STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	082462	A. BUILDING: _____ B. WING _____	C 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT FORSGATE	319 FORSGATE DRIVE JAMESBURG, NJ 08831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Complaint Complaint #: NJ00166945 Census: 100 Sample Size: 3 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 235	8:36-2.4(d) Licensure Procedures (d) Survey visits may be made to a facility at any time by authorized staff of the Department. Such visits may include, but not be limited to, the review of all facility documents and resident records and conferences with residents. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00166945 Based on interview and record review it was	A 235		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 235	Continued From page 1	A 235		

determined that the facility failed to provide residents' medical records and pertinent facility documents to rule out [redacted] for [redacted] for 1 of 3 residents reviewed, Resident #2 and 2 of 3 reviewed for close medical records, Resident #1 and Resident #3. This deficient practice was evidenced by the following:

On 5/10/24 the Department of Health (DOH) investigated a Facility Reportable Event (FRE) regarding NJ Ex Order 26.4(b)(1) received [redacted] which occurred on [redacted]. According to the FRE, Resident # NJ ex order 26.4b1 [redacted] The resident [redacted]

At 9:24 a.m., the surveyor interviewed the Director of Nursing (DON) regarding access to the resident's closed medical record (MR). The DON stated that the Executive Director (ED) was not available at the time but was notified that the surveyor was at the facility and had requested access to the medical records.

At 9:35 a.m., the surveyor requested the closed MR of Resident #2 and the facility NJ ex order 26.4b1 [redacted]. The DON stated the facility was under a new management and the facility no longer had access to the resident's medical record or the facility NJ ex order 26.4b1 [redacted]. The DON provided the surveyor with a copy of an email dated [redacted] from the ED to the DOH which indicated the facility transitioned to a new company.

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A 235	Continued From page 2 The surveyor reviewed the resident's assessment dated [NJ ex order 26.4b] and the resident's "Plan of Care" last updated [NJ ex order 26.4b] provided by the DON. However, the DON [NJ ex order 26.4b1 redacted] At 3:34 p.m., the surveyor interviewed the Regional Director of Nursing (RDON) via telephone regarding Resident #2's [NJ ex order 26.4b1 redacted]. The RDON stated that she was not familiar with the above incident and explained that the facility was working on getting access to all their records from the prior facility owner. At 3:55 p.m., during exit conference, the surveyor interviewed the ED via the telephone regarding access to facility records and the need for a removal plan. The ED confirmed that the facility no longer had access to documentation from the resident's medical record nor pertinent facility documents related to the resident's [NJ Ex Order 26.4 redacted] for the surveyor to complete the investigation. The facility submitted a removal plan that was accepted on which revealed the following: ..."all investigations will be kept in accordance with state regulations and managed by the Executive Director. ..." The resident's chart with all accessible information [assessments] was located and records will be retained along with records of other residents as per state regulations. "This will be executed by the Executive Director and storage management will be maintained by the Director of Plant Operations. ...Care Plans and other resident files	A 235		

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A 235	Continued From page 3 will remain in the facility per state regulations." On 6/17/24 the surveyor conducted a re-visit to the facility to confirm that the removal Plan was implemented. The surveyor reviewed resident assessments, care plans, and reviewed incident/accident investigation reports. However, the surveyor was not granted access to electronic residents' medical records prior to [redacted] At 10:13 a.m., the surveyor interviewed the ED regarding access to resident MR. The ED stated that the facility retrieved the resident MR prior to [redacted] and that all medical records were currently maintained at the facility. At 10:57 a.m., the surveyor requested the closed MR of Resident #1, Resident #2, and Resident #3. The ED provided the surveyor with the hard copy of the closed MR's but was not able to provide the surveyor access to the electronic MR. At 12:46 p.m., the surveyor interviewed the ED regarding access to resident electronic MR. The ED stated that the facility's previous owner granted access to their electronic MR program, however, she was not able to share the password to the surveyor.	A 235		
A 473	8:36-5.1(g) General Requirements (g) The assisted living residence, comprehensive personal care home, or assisted living program shall adhere to applicable Federal, State, and local laws, rules, regulations, and requirements.	A 473		

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A 473	Continued From page 4 This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00166945 Based on interview, observation, and review of pertinent facility documents it was determined that the facility failed to ensure final approval from the Division of Certificate of Need and Licensing before changing the name of the facility as evidenced by the following: On 6/17/24 at 9:15 a.m, the surveyor observed the facility sign in front of the building read another name than what was on record with the Department of Health (DOH) data base. At 9:20 a.m., the surveyor observed the facility license posted on the wall in the lobby and identified the name on the facility license did not match the name on the facility signage. At 1:20 p.m., the surveyor reviewed the facility policy and procedure for "Preservation and Thinning of Records" and observed that the owner's name on the policy also did not match the name listed on the faciliy license. At 1:30 a.m., the surveyor interviewed the Executive Director (ED) regarding the facility license. The Ed stated that the facility had a new owner as of [redacted], and she did not receive the new license that reflected the new facility name. In addition, the ED stated that she had an approval letter from the DOH that reflected the change of ownership. At 1:45 p.m., the surveyor reviewed the DOH approval letter dated 3/4/24, which revealed that	A 473		

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	082462	A. BUILDING: _____ B. WING _____	C 06/17/2024

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A 473	Continued From page 5 the facility submitted a request for transfer of ownership with facility and operator name changes. In addition, the approval letter also revealed, "Although the new owners are authorized to operate the facility following the transaction, the Department will not issue the license under the new ownership until the items listed below are received and reviewed by staff from this Program. ...1. A notarized letter, or letter from an attorney, indicationg the actual date on which the transaction occurred. 2. Copies of all fully executed closing documents associated with the aforementioned transaction, signed, and dated by the current and prospective owners of the facility. 3. an executed copy of the Lease Agreement. ..." At the time of survey, on 6/17/24, when requested by the surveyor, the ED was unable to provide confirmation that the three listed items required were submitted to confirm that the transaction was completed.	A 473		
A 745	8:36-7.2(f) Resident Assessments and Care Plans (f) The initial health care assessment shall be documented by the registered nurse and shall be updated as required, in accordance with the rules of this chapter and professional standards of practice. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00166945 Based on interview, record review, and review of	A 745		

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A 745	Continued From page 6	A 745		

pertinent facility documents it was determined that the facility failed to ensure that the resident assessment reflected a change of condition for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

According to the "Initial Evaluation" dated NJ ex order 26.4b1 that was received from the facility Reportable Event (FRE) on NJ ex order 26.4b1, the resident NJ ex order 26.4b1 [redacted]

On 5/10/24 at 9:35 a.m., the surveyor requested Resident #2's medical records (MR) from the Director of Nursing (DON). The DON stated that the resident NJ ex order 26.4b1 [redacted]

At 11:25 a.m., the DON provided the surveyor with Resident #2's "Face Sheet" which revealed that the resident moved into the facility on NJ ex order 26.4b1 and moved out on NJ ex order 26.4b1 with diagnoses of NJ ex order 26.4b1. Additionally, the DON provided the surveyor with the resident's "Plan of Care Problem List" which revealed that on NJ ex order 26.4b1 the resident NJ ex order 26.4b1 the resident required NJ ex order 26.4b1 [redacted]

At 12:00 p.m., the surveyor interviewed Care Partner (CP) #1, regarding Resident #1's NJ Ex Order 26.4(b)(1) The CP #1 stated that the resident used a NJ ex order 26.4b1 [redacted].

At 1:35 p.m., the surveyor interviewed CP #2 regarding the residents NJ Ex Order 26.4(b)(1). The CP #2 stated that the resident used a NJ ex order 26.4b1 [redacted]

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A 745	Continued From page 7 During review of the documents provided by the DON, the surveyor observed that the "NJ ex order 26.4b1 " dated NJ ex order 26.4b revealed that the resident was NJ ex order 26.4b1 and NJ ex order 26.4b1 At 2:40 p.m., the surveyor interviewed the DON regarding assessments. The DON stated that the facility procedure was to assess residents when there was a change in condition. However, the DON explained that she had no access to any of the assessments/evaluations for Participant #2. The DON was unable to show documented evidence that the participant was assessed after NJ ex order 26.4b. The surveyor reviewed the facility policy titled "Assessments," which revealed "All assessments will be completed per state regulation. ...All residents with general service plan shall be reassessed at least semi-annually. ..." Reference: A-0235, 8:36-2.4(d)	A 745		
A 749	8:36-7.3(a) Resident Assessments and Care Plans (a) 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.	A 749		

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A 749	Continued From page 8 This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00166945 Based on interview and record review it was determined that the facility failed to ensure the residents "Plan of Care" (POC) was updated to include behaviors during staff care for 1 of 3 residents reviewed, Resident #2 as evidenced by the following: On 5/10/24 at 11:25 a.m., the surveyor reviewed Resident #2's "Face Sheet" which revealed the resident moved into the facility on [redacted] and moved out on [redacted] with diagnoses of [redacted] At 12:00 p.m., the surveyor interviewed Care Partner (CP #1) regarding Resident #2's care. The CP #1 stated that the participant had [redacted] and [redacted] at times. At 12:05 p.m., the surveyor interviewed the Certified Medication Aide (CMA) regarding the resident's care. The CMA stated that the resident [redacted] and the staff would call the family for assistance. At 12:18 p.m., the surveyor interviewed CP #2 regarding the resident's care and she stated that staff would go into the resident's apartment to provide morning care and the resident would [redacted] The CP explained that staff would wait until the resident [redacted] to receive care. During review of the resident's "Face Sheet" the surveyor observed the "Plan of Care" dated [redacted] and [redacted] which revealed the resident was care planned for [redacted] with	A 749		

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A 749	Continued From page 9 NJ Ex Order 26.4(b)(1) However, the surveyor did not observe interventions for the resident's NJ Ex Order 26.4(b)(1) [redacted] At 2:40 p.m., the surveyor interviewed the Director of Nursing (DON) regarding the procedure for updating the Plan of Care. The DON stated that the POC was completed on initial admission and updated with change in condition. Reference: A-0235, 8:36-2.4(d)	A 749		
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 #: NJ 00166945 Based on interview, record review, and review of pertinent facility documents it was determined that the facility failed to ensure availability of resident medical records for surveyor review for 1 of 3 residents, Resident #2 as evidenced by the following: At 9:35 a.m., the surveyor requested Resident #2's medical records (MR) from the Director of Nursing (DON) for review. The DON stated that the resident NJ ex order 26.4b1, and she was not able to locate the MR. Additionally, the DON	A1057		

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A1057	Continued From page 10 stated that the facility had a new electronic medical record (EMR) system and she was not able to access the resident's records prior to [NJ ex order 26.4] At 3:55 p.m., the surveyor interviewed the Executive Director (ED) regarding the resident's MR over the telephone. The ED confirmed that the facility no longer had access to Resident #2's MR prior to [NJ ex order 26.4] The surveyor reviewed the facility policy and procedure titled, "PRESERVATION AND THINNING OF RECORDS" which revealed "The resident record is retained in a manner that maintains accessibility, confidentiality, and safety of the record. ...Upon discharge or death of a resident, the entire record is closed and retained per policy and state requirements. The facility's failure to maintain and provide residents' records for review impeded the Department of Health's investigation of a resident's (Resident #2) [NJ ex order 26.4b1] Reference: A-0235, 8:36-2.4(d)	A1057		

MIRA VIE
FORSGATE

September 16, 2024

Complaint Survey 6/17/24

Complaint # NJ00166945

Tag A235:

1. Residents 1, 2 and 3 were found to be affected by the deficient practice.
    - Moving forward, the Executive Director will in-service all team department heads to compile all resident files for record retention. This began on 6/18 and will conclude by September 30, 2024.
    - Investigations completed for residents will be maintained per State Regulations.
    - EHR (Eldermark) access will be given to State Surveyor upon request. Administrator/Designee will contact RVP Clinical for login and password information. This policy has been in effect since 5/15/2024. Surveyor was given EHR-Eldermark access on 6/17/2024.
    - All discharged and deceased resident files will be on premises for Surveyor access by September 30, 2024.
2. The community will identify residents that have the potential to be affected by the same deficient practices by completing and gathering resident files to identify at-risk residents. This will be done by the Director of Nursing and Assistant Director of Nursing by July 12, 2024.
3. To ensure the deficient practice will not recur, the Building Service Director will do a monthly check to ensure the resident files including accident/incident reports are stored properly and available on premises upon surveyor request. This will be effective June 18, 2024.
4. To monitor that the corrective actions are being taken for the deficient action to not recur, the Executive Director will review our corrective actions monthly with the department head team to ensure that the resident files and retention of files are in order. This will be effective June 18, 2024.
5. Completion Date for Tag A235 is September 30, 2024.

accepted 9/25/24 DL

Tag A473:

1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected.

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

   All residents have the potential to be affected.

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

   Going forward, if a change in management or name title were to occur, the Director of Operations will ensure the name of the building will not be changed until official license from DOH has been received.

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

   Licenses will be renewed when due to ensure current license is always on site. **Date of Completion, September 13, 2024.**

accepted 9/25/24

Tag A745:

1. Residents 2 was found to be affected by the deficient practice in Tag A745. Resident 2 was discharged on [redacted] NJ ex order 26.4b1 We were unable to complete assessments after that date. The Executive Director will follow the Community Policy and Procedure of Service Plans and Assessments that ensures that assessments will be completed on admission, 30 days after admission, and then every 6 months or change in condition. This policy is effective 4/1/2024 with a date of completion of all assessments and service plans on Eldermark EHR system for current residents on 7/22/2024. DON was in-serviced on 6/18/24 to complete all assessments due as necessary.
2. The community will identify residents that have the potential to be affected by the same deficient practices by following the daily 24-hour book review to identify any residents with a change in condition. This is to be completed by ED and Director of Nursing and/or Designee. This is a daily process and is effective 6/18/2024.
3. To ensure the deficient practice will not recur, the Director of Nursing and Assistant Director of Nursing will closely monitor residents and pro-actively complete Change of Condition Assessments when appropriate. DON was in-serviced on 6/18/24 on the Policy and Procedures regarding resident assessments and change in-condition. The Director of Nursing and/or Designee will follow the assessments due report in Eldermark accordingly and complete all assessments in accordance to policy. This is policy began on 4/1/24 and will be effective on June 18, 2024.
4. To monitor that the corrective actions are being taken for the deficient action to not recur, the Executive Director will review our corrective actions monthly with the Director of Nursing and Assistant Director of Nursing to ensure assessments are completed per change in condition and as per policy. Regional Vice President of Clinical Services will

monitor assessments completed on Monthly Clinical Quality Report. This is effective 6/18/2024.

5. Completion for Tag A745 is 6/18/24.

accepted 9/10/24

Tag A749:

1. Residents 2 was found to be affected by the deficient practice in Tag A749. Resident 2 was discharged on [NJ ex order 26.4b1] We were unable to complete assessments after that date to update Care Plan for Refusal of Care. The Executive Director will follow the Community Policy and Procedure of Service Plans that are to be created and initiated on admission to community, updated every 6 months/ and or change in condition. This policy was effective 4/1/2024 and DON was re-educated on new Policy and Procedure on 6/18/24.
2. The community will identify residents that have the potential to be affected by the same deficient practices by following community's policy on assessments and following 24 hour report policy to identify at-risk residents; ensuring that service plans are updated with appropriate interventions. This will be completed by the Director of Nursing and Assistant Director of Nursing/Designee by July 12, 2024.
3. To ensure the deficient practice will not recur, the Director of Nursing and Assistant Director of Nursing will continue to assess according to our Policy and Procedure and update Service Plans with changes of condition. Director of Nursing and/or Designee will follow the assessments due report in Eldermark accordingly and complete all assessments in accordance with policy. Resident Service Plans will be updated with any changes at that time. This policy was effective 4/1/2024 and DON was re-educated on updating Resident Service Plans on 6/18/24.
4. To monitor that the corrective actions are being taken for the deficient action to not recur, the Executive Director will review our corrective actions monthly with the Director of Nursing and Assistant Director of Nursing to ensure assessments are completed according to Policy and Procedure. RVP of Clinical Services will monitor assessments completed on Monthly Clinical Quality Report. This is effective 6/18/2024.
5. Completion of Tag A749 is 7/12/24.

accepted 9/10/24

Tag A1057:

1. Resident 2 was found to be affected by the deficient practice. Resident 2 was discharged on [NJ ex order 26.4b1] Moving forward, the Executive Director will in-service all team department heads to compile all resident files for record retention. Medical Records are on-site for all current residents at the community. The in-service has occurred on July 2, 2024, and all records will be on premise by September 30, 2024.

2. The community will identify residents that have the potential to be affected by the same deficient practices by following the Distinctive Living Policy of Medical Records- All records need to be kept for 10 years. This will be done by the Director of Nursing and Assistant Director of Nursing by July 12, 2024.

3. To ensure the deficient practice will not recur, the Building Service Director will do a monthly check to ensure the resident files are stored properly, easily

identifiable/accessible, and available on premises upon surveyor request. This will be effective 7/4/2024 and ongoing.

4. To monitor that the corrective actions are being taken for the deficient action to not recur, the Executive Director will review our corrective actions monthly with the department head team to ensure that the resident files and retention of files are in order. This will be effective 7/4/2024 and ongoing.

5. Completion of Tag A1057 is September 30, 2024.

accepted 9/25/24 JR

If you have any further questions, please do not hesitate to contact me.

Thank you.

Sincerely,

NJ Ex Order 26.4b1

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
082462 Y1	A. Building B. Wing Y2	6/17/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT FORSGATE	319 FORSGATE DRIVE JAMESBURG, NJ 08831

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0235	Correction	ID Prefix A0745	Correction	ID Prefix A0749	Correction
Reg. # 8:36-2.4(d)	Completed	Reg. # 8:36-7.2(f)	Completed	Reg. # 8:36-7.3(a)	Completed
LSC	09/30/2024	LSC	06/18/2024	LSC	07/12/2024
ID Prefix A1057	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-15.4	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/30/2024	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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
6/17/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
082462		6/17/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT FORSGATE	319 FORSGATE DRIVE JAMESBURG, NJ 08831

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ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix A0473 Reg. # 8:36-5.1(g) LSC	Correction Completed 09/13/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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
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	
6/17/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO