

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/08/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MIRA VIE AT MONTVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ00172254, NJ00156353</p> <p>CENSUS:</p> <p>SAMPLE SIZE: 3</p> <p>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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

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

TITLE

(X6) DATE

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/08/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MIRA VIE AT MONTVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00156353</p> <p>Based on interview and review of facility's policies and procedures, it was determined that the facility failed to ensure that a comprehensive policy for record retention was developed according to state regulations and implemented for 1 out of 7 residents reviewed, Resident #5. This deficient practice was evidenced by the following:</p> <p>On 04/08/2024 at 10:13 a.m., the surveyor requested the Medical Record (MR) for Resident #5 from the Executive Director (ED) who stated it may be difficult, but would attempt to find.</p> <p>At 11:45 a.m., the ED stated he was unable to locate Resident #5's MR. The ED further stated that some boxes may have been inadvertently taken during the transition of ownership.</p> <p>At 12:05 p.m., the surveyor requested the record retention policy from the Vice President of Clinical Services.</p> <p>At 1:11 p.m., the surveyor reviewed the policy and procedure titled, "Resident Records" which addressed maintaining an organized system to access resident related records; however, the policy does not address how records are retained and stored in accordance with state regulations.</p>	A 310		
A1057	8:36-15.4 Resident Records	A1057		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/08/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MIRA VIE AT MONTVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

A1057	<p>Continued From page 2</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00156353</p> <p>Based on interview and record review, it was determined that the facility failed to provide the closed record of 1 of 7 residents reviewed, Resident #5, during the surveyor's on-site visit to the facility. This deficient practice was evidenced by the following:</p> <p>On 4/08/2024 at 9:56 a.m., the surveyor reviewed the discharge list which revealed that Resident #5 NJ ex order 26.4b1</p> <p>At 10:13 a.m., the surveyor requested the Executive Director (ED) and the Director of Health and Wellness (DHW) to provide Resident #5's closed medical record for review.</p> <p>At 11:45 a.m., the ED stated he was unable to locate Resident #5's MR. The ED further stated some boxes may have inadvertently been taken during the transition of ownership.</p> <p>At 12:45 am., the Vice President of Clinical Services stated the facility is working with the previous owners access to the archived files, the two companies are trying to work something out for survey purposes.</p>	A1057		
-------	---	-------	--	--

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/08/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MIRA VIE AT MONTVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
A1057	<p>Continued From page 3</p> <p>At 2:00 p.m., the DHW provided a partial MR for Resident #5; however, physician orders, medication administration records, and ^{NJ Exec Order 21} notes were not available and accessible to the surveyor.</p> <p>The facility failed to ensure Resident #5's ^{NJ ex order 25.4b} </p>	A1057		
A1073	<p>8:36-15.6(b) Resident Records</p> <p>(b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice.</p> <p>This REQUIREMENT is not met as evidenced by: COMPLAINT #: NJ00172254</p> <p>Based on interview and record review, it was determined that the Registered Nurse (RN) failed to accurately document in the resident medical record the condition, treatment, and coordination of care in accordance with the standards of professional practice for 1 of 7 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 3/25/2024, the surveyor reviewed Resident</p>	A1073		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 031446	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/08/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MIRA VIE AT MONTVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
A1073	<p>Continued From page 4</p> <p>#2's medical record (MR) which revealed the NJ ex order 26.4b1 According to the MR the resident was NJ ex order 26.4b1.</p> <p>Continued surveyor's review of the MR, the surveyor observed on 12/9/2023 documentation that the resident NJ ex order 26.4b1.</p> <p>The surveyor noted that the next documentation was on NJ ex order 26.4b1 which indicated that the resident NJ ex order 26.4b1.</p> <p>On 3/25/2024 at 2:30 p.m., the surveyor interviewed the RN who stated that she informed the family and the doctor of the resident's NJ ex order 26.4b1.</p> <p>The RN stated that she should have documented in Resident #4's MR when the NJ ex order 26.4b1.</p> <p>The RN failed to document in the nurses notes when Resident #4 NJ ex order 26.4b1.</p>	A1073		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 031446	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 5/7/2024
NAME OF FACILITY MIRA VIE AT MONTVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 165 CHANGEBRIDGE ROAD MONTVILLE, NJ 07045

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A1057	Correction	ID Prefix A1073	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-15.4	Completed	Reg. # 8:36-15.6(b)	Completed
LSC	05/02/2024	LSC	05/02/2024	LSC	05/02/2024
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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/8/2024	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---	--