STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031446	A. BUILDING: _____ B. WING _____	C 11/23/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00178860, NJ00139892, NJ00179319, NJ00183905, NJ00184267, NJ00184913, NJ00185520, NJ00188112, NJ00189049 CENSUS: 103 SAMPLE SIZE: 23 SURVEY DATE: 11/20/2025 - 11/23/2025 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 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;	A 389		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/06/26

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A 389	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint #NJ00183905, NJ00184267, and NJ00184913 Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to ensure staff provided appropriate NJ Exec Order 26.4b1 to prevent NJ Exec Order 26.4b1 for 4 (Residents #10, #7, #5, and #6) of 4 residents reviewed for NJ Exec Order 26.4b1. Specifically, Resident #10 NJ Exec Order 2 from the NJ Exec Order 26.4b1 unit on NJ Exec Order 26.4b1 through a NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1, leading to the kitchen and the assisted living wing that did not NJ Ex Orde. Resident #7 NJ Exec Order 2 from the NJ Exec Order 26.4b when they NJ Exec Order 26.4b1 after visitors opened the NJ Exec Order 26.4b1. Resident #5 and Resident #6 NJ Exec Order 2 from the NJ Exec Order 26.4b1 and were observed NJ Exec Order 26.4b1, knocking to request entry back onto the unit; staff did not respond to the 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 11/23/2025 at 4:55 PM, the facility's Executive Director, Director of Health and Wellness, and Resident Care Coordinator were verbally informed of the immediacy of the situation involving the resident NJ Exec Order 26.4b1 Findings included: A facility policy titled, "Elopement- Missing	A 389		

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Person," dated 05/2020, indicated, "Elopement is an event in which a resident leaves the community or Memory Support Environment without the knowledge of community employes. This especially applies when residents have impaired decision-making abilities and are not aware of their safety and needs." The policy revealed the section titled, "Preventive Checks," included, "1. The Maintenance Director/Designee is responsible [sic] managing and maintaining functionality of community doors, windows and community physical plant operations. 2. Employees are expected to communicate concerns or issues on the 24-hour report and ensure residents are maintained in a safe environment. If employees observe an unsafe environment or unsafe equipment, the employee will ensure residents are maintained in a safe environment and will immediately notify the Executive Director."

1. A "Face Sheet" revealed the facility admitted Resident #10 on NJ Exec Order 26.4b1. According to the Face Sheet, Resident #10 had a medical history that included diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.

A "Master Assessment" dated NJ Exec Order 26.4b1 revealed Resident #10 did not use NJ Exec Order 26.4b1 and only needed NJ Exec Order

A "Resident NJ Exec Order 26.4b1 Assessment" dated NJ Exec Order 26.4b1 revealed Resident #10 had NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1.

A "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, revealed that Resident #10 NJ Exec Order 2 from the facility on NJ Exec Order 26.4b1. According to the Reportable Event Record/Report, on NJ Exec Order 26.4b1

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A 389	Continued From page 3 at approximately 11:15 PM, Resident #10 [NJ Exec Order redacted] unit) through a door to the kitchen. The Reportable Event Record/Report revealed that a care partner was walking in the hallway leading toward the assisted living area and [NJ Exec Orde redacted] Resident #10 and [NJ Exec Order 26 redacted] the resident [NJ Exec Or redacted] to the [NJ Exec Order 26.4b1 redacted] unit. During an observation of the [NJ Ex Order 26.4(b)(1) redacted] unit with Care Partner (CP) #1 on 11/20/2025 at 11:33 AM, the kitchen door was ajar. The care partner tested both double doors three times, by opening the door and then letting it naturally swing closed. Neither door latched closed on any of the three tests. The left door of the [NJ Exec Order 26.4b1 redacted] did not close all the way, and the door was able to be opened without a key fob. The door being left ajar did not trigger the door alarm. The right door also did not consistently close. During a concurrent interview, CP #1 stated she had not noticed the door did not close. She stated that the door (if functioning properly) required a key fob for entry, or the kitchen staff inside could open the door from the other side to allow entry. CP #1 stated that there was a 30-second countdown for the door to remain open, after which the door was supposed to alarm. During an interview on 11/22/2025 at 9:28 AM, CP #3 revealed she was working on [NJ Exec Order 26.4b1 redacted] the night Resident #10 [NJ Exec Order 26 redacted] She stated the resident was [NJ Ex Order 26.4(b)(1) redacted] and would try all the [NJ Exec Order 26.4b1 redacted]. She stated that she noticed the [NJ Exec O redacted] to the [NJ Exec Order 26.4b1 redacted] and found the resident in the hall that led to the assisted living. She stated that she [NJ Exec Order 26.4b redacted] Resident #10 [NJ Exec Or redacted] to the [NJ Exec Order 2 redacted] unit. She stated the door to the [NJ Exec Order 26.4b1 redacted], and she reported that.	A 389		

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A 389	Continued From page 4 A facility "In-Service/Training Documentation" form dated [NJ Ex Order 26.4(b)(1)] revealed kitchen staff received an in-service on [NJ Ex Order 26.4(b)(1)] to close the door to the [NJ Exec Order 26.4b1] dining room at night. During a lunch service observation on 11/20/2025 at 11:52 AM with the Director of Culinary Services (DOCS), she and another dietary staff wheeled electric hot boxes to the [NJ Exec Order 26.4b1] through the double doors. Upon approaching the doors from the kitchen side, the right door was ajar. During a concurrent interview, the DOCS acknowledged the door was ajar and asked Cook #4, who was standing nearby, if he was aware the door was ajar. Cook #4 stated yes and that the door often did not close all the way, ever since they had changed the system. During a follow-up interview on 11/23/2025 at 1:10 PM, Cook #4 stated he had not reported to anyone that the doors to the [NJ Exec Order 26.4b] unit did not consistently close all the way, but he was aware the malfunction had existed for at least a month. During an interview on 11/21/2025 at 12:50 PM, the Maintenance Director revealed he was aware the doors to the [NJ Exec Order 26.4b] unit from the kitchen did not close all the way without being forced closed. He stated he did not know how long the doors had not been operating properly but indicated it had been for an extended period of time. When asked how the facility was ensuring the security of the [NJ Exec Order 26.4b1] unit and the safety of its residents while the doors were awaiting repair, the Maintenance Director stated residents did not have a key fob, which was the only way to unlock the doors; therefore, they were not able to access the kitchen. The surveyor demonstrated that the door did not latch when allowed to naturally swing closed, and the surveyor manually reopened the	A 389		

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door without a key fob. The Maintenance Director continued to insist that residents could not access the kitchen without a key fob.

Upon request for any work orders, invoices, or documentation that repairs were pending or had been attempted, the Maintenance Director was not able to provide any. The Executive Director stated on 11/21/2025 at 1:45 PM that the facility did not have any evidence of attempts to repair the doors.

A tour of the kitchen on 11/22/2025 at 2:30 PM revealed safety hazards, including knives and other sharp items mounted on the wall, gas stove tops, and a walk-in refrigerator and freezers.

2. A "Face Sheet" revealed the facility admitted Resident #7 on NJ Exec Order 26.4b1. According to the Face Sheet, Resident #7 had a medical history that included a diagnosis of NJ Exec Order 26.4b1

A "Master Assessment" dated NJ Exec Order 26.4b1 revealed Resident #7 did not use NJ Exec Order 26.4b1 and was able to NJ Exec Order 26.4b1

A "Resident NJ Exec Order 26.4b1 Assessment" dated NJ Exec Order 26.4b1 revealed Resident #7 had NJ Exec Order 2 .

A "Reportable Event Record/Report," dated NJ Exec Order 26.4b1 revealed that Resident #7 NJ Exec Order 2 from the facility on NJ Exec Order 26.4b1. According to the Reportable Event Record/Report, on NJ Exec Order 26.4b1 Resident #7 NJ Exec Order 26.4b1 through an NJ Exec following a family member of another resident. The Reportable Event Record/Report revealed that the NJ Exec Order 26.4b led to a service hallway that connected the NJ Exec Order 26.4b1 unit to

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the assisted living facility. Per the Reportable Event Record/Report, a care partner found Resident #7 in the hallway outside the NJ Exec Order 2 unit where the resident resided. The Reportable Event Record/Report revealed that the care partner NJ Exec Order 26.4b1 Resident #7 NJ Exec Or to the NJ Exec Order 26.4b1 unit.

Facility "Progress Notes for [Resident #7]," dated NJ Exec Order 26.4b1 at 6:44 PM, revealed that at 2:00 PM, Resident #7 was observed following a visitor who was NJ Exec Order 26.4b1 by Care Partner (CP) #1, who was in the employee breakroom located in the service hallway outside the NJ Exec Order 2 unit. The notes revealed CP #1 then NJ Exec Order 26.4b1 the resident NJ Exec Or to the NJ Exec Order 2 unit.

3. A "Face Sheet" revealed the facility admitted Resident #5 on NJ Exec Order 26.4b1. According to the Face Sheet, Resident #5 had a medical history that included diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

A "Master Assessment" dated NJ Exec Order 26.4b1 revealed Resident #5 did not use NJ Exec Order 26.4b1 and was able to NJ Exec Order 26.4b1

A "Resident NJ Exec Order 26.4b1 Assessment" dated NJ Exec Order 26.4b1 revealed Resident #5 had NJ Exec Order 26.4b1 .

A "Face Sheet" revealed the facility readmitted Resident #6 on NJ Exec Order 26.4b1. According to the Face Sheet, Resident #6 had a medical history that included diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4

A "Master Assessment" dated NJ Exec Order 26.4b1 revealed Resident #6 did not use NJ Exec Order 26.4b1 and was able to NJ Exec Order 26.4b1

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NJ Exec Order 26.4b1 The assessment indicated Resident #6 was NJ Exec Order 26.4b1 and had the potential to NJ Exec Order 26.4b1 of the building.

A "Resident NJ Exec Order 26.4b1 Assessment" dated NJ Exec Order 26.4b1 revealed Resident #6 had NJ Exec Order 26.4b1 .

A "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, revealed that on NJ Exec Order 26.4b1 Resident #5 and Resident #6 NJ Exec Order 2 from the facility. According to the Reportable Event Record/Report, on NJ Exec Order 26.4b1, Resident #5 and Resident #6 NJ Exec Order 26.4b1 from their residences on the NJ Exec Order 26.4b1 unit to the NJ Exec Order 26.4b1 unit and were NJ Exec Order 26.4b1 back up the elevator to the second floor. The Reportable Event Record/Report revealed that later that morning at approximately 7:45 AM, Resident #5 and Resident #6 were observed NJ Exec Order 26 the NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 k onto the unit.

During an interview on 11/23/2025 at 11:00 AM, Care Partner (CP) #2, who witnessed the NJ Exec Order 26.4b1 event on NJ Exec Order 26.4b1 stated both residents had come down to the first floor of the NJ Exec Order 26.4b1 unit two times that morning, stating they wanted to go on a NJ Exec Order 26.4b1. She stated she NJ Exec Order 26.4b1 both residents back upstairs both times. She stated she did not report to the second floor CP that the residents had left the second floor. She stated that on the third occasion, she was passing by the door and noticed Resident #5 and Resident #6 NJ Exec Order 26.4b1 . She stated the door was alarmed, and it would go off if you touched it. She stated that the door was locked but if you kept pushing on the door, it would unlock. She stated that she was not sure what happened, and she

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A 389	Continued From page 8 did not hear the alarm. During an interview on 11/23/2025 at 11:30 AM, the Director of Health and Wellness (DHW) stated she recalled the former DHW at the time had been NJ Exec Orde due to staff not investigating the NJ Exec Order 26.4b1 going off. She stated that she recalled the former DHW had in-serviced all staff on NJ Exec Order 26.4b1 . Facility training and in-service documents revealed the memory care unit staff received an in-service on NJ Exec Order 26.4b1 on 02/25/2025.	A 389		
A 565	8:36-5.10(a)(3) General Requirements (a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following: 3. Any suspected cases of resident abuse or exploitation which have been reported to the State Long-Term Care Ombudsman. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility document and policy review, the facility failed to ensure incident reports were sent to the state	A 565		

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agency within 72 hours as required for 1 (Resident #1 and #2 NJ Exec Order incident) of 4 reportable incidents reviewed.

Findings included:

A facility policy titled, "Internal Incident Reports and State Reports," issued 04/2021, revealed, "Injury and unusual incidents will be reported in compliance with state regulatory requirements." The policy also noted "The facility shall notify the Department immediately by telephone at [telephone number] or [after-hours telephone number] after business hours, followed within 72 hours by written confirmation, of the following:" and "2) Any elopements; and Any [sic] suspected cases of resident abuse or exploitation."

A facility policy titled, "Elder Abuse/Neglect New Jersey," issued 04/2021, revealed, "6. Reporting of any suspected, alleged, or witnessed abuse or neglect will be completed according to state reporting requirements."

A "Face Sheet" revealed the facility admitted Resident #1 on NJ Exec Order 26.4b1. According to the Face Sheet, the resident had diagnoses including NJ Exec Order 26.4b1

Resident #1's "[Facility name] Service Plan" included a service area with an effective date of NJ Exec Order 26.4b1 that indicated the resident had a behavior management plan. Interventions directed staff to follow the resident's responsive NJ Exec Order 26.4b plan as needed.

A "Face Sheet" revealed the facility admitted Resident #2 on NJ Exec Order 26.4b1 According to the Face Sheet, the resident had diagnoses including NJ Exec Order 26.4b1

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Resident #2's "Service Plan" included a service area with an effective date of NJ Exec Order 26.4b1 indicated the resident had an NJ Exec Order 26.4b1 with Resident #1 on NJ Exec Order 26.4b1. Interventions directed staff to NJ Exec Order 26.4b1 and ensure Resident #2 NJ Exec Order 26.4b1 areas or the resident's NJ Exec Order 26.4b1.

A "LTC [long-term care] Reportable Event Survey" regarding NJ Exec Order 26.4b1, dated NJ Exec Order 26.4b1 was submitted by the previous Executive Director (ED). The report revealed that, on NJ Exec Order 26.4b1, Resident #1 NJ Exec Order 2 Resident #2. Resident #1 NJ Exec Orde Resident #2 in Resident #1's NJ Exec O and as a caregiver NJ Exec Order 26.4b1 Resident #2 out of the room, Resident #1 NJ Exec Order 2 Resident #2. Both residents were NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 s occurred related to the incident.

During an interview on 11/20/2025 at 3:07 PM, Care Partner (CP) #5 stated she reported the incident involving Resident #1 and Resident #2 right after it happened to Medication Aide/Tech (MA) #6. CP #5 stated MA #6 then reported the incident to Licensed Practical Nurse (LPN) #7.

During an interview on 11/22/2025 at 10:22 AM, MA #6 stated she did not witness the incident involving Resident #1 and Resident #2, but was notified of it by CP #5. MA #6 stated she then notified the previous Director of Health and Wellness (DHW) and LPN #7 of the incident.

During an interview on 11/21/2025 at 2:08 PM, LPN #7 stated he did not remember who notified him of the incident involving Resident #1 and Resident #2, but noted it must have been the medication aide working that day. LPN #7 stated he notified the regional nurse and the previous

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A 565	Continued From page 11 ED. LPN #7 stated he did not remember the times that each person was notified, but identified that the incident report would have also automatically notified the previous ED. During an interview on 11/21/2025 at 2:46 PM, the DHW stated she did not work at the facility at the time of the incident involving Resident #1 and Resident #2. The DHW stated she expected staff to notify the ED immediately if a NJ Exec Order 26.4b1 occurred, and she expected the ED to complete resulting reports timely. The DHW stated the ED was responsible for submitting reports to the DOH. During an interview on 11/23/2025 at 11:23 AM, the ED stated he did not work at the facility at the time of the incident involving Resident #1 and Resident #2 and did not know why the report was submitted late to the DOH. The ED stated he expected a final report to be sent to the DOH within 24 to 48 hours. The ED stated that the ED was responsible for ensuring such reports were submitted timely, with the assistance of the DHW.	A 565		
A1127	8:36-16.13(a) Physical Plant (a) Construction, equipment, and installation of food service facilities shall meet the requirements of the dietary programs as contained in this chapter. This REQUIREMENT is not met as evidenced by: Complaint # NJ00188112 Based on observation, interview, facility document review, and facility policy review, the	A1127		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1127	Continued From page 12	A1127		

facility failed to ensure hot holding equipment in food service facilities was in a state of repair and good condition to keep potentially hazardous foods at the proper temperature. This had the potential to affect all residents receiving food from the kitchen.

Findings included:

A facility policy titled, "Holding Food Temperature," issued 04/2021, indicated, "Holding food at or above the required minimum temperature inhibits the growth of harmful micro-organisms." The policy further indicated, "Hot food must be cooked to the correct internal temperature specified in the recipe and then may be held using temperature as a control, for up to four hours as long as food remains above 135 degrees Fahrenheit or as specified in the state food code. Potentially hazardous food held with time as a control must be held no more than two hours, must be labeled with the temperature and the time food left temperature as a control and pull time."

A facility document titled, "[Company name] Food Service Design, Equipment & Supply Quote," dated 07/01/2024 revealed the facility solicited a quote for a new "hot food serving counter/table."

A Montville Township Department of Health "Sanitation Inspection Report" dated 12/06/2024 revealed the facility was out of compliance with hot holding for potentially hazardous food in appropriate equipment. The report revealed the facility "steam table is still broken. Plated food sits without any means to keep from cooling off before being served. Last report indicated steam stable needing to be serviced which was 5 months ago 7/5/24." The report further indicated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031446	A. BUILDING: _____ B. WING _____	C 11/23/2025

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MIRA VIE AT MONTVILLE	165 CHANGEBRIDGE ROAD MONTVILLE, NJ 07045

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"It has been discussed that a new steam table has been ordered as fixing one in kitchen not cost effective stated by them due to is [sic] being unreliable after servicing. Should arrive in a few weeks."

The facility's "Resident Council Minutes," for the timeframe from 11/22/2024 through 06/23/2025, revealed that on 11/22/2024 residents stated the food was warm and not hot. The Resident Council Minutes revealed that on 12/27/2024, residents again stated the food was not always hot. The Resident Council Minutes revealed that on 06/23/2025, the facility reported at the Resident Council meeting that a steam table had been ordered, and the facility was waiting for delivery and installation.

During an interview on 11/20/2025 at 10:40 AM, the day shift cook, Cook #8, stated that he started working at the facility in NJ Exec Order 26.4b1. He stated that when he started, the facility did not have a steam table and the facility only had a preparation table where the current steam table was. He stated that the facility had canned chafing fuel and chafing dishes, which were set up in the dining room, in a buffet style.

During an interview on 11/20/2025 at 11:40 AM, the afternoon cook, Cook #9, stated that the facility did not have a steam table until approximately six months ago. When asked how the kitchen staff was able to maintain proper holding temperatures for potentially hazardous food prior to getting the steam table, he stated the staff just ensured food was covered at all times. He stated that food pans were set up in the dining room, where servers plated food directly for residents. He stated that they placed boiling water in pans over the canned chafing fuel and placed

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	031446	A. BUILDING: _____ B. WING _____	C 11/23/2025

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A1127	Continued From page 14	A1127		

the food on top. He stated that food temperatures were taken only before food went out into the dining room. Cook #9 stated that once the food was in the dining room, the temperature was not monitored.

During an interview on 11/21/2025 at 1:45 PM, Server #10 stated that to his recollection the steam table broke in December of 2024. He stated that during that time the facility utilized canned chafing fuel and chafing dishes in the dining room to serve residents. He stated that servers did not monitor the temperature of the food once it came out of the kitchen. He stated that if they noticed that the canned chafing fuel was going out, they would light a new one to replace it and stir the food. He stated he did recall a number of residents complaining about cold food during this time period.

During an interview with the Vice President of Restaurants and Hospitality (VPRH) on 11/20/2025 at 2:17 PM, he stated the facility did not have an operational steam table since approximately August or September of 2024. He stated that the new steam table was installed approximately three months prior. When asked why it took over a year to replace, he stated that they had been doing an overhaul of multiple properties, and it was on the list of items to replace. He stated that during the period of time the facility did not have a hot holding table; they utilized canned chafing fuel and chafing dishes in the kitchen. The VPRH stated that the canned chafing fuel did not have a temperature gauge like a traditional steam table, but dietary staff should have served the food when it came out and was hot. He stated that any alternative method of serving food in the dining room buffet style was outside of policy and procedure, and he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1127	Continued From page 15 was not on site to observe that. During an interview on 11/23/2025 at 11:30 AM, the Director of Health and Wellness (DHW) stated she expected that the kitchen would have fully operational equipment for hot holding equipment. She stated she would expect that dietary staff would keep the food served to residents at the proper holding temperature to prevent it from entering the danger zone. During an interview on 11/21/2025 at 1:57 PM, the Executive Director stated that he expected the kitchen to function well, including taking temperatures and serving food in a way to keep it out of the danger zone. He stated that if the kitchen did not have a steam table, he would expect that they had a way to hold food at a proper temperature. He stated not having a steam table, he would expect them to take additional precautions to monitor holding temperature. He stated the risk of not having hot holding equipment could be that potentially hazardous food went into the danger zone and caused residents to get sick.	A1127		

POC # 2 received 1/13/26

Accepted 1/13/26

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DEFICIENCY A389

8:36-4.1(a)(16) – Resident Rights: Freedom from Abuse, Neglect, and Unsafe Conditions (Elopement)

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

- Residents #10 was immediately assessed following NJ Exec Order 26.4b1 incidents to ensure NJ Exec Order 26.4b1, outcomes occurred NJ Exec Order 26.4b1 Risk Assessment completed and Service Plan was reviewed and updated on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to reflect individualized NJ Exec Order 26.4b1 needs, NJ Exec Order 26.4b1 strategies, and environmental NJ Exec Order 26.4b1 Increased staff NJ Exec Order 26.4b1 were implemented immediately following NJ Exec Order 26.4b1

- Resident # 7 was immediately assessed following NJ Exec Order 26.4b1 incidents to ensure no NJ Exec Order 26.4b1 outcomes occurred. NJ Exec Order 26.4b1 Assessment completed and Service Plan was reviewed and updated on NJ Exec Order 26.4b1 to reflect individualized NJ Exec Order 26.4b1 needs NJ Exec Order 26.4b1 strategies, and environmental NJ Exec Order 26.4b1. Increased staff NJ Exec Order 26.4b1 were implemented immediately following NJ Exec Order 26.4b1
- Resident #5 were immediately assessed following NJ Exec Order 26.4b1 incidents to ensure NJ Exec Order 26.4b1 occurred. NJ Exec Order 26.4b1 sk assessment and service plan was reviewed and updated on NJ Exec Order 26.4b1 to reflect individualized NJ Exec Order 26.4b1 needs, NJ Exec Order 26.4b1 trategies, and environmental NJ Exec Order 26.4b1 Increased staff NJ Exec Order 26.4b1 were implemented immediately following NJ Exec Order 26.4b1 n NJ Exec Order 26.4b1
- Resident # 6 is no longer at the community. NJ Exec Order 26.4b1 Risk Assessment completed with Service Plan update on NJ Exec Order 26.4b1

- The NJ Exec Order 26.4b1 care double egress doors were repaired and restored to proper function on 11/21/2025, ensuring doors latch fully, alarms activate appropriately, and unauthorized access is prevented. All call bell systems, door alarms, magnet doors, and pager systems were tested and confirmed fully operational on 11/27/2025 to ensure staff are alerted promptly to potential elopement risks.

2. Identification of other residents potentially affected:

- All residents have the potential to be affected.

3. Systemic changes to prevent recurrence

The facility implemented the following systemic measures:

- The Director of Health and Wellness completed a facility-wide review of all residents in memory care and those with cognitive impairment or wandering behaviors. Elopement risk assessments were reviewed and updated as indicated. Completed on 11/27/25.
- Environmental rounds were conducted by Director of Plant Operations to identify any additional door, alarm, or security vulnerabilities. Completed on 11/27/25.
- Established routine preventive maintenance checks for all secured doors and alarm systems to occur on a weekly basis to be conducted by Director of Plant of Plant Operations and/or Designee. Effective: 12/1/2025.
- Executive Director reinforced staff responsibility to immediately report malfunctioning doors, alarms, or unsafe conditions. Completed on 12/1/2025.
- Executive Director along with Management Team provided mandatory in-service education to all staff, completed on 11/27/2025, including: Elopement Prevention Training, Call Bell, Pager, and Magnet Door Operations, and Resident Rights Training.

4. Monitoring and ongoing compliance

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ASSISTED LIVING | MEMORY CARE

The Executive Director (ED) and Director of Health and Wellness (DHW) will oversee compliance through:

- Weekly environmental safety rounds focused on door and alarm functionality. Completed 12/1/25 and Ongoing.
- Monthly audits of elopement risk assessments and care plans. Completed 12/1/25 and Ongoing.
- Quarterly staff competency validation related to elopement prevention systems. Completed 12/1/25 and Ongoing.
- Monthly Elopement Drills conducted by Director of Plant Operations and then entered into TELS for QA and verification by RVP Plant Operations. Completed 12/1/25 and Ongoing.
- Review of all elopement-related incidents through the QAPI program, with corrective action implemented as needed. To be completed on next QAPI 1/21/26 and Ongoing.

All statements above reviewed during quarterly QAPI Meeting by Director of Health and Wellness, Executive Director, and Director of Plant Operations. Next QAPI Meeting on January 21, 2026.

Final Completion Date of all elements on 1/21/26.

KZ approved 1/13/26

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DEFICIENCY A565

8:36-5.10(a)(3) – Failure to Timely Report Abuse Incidents to the Department of Health

1. Corrective action for residents affected

- The NJ Exec Order 26.4b1 involving Residents #1was reviewed to confirm resident NJ Exec Order 26.4b1 Resident #1 continues to reside at the community.
- Resident #2 no longer at the community Service plans were reviewed and reinforced to ensure appropriate NJ Exec Order 26.4b1 management.

2. Identification of other residents potentially affected

- All residents have the potential to be affected.

3. Systemic changes to prevent recurrence

The following changes were implemented:

- A retrospective review of reportable incidents was conducted to ensure no additional reporting delays occurred. Completed by Director of Health and Wellness and Executive Director on 12/1/2025.
- Reinforced that the Executive Director, with oversight by the DHW, is responsible for timely submission of all reportable incidents. Completed by RVP Operations on 11/26/25.
- Director of Health and Wellness conducted mandatory Abuse & Neglect Training with all staff, completed on 11/27/2025, which included: Recognition of abuse and neglect, Immediate reporting expectations, State reporting timelines and procedures, Reinforced facility policies regarding mandatory reporting and documentation. This is ongoing at Monthly Staff Meeting.

4. Monitoring and ongoing compliance

Ongoing monitoring includes:

- Weekly review of incident logs by the Director of Health and Wellness and Executive Director. Completed on 12/1/25 and Ongoing.
- Weekly audits of reportable events for timeliness and completeness. Completed 12/1/25 and Ongoing.
- QAPI reviews all abuse and neglect incidents to be completed on 1/21/26 and Ongoing.

All statements above reviewed during quarterly QAPI Meeting by Director of Health and Wellness, Executive Director, and Director of Plant Operations. Next QAPI Meeting on January 21, 2026.

All elements to be completed with final completion date of 1/21/26.

KJ approved 1/13/26

DEFICIENCY A1127

8:36-16.13(a) – Physical Plant: Food Service Equipment and Hot Holding Temperatures

1. Corrective action for residents affected

No residents were affected; however, corrective actions were implemented immediately to mitigate risk.

- The facility ensured hot holding equipment was functional and that improper alternative serving methods were discontinued immediately at initial time of discovery of defective steam table.

- Steam Table replaced on 8/1/2025 and improper alternative serving method was discontinued.

2. Identification of other residents potentially affected

All residents have the potential to be affected.

3. Systemic changes to prevent recurrence

The facility implemented the following corrective measures:

- Ensured operational hot holding equipment is maintained and available. Weekly Audit of all equipment to be completed by Director of Restaurant and Hospitality. Completed on 12/1/25 and Ongoing Weekly.
- Director of Restaurant and Hospitality conducted Kitchen Sanitation & Food Safety Training, completed on 11/29/2025, addressing: Proper hot holding temperatures, Continuous temperature monitoring, Dishwasher operation, Hand hygiene, Cross-contamination prevention.
- Director of Restaurant and Hospitality reinforced dietary policies related to food safety and temperature documentation.

4. Monitoring and ongoing compliance

Monitoring includes:

- Daily food temperature logs reviewed by Director of Restaurant and Hospitality or designee. Completed on 12/1/25 and Ongoing.
- Monthly oversight rounds by the Executive Director and Director of Restaurant and Hospitality. Completed on 12/1/25 and Ongoing.
- Director of Restaurant and Hospitality to review of dietary compliance through the QAPI program with immediate corrective action if needed. Next QAPI Meeting on January 21, 2026.
- **Final Completion Date of all elements on 1/21/26.** KT approved 1/13/26

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
031446		1/13/2026

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

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

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix A0389 Reg. # 8:36-4.1(a)(16) LSC	Correction Completed 01/21/2026	ID Prefix A0565 Reg. # 8:36-5.10(a)(3) LSC	Correction Completed 01/21/2026	ID Prefix A1127 Reg. # 8:36-16.13(a) LSC	Correction Completed 01/21/2026
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 11/23/2025

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