New Jersey Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		082462	B. WING		The second secon	C 08/2025
	PROVIDER OR SUPPLIER	319 FOR	DDRESS, CITY, S SGATE DRIVI BURG, NJ 088			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
A 000	Initial Comments: TYPE OF SURVEY COMPLAINT #: No CENSUS: 96 SAMPLE SIZE: 5 The facility is not in all of the standards Administrative Cod Licensure of Assiste Comprehensive Pe Assisted Living Pro submit a Plan of Co completion date for that the plan is impledeficiencies may re accordance with pro Administrative Cod Enforcement of Licenside Signature Cod Enforcement o	substantial compliance with in the New Jersey e 8:36, Standards for ed Living Residences, ersonal Care Homes and grams. The facility must brrection, including a reach deficiency and ensure lemented. Failure to correct esult in enforcement action in ovisions of New Jersey e Title 8, Chapter 43E, ensure Regulations. inistration or or designee shall be a not limited to, the following:	A 310			
	Ensuring the implementation, an and procedures,	development, d enforcement of all policies including resident rights;				

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

TITLE

(X6) DATE 02/03/25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		*5.50** (C1500-2500-8	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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111.11		082462	b. WING	-	01/0	08/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MIRA VI	E AT FORSGATE		SGATE DRIVE URG, NJ 088			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE
A 310	Continued From pa	age 1	A 310			
	Based on interview determined that the the implementation facility policy on Se Service Plans (HSF reviewed, Resident practice was evider on 10/17/2024 at 2 Department of Hea Facility Reportable used by health care the NJDOH. The reof was observed approximately 12:3 was observed the night before him/herself. An which revealed a	NT is not met as evidenced 0178721 If and record review, it was a Administrator failed to ensure and enforcement of the ervice Plans, regarding Health P), for 3 of 5 residents at #1, #2 and #4. This deficient need by the following: 2:40 p.m., the New Jersey with (NJDOH) received a Event (FRE), a document at facilities to report incidents to be entitled a "date of event" of 12:30 p.m. at that on statement at the facilities to report incidents to be entitled as at the statement of the entitled as at the statement of the entitled and entitled as at the statement of the entitled and entitled as a completed on the entitled and entitled as a completed on the entitled and entitled entitled and entitled entitle				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\$54500 \$14,000 \$1000 \$1000 \$1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	Record (EMR) under Additionally, the DH also located in the IPlan." 1.) On 1/7/25 at 12: reviewed Resident which revealed a manadistration of the IPLAN CONTROL OF The Surveyor reviewed that Resident #1 was secomplaint of IPLAN CONTROL OF THE SURVEYOR RESIDENT #1 was accomplaint of IPLAN CONTROL OF THE SURVEYOR RESIDENT #1 was accomplaint of IPLAN CONTROL OF THE WINDOW OF THE WIND CONTROL OF THE WIND CO	in the Electronic Medical er the title, "Service Plan." W stated that the HSPs were EMR under the title, "Care 57 p.m., the surveyor #1's Medical Record (MR), ove-in date of WEX Order 26.481, and Order 26.481. The surveyor rogress Notes (PN) which #1 had WEX Order 26.481 at 8:10 or detection on WEX Order 26.481 at 8:10 or detection on WEX Order 26.481, which the hospital via 911 for the hospital via 911 for the DHW on WEX Order 26.481, which then #1 was hospitalized for a and WEX Order 26.481 to repair R further indicated that denitted to a skilled nursing tion on WEX Order 26.481 and returned or detection of Nursing that Resident #1 had another 0:30 p.m., with no documented at 9:20 a.m., the DHW or WEX ORDER 26.481 at 3:30 p.m., the ditional NJ Ex Order 26.481 at the PN did not indicate the	A 310			

STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CONTRACTOR STATES	E CONSTRUCTION	(X3) DATE COMP	SURVEY
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		082462	B. WING		01/0	8/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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A 310	Continued From part at which the reside would be reviewed to assess the effect 2.) On 1/7/25 at 12 reviewed Resident which revealed a midiagnosis of NJ Eximidicated that Resident facility in The surveyor review Resident #2 dated Director of Health a of the assessment which revealed that since admitted, "Resident India the initial record of investigations, which had NJ Ex Order 26.4b1 of times: On at 5:45 VEX. Order 26.4b1 of times: On at 5:30 a.m. at 1:30 p.m., VEX. Order 26.4b1 of times: On at 5:45 VEX. Order 26.4b1 of times:	age 3 Int's response to treatment and the measures to be used the softhe treatment. Interpolation of the treatment and the measures to be used the softhe treatment. Interpolation of the treatment and the measures to be used the treatment. Interpolation of the treatment and the surveyor and the softher and the sof	A 310			
	was noted with W written by the ADO stated that he/she I by him/herse	on which we at 12:37 p.m., staff DN that Resident #2's which was a standard with the PN indicated that Resident #2 had which will be during the night and left. Review of a PN dated in, written by the DHW				

PRINTED: 03/06/2025 FORM APPROVED New Jersey Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 082462 01/08/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 319 FORSGATE DRIVE MIRA VIE AT FORSGATE JAMESBURG, NJ 08831 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) A 310 Continued From page 4 A 310 indicated that we only of Resident #2's of the NJ Ex Order 26.4b1 on the showed a The surveyor reviewed Resident #2's HSP which documented an entry dated N Ex Order 26.461, that indicated a "Problem/Need" and revealed that Resident #2 had NEX ONLEX ONE. However, there was no documented evidence to show that the HSP was updated with specific interventions to address the resident's NJ Ex Order 26.4b1 3.) On 1/7/25 at 12:15 p.m., the surveyor reviewed Resident #4's MR which revealed a move-in date of NJ Ex Order 26. 4B1, and diagnosis of NJ Ex Order 26, 4B1 . Resident #4's Care Plan indicated that Resident #4 was an elopement risk, with a desired outcome which included that Resident #4 would have a NJ Ex Order 26. 4B1 on his/her WE construct at all times. The surveyor observed that there were comments with the following review dates entered by the facility DHW on NJ Ex Order 26.4b1 . However, review of the Care Plan did not indicate that Resident #4's Care Plan was reviewed further for elopement to include the effectiveness and response to the interventions. On 1/7/25 at 12:30 p.m., during follow up

interview with the DHW, the surveyor inquired about how often the Service Plans (GSP) and Care Plans (HSP) were updated, and the DHW stated that the Service Plans were updated for NJ Ex Order 26.4b1 and changes in the resident level of care. The DHW also stated that the Care Plans were not updated routinely, but that they were updated when there was an incident or change in

a resident. The DHW explained that if the resident had a wound, the Care Plan would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		\$16.05 (CD00-1960C)	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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A 310	Continued From pa	ge 5	A 310			
	updated monthly.					
	facility policy titled,	Jersey", dated 4/2021, which				
	written health service	ne health care assessment, a ce plan shall be developed. plan shall include, but not be ing:				
	(t) Orders for treatr and diet if needed;	ment or services, medications,				
	(u) The resident's r himself or herself;	needs and preferences for				
	(v) The specific go appropriate;	als of treatment or services, if				
		rals at which the resident's ent will be reviewed; and				
	(x) The measures effects of treatment	to be used to assess the				
	reviewed, and if ned as needed, based u to the care provided	olth service plan shall be cessary, revised quarterly, and upon the resident's response d and any changes in the or cognitive status."				
A 735	8:36-7.2(e)(1-5) Re Plans	sident Assessments and Care	A 735			
	written health service	ealth care assessment, a ce plan shall be developed. plan shall include, but not be				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		STATE OF THE PROPERTY OF	CONSTRUCTION	\$44.00 pt.	LETED	
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A 735	limited to, the follow 1. Orders for tre medications, and d 2. The resident himself or herself; 3. The specific if appropriate; 4. The time interesponse to treatment will b	eatment or services, iet, if needed; 's needs and preferences for goals of treatment or services, ervals at which the resident's e reviewed; and es to be used to assess the	A 735			
	by: Complaint #: NJ 00 Based on interview determined that the Health Service Plar health care assess reviewed, Resident was evidenced by to On 1/7/25 at 10:51 the Director of Health Care obtain clarity on the Plans (GSP) and Hincluding their titles in the medical reco	and record review, it was facility failed to ensure that a was developed based on the ment for 1 of 5 residents #1. This deficient practice				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\$2400 \$1400 \$2400 CO	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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A 735	care partners provi Electronic Medical "Service Plan". The the HSP needs we under the title, "Cal On 1/7/25 at 12:57 Resident #1's MR, of "Jescotte 20:33", and of The surveyor review Notes (PN) which resident wia 911 for complaint Additionally, the susuassessment dated on "Jescotte 20:48" which was hospitalized for had NJ Ex Order 20:48 indicated that Resident will be reviewed to assess the effect of the carbon with the resident which the resident which the residence would be reviewed to assess the effect of the carbon with the residence of the carbon with the carbon with the residence of the carbon with the carb	ided, was documented in the Record (EMR) under the title, a DHW additionally stated that re also located in the EMR re Plan." p.m., the surveyor reviewed which revealed a move-in date diagnosis of NJ Ex Order 26. 4BJ. wed the electronic Progress revealed that Resident #1 had 8:10 p.m., with NJ Ex Order 26.4bJ PN indicated that on NJ Ex Order 26.4bJ at the HJ was sent to the hospital int NJ Ex Order 26.4bJ to NJ Ex Order 26.4bJ., signed by the DHW indicated that Resident #1 of the NJ Ex Order 26.4bJ of the NJ Ex Order 26.4bJ and both the NJ Ex Order 26.4bJ. The MR further dent #1 was admitted to a lity for rehabilitation on NJ Ex Order 26.4bJ and both the NJ Ex Order 26.4bJ of the NJ Ex Order 26.4bJ and both the NJ Ex Order				

STATEMEN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONTRACTOR STREET, STR	CONSTRUCTION	(X3) DATE COMP	SURVEY
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	PROVIDER OR SUPPLIER	STREET AD		TATE, ZIP CODE	1 01/0	10/2023
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A 735	interview with the Dabout how often the Care Plans (HSP) is stated that the Serving Ex Order 26:451, and resident level of care Additionally, the Drivere not updated mupdated when there in a resident. The Dresident had a wou updated monthly. On 1/8/25 at 1:00 pfacility policy titled, Assessments New revealed the follow. "(s) (e) Based on the written health service limited to the follow. (t) Orders for treatment and diet if needed; (u) The resident's himself or herself; (v) The specific go appropriate; (w) The time intervices ponse to treatment.	OHW, the surveyor inquired be Service Plans (GSP) and were updated. The DHW vice Plans were updated for d mostly for changes in the re. HW stated that the Care Plans outinely, but that they were a was an incident or a change OHW also stated that if the re. Indicate the care Plan would be outlined the care Plan would be outlined the care Plan would be outlined. The surveyor reviewed a "Service Plans and Jersey", dated 4/2021, which ing The health care assessment, a complan shall include, but not be ring: The ment or services, medications, and the care and preferences for the care and	A 735			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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A 735	reviewed, and if ne as needed, based u to the care provided	nge 9 cessary, revised quarterly, and upon the resident's response d and any changes in the or cognitive status."	A 735			
A 751	Plans (b) The resident he reviewed, and if new as needed, based to	alth service plan shall be cessary, revised quarterly, and upon the resident's response d and any changes in the or cognitive status.	A 751			
	by: Complaint #: NJ 00 Based on observation records, it was determined to ensure that a Hereviewed, revised of 5 residents reviewed revidenced by the formula of the Director of Hear regarding the General Health Service Planthe Electronic Medistated that the residued that the care documented in the Plan." Additionally,	ion, interview and review of ermined that the facility failed alth Service Plan (HSP) was juarterly and as needed for 2 wed, Resident #2 and leficient practice was				

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NAME OF	PROVIDER OR SUPPLIER	082462	· ·	TATE, ZIP CODE	01/0	08/2025
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A 751	Continued From pa	age 10	A 751			
	reviewed Resident move-in date of included NJ Ex Orde from the facility on The surveyor review Resident #2 dated Director of Health a of the assessment which revealed that since adm. Additionally, the surdocuments titled, "I which included the and incident investi	200 p.m., the surveyor #2's MR which revealed a Order 26. 481 with diagnosis which and was discharged Wed a "30 day Assessment" of wed a "30 day Assessment" of and Wellness (DHW). Review included a "Secondar 26.481" evaluation to Resident #2 had greater than ission and was a "VEX Order 26.481". Treyor reviewed MR Resident Incident Report" initial record of the incidents igations, which revealed that the following dates and				
	at 1:30 p.m., Wexonder 20, 48 at 4:0 and on Wexonder 20, 48 at 5					
	Progress Note (PN 12:37 p.m., staff re of Nursing (ADON) was noted with NJ further indicated the he/she had him/herself. Review 8:51 a.m., indicated showed a of the Nacondo 30.481.	Resident #2's electronic) indicated that on the Assistant Director that Resident #2's the PN at Resident #2 stated that the principle of the PN at Resident #2 stated that the principle of the PN at Resident #2 stated that the principle of the PN at PN at PN dated that the principle of the PN at PN dated that the principle of the PN at PN dated that the principle of the PN at PN at PN dated that the principle of the PN at				

PRINTED: 03/06/2025 FORM APPROVED New Jersey Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ C B. WING 082462 01/08/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 319 FORSGATE DRIVE MIRA VIE AT FORSGATE JAMESBURG, NJ 08831 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) A 751 Continued From page 11 A 751 which revealed an entry dated NJ EX Order 25.401, that indicated a "Problem/Need", and documented that Resident #2 had falls since last assessment. The surveyor observed a "Desired Outcome" which included monitoring resident's stability, safety and independence. The surveyor did not observe documentation within the Care Plan to include interventions after the falls or evaluation of the resident's response to the interventions regarding the falls. 2.) On 1/7/25 at 12:15 p.m., the surveyor reviewed Resident #4's MR which revealed a move-in date of NJEx Order 26. 4BI, and diagnosis of NJ Ex Order 26. 4B1 . Resident #4's Care Plan indicated that Resident #4 was NJ Ex Order 26.4b1 and a desired outcome which included that Resident #4 would have a NJ Ex Order 26. 4B1 applied to the WAR Order 26 of at all times. The surveyor observed that there were comments with the following review dates entered by the facility DHW on NJ Ex Order 26.4b1 Surveyor review of the Care Plan did not reveal that Resident #4's Care Plan was reviewed further for elopement to include the effectiveness and response to the interventions. On 1/7/25 at 12:30 p.m., during follow up interview with the DHW, the surveyor inquired

about how often the Service Plans (GSP) and Care Plans (HSP) were updated. The DHW stated that the Service Plans were updated for NJ Ex Order 26.4b1, and mostly for changes in the resident level of care. The DHW stated that the Care Plans were not updated routinely, but were updated when there was an incident or a change in a resident. The DHW also stated that if the resident had a wound, the Care Plan would be

updated monthly.

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	STATE OF THE PROPERTY OF	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(man		082462	D. WING		01/0	8/2025
NAME OF	PROVIDER OR SUPPLIER		SECURIOR SALES OF THE SECURIOR SALES	STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
A 751	Continued From pa	ge 12	A 751			
A 751	On 1/8/24 at 1:00 p facility policy titled, Assessments New which revealed the "(s) (e) Based on the written health service limited to the follow (t) Orders for treatr and diet if needed; (u) The resident's in himself or herself; (v) The specific go appropriate; (w) The time interverseponse to treatment (x) The measures effects of treatment 9. The resident hear reviewed, and if needed, based up to the care provided	.m., the surveyor reviewed a "Service Plans and Jersey", with a date of 4/2021, following the health care assessment, a the plan shall be developed. plan shall include, but not be ting: ment or services, medications, the health care assessment, a the plan shall include, but not be ting: ment or services, medications, the health care assessment, a the plan shall include, but not be ting: the health care assessment, a the plan shall be developed. The plan shall include, but not be ting: the health care assessment, a the plan shall be developed. The plan shall include, but not be ting: The plan shall include, but not b	A 751			

STATE FORM: REVISIT REPORT MULTIPLE CONSTRUCTION PROVIDER / SUPPLIER / CLIA / DATE OF REVISIT **IDENTIFICATION NUMBER** A. Building 2/14/2025 082462 B. Wing **Y3** NAME OF FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE 319 FORSGATE DRIVE MIRA VIE AT FORSGATE 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 DATE DATE ITEM ITEM DATE **Y4 Y5** Y4 Y5 Y4 Y5 Correction ID Prefix A0310 Correction ID Prefix A0735 Correction ID Prefix A0751 8:36-3.4(a)(1) 8:36-7.3(b) 8:36-7.2(e)(1-5) Reg. # Completed Reg. # Completed Reg. # Completed 02/01/2025 LSC 02/01/2025 LSC LSC 02/01/2025 **ID Prefix ID Prefix ID Prefix** Correction Correction 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 LSC LSC LSC **ID Prefix** Correction **ID Prefix** Correction **ID Prefix** Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC **ID Prefix ID Prefix ID Prefix** Correction Correction Correction Reg. # Completed Reg. # Completed Reg. # Completed LSC LSC LSC REVIEWED BY REVIEWED BY DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) 1 REVIEWED BY DATE TITLE DATE **REVIEWED BY** CMS RO (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

Page 1 of 1 EVENT ID: 95YX12

YES NO

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

1/8/2025