/30/2025 and on-going.
   - Immediate staff training by Executive Director on Resident Abuse/Neglect and Resident Rights. Completed 12/9/2025.
   - Service plans were updated to include interventions for any residents with behaviors. Completed 12/10/2025.

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.
   - DHW to review incidents as part of QAPI. Next QAPI will be held on 1/30/2025.
   - Executive Director or designee to monitor grievances and incident reports as part of monthly review. Completion date 12/30/2025.
   - Completion date: 12/30/2025.

KF approved 1/13/26

A1057 8:36-5.4 Resident Records

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
   - Resident records are maintained on site for minimum of 10 years.
   - Certi-Serv offered records during re-visit and declined. Executive Director was on vacation during initial visit.
   - Resident #4 Moved out of facility NJ Exec Order 26.4b1 Resident #5 NJ Exec Order 26.4b1 resident #6 NJ Exec Order 26.4b1

2. How the corrective action will be accomplished for those residents found to have been

3. affected by the deficient practice.
    - All residents have the potential to be affected.

4. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.
    - Resident medical records will be available for 10 years in on-site storage.
    - All records are currently on-site in a secure location. Verified on 12/9/2025 by Executive Director.
    - Education regarding on-sit storage provided by Executive Director to Management Team on 12/9/2025.

5. 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.
    - On-site storage inventory review to be completed by Executive Director or designee by 1/30/2025 and reviewed as part of QAPI meeting on 1/30/2025.
    - Completion date 1/30/2026.

    ✗ approved 1/13/26

    Submitted January 13, 2025 by NJ Ex Order 26.4(b)(1)

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
65A114		1/13/2026

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT TOMS RIVER	1657 SILVERTON ROAD TOMS RIVER, NJ 08753

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 12/30/2025	ID Prefix A0389 Reg. # 8:36-4.1(a)(16) LSC	Correction Completed 12/30/2025	ID Prefix A1057 Reg. # 8:36-15.4 LSC	Correction Completed 01/30/2026
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	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	
12/8/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: 114V12

STATE FORM: REVISIT REPORT (11/06)

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
65A114		1/13/2026

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT TOMS RIVER	1657 SILVERTON ROAD TOMS RIVER, NJ 08753

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).

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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	
12/8/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: 114V12