

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55A000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/15/2025
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NAME OF PROVIDER OR SUPPLIER MIRA VIE AT TINTON FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE ONE HARTFORD DRIVE TINTON FALLS, NJ 07701
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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
A 000	<p>Initial Comments</p> <p>Initial Comments: COMPLAINT #: NJ181324 CENSUS: 49 SAMPLE SIZE: 5</p> <p>TYPE OF SURVEY: Standard Survey of 61 residential units with complaint</p> <p>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.</p> <p>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> <p>A Life Safety Code Survey was conducted by the State Agency on 10/15/2025. The facility was not in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs.</p>	A 000		
A 775	<p>8:36-7.5(a) Resident Assessments and Care Plans</p> <p>(a) The facility or program shall arrange for health care services to be provided to residents as needed, in accordance with assessments and with the health service plan. The administrator shall develop a system to identify the residents receiving health care services.</p>	A 775		

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

TITLE

(X6) DATE

11/18/25

New Jersey Department of Health

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A 775	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to consistently implement the service plan for 1 (Resident #2) of 5 residents whose service plans were reviewed.</p> <p>Findings included:</p> <p>A facility policy titled, "Service Plans and Assessments New Jersey," issued 04/2021, revealed "Individualized service plans are used to plan for and meet resident needs using an interdisciplinary approach."</p> <p>A "Face Sheet" indicated the facility admitted Resident #2 on [redacted] NJ Exec Order 26.4b1. According to the Face Sheet, Resident #2 had a medical history that included a diagnosis of [redacted] NJ Exec Order 26.4b1 [redacted]</p> <p>Resident #2's "[Facility name] Service Agreement" contained a listing of services to be provided to the resident. One listed service type, with an effective date of [redacted] NJ Exec Order 26.4b1, indicated "Community to [redacted] NJ Exec Order 26.4b1 to [redacted] NJ Exec Order 26.4b1 and [redacted] NJ Exec Order 26.4b1."</p> <p>During an interview on 10/14/2025 at 9:32 AM, Medical Care Aide (MCA) #1 said she remembered Resident #2, but had nothing to do with the [redacted] NJ Exec because [redacted] NJ Exec Order 26.4b1</p> <p>During an interview on 10/14/2025 at 10:06 AM, Medical Technician (MT) #2 said it was difficult to</p>	A 775		

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A 775	<p>Continued From page 2</p> <p>take Resident #2's ^{NJ Exec Order 26.4b1} and also complete her duties as an MT. MT #2 stated staff were to take turns taking the ^{NJ Exec Order 26.4b1}. She also indicated she was not sure who took the ^{NJ Exec} out at night.</p> <p>During an interview on 10/14/2025 at 11:02 AM, Licensed Practical Nurse (LPN) #4 said Resident #2 was at the ^{NJ Exec Order 26.4b1} and had a ^{NJ Exec Order 26.4b1} with an ^{NJ Exec Order 26.4b1}. She said she knew Resident #2 had to take out ^{NJ Exec Order 26.4b1} least once. She said she was unsure if it was because the staff refused to.</p> <p>During an interview on 10/14/2025 at 3:00 PM, the Director of Health and Wellness (DHW) said she expected staff to follow residents' service plans. She indicated if a resident's service plan included caring for a resident's ^{NJ Exec O} then staff were to follow the service plan.</p> <p>During an interview on 10/14/2025 at 3:05 PM, the Associate Executive Director (AED) said she expected staff to follow a resident's service plan, including caring for their ^{NJ Exec Ord}</p>	A 775		
A1249	<p>8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance</p> <p>The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety.</p>	A1249		

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A1249	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure:</p> <ol style="list-style-type: none"> 1. the main kitchen was free of dirt, debris, and grease accumulation; and 2. fire door assemblies throughout the facility were maintained and inspected/tested annually as required by "NFPA 80 Standard for Fire Doors and other Opening Protectives." <p>This had the potential to affect the 47 residents residing in the facility. The facility was licensed for 60 beds.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. An observation on 10/15/2025 at 10:35 AM revealed the main kitchen had a significant amount of dirt, debris, trash, and grease accumulated in the following areas: on all floor surfaces, behind the main cook line appliances, in preparation areas, and in dietary storage areas. An interview with Chef #6 during the main kitchen observation revealed the facility lacked a written policy regarding the expected frequency of kitchen cleaning. The Director of Plant Operations stated there were no policies regarding environmental surveillance rounds for the kitchen area. 2. On 10/15/2025 at 9:40 AM, the surveyor identified during a review of all life safety code inspection reports that the facility failed to 	A1249		

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A1249	<p>Continued From page 4</p> <p>conduct annual fire door inspection/testing as required by the standards set forth by "NFPA 80 Standard for Fire Doors and other Opening Protectives."</p> <p>On 10/15/2025 at 10:50 AM, the surveyor, accompanied by the Director of Plant Operations (DPO), observed that the exit discharge door for stairwell #2 had holes and non-compliant hardware installed, negating the fire-rated door assembly's ability to resist the passage of smoke and/or fire. The DPO stated the facility had not conducted an annual fire door inspection, and the facility had no policy regarding environmental surveillance rounds for all facility fire doors.</p>	A1249		



MIRAVIE

AT TINTON FALLS

ASSISTED LIVING | MEMORY SUPPORT

POC #2 received 1/7/26

Accepted 1/8/26

November 12, 2025
Complaint Survey 10/15/2025

Tag A775:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
 - **Resident #2 found to be affected by this deficient practice is no longer a resident of the community.** Resident #2 [redacted] as found to be [redacted] and care staff were [redacted] Resident and POA were issued a letter citing that community would be unable to [redacted] Resident #2 [redacted] moving forward, however, Service Plan was not updated in a timely manner.
2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
 - All residents in our community have the potential to be affected by these deficient practices.
3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.
 - Director of Health and Wellness educated on updated resident Service Plans immediately upon changes in condition/care. Completed on 10/15/25 by Regional VP of Clinical.
 - Director of Health and Wellness/Designee will review daily care partner assignments to assure they are completed accordingly to resident plan of care on a weekly basis beginning on 10/23/25.
 - Director of Health and Wellness will continue to review resident service plan assignments during Nursing stand-up meetings with care staff Monthly beginning on 10/30/25.



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ASSISTED LIVING | MEMORY SUPPORT

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.
 - Care Staff will sign off on Service Check-Off Sheets daily when care is completed. Effective 10/15/25.
 - Director of Health and Wellness/Designee will audit Service Check-Off Sheets to assure they are begin signed by staff upon completion on a weekly basis. Completed on 10/23/25 by Director of Health and Wellness/Designee and weekly.

Completion Date: 10/30/25 and ongoing.

*KF approved
1/8/26*

TAG 1249

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
 - 47 of 47 residents found to be affected due to deficient practice.
 - On 10/15/2025 kitchen area was thoroughly cleaned.
 - On 10/15/2025 contact was made and annual fire door inspection was scheduled by Director of Plant Operations.
 - On 10/15/2025 an estimate to replace exit discharge door for stairwell #2 was requested by Director of Plant Operations.
2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
 - All residents in our community have the potential to be affected by these deficient practices.
3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.
 - Dietary staff will continue to complete daily cleaning of kitchen and sign off once completed. This is completed 10/15/25 and ongoing.
 - Dining training was completed on 1/6/2026 to ensure staff continues to complete daily cleaning of kitchen and sign off as required.



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- Daily audit will be completed by Director of Restaurant and Hospitality to ensure that kitchen is properly maintained, and staff is signing once completed.
 - Fire door will be replaced and routinely audited by Director of Plant Operations. Door will be replaced by February 28, 2026.
 - Education provided to Director of Plant Operations regarding Annual Fire Door Inspections by Executive Director. Completed 10/15/25.
 - Director of Plant Operations will schedule annual fire door inspection accordingly. Inspection completed 11/17/25.
4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.
- Daily assignments given to dietary staff to maintain kitchen cleanliness and signature required upon completion by Director of Restaurant and Hospitality. Effective 10/15/25 and Ongoing.
 - Director of Restaurant and Hospitality will audit documentation daily and sign once completed. Effective 10/15/25 and Ongoing.
 - Executive Director will audit kitchen weekly to assure tasks have been completed and documentation is on file. Effective 10/21/25 and Ongoing.
 - Director of Plant Operations will monitor and record completion of annual fire door inspection. Information for Annual Inspection is recorded into TELS and is monitored by Regional VP of Plant Operations for completion. 11/17/25 and ongoing annually.
 - Director of Plant Operations will perform audits on a monthly basis of fire and exit doors and replace them as needed. Effective 10/21/25 and monthly.
 - Executive Director will follow up with Director Plant Operation monthly to ensure audits are completed. Effective 10/21/25 and monthly.

Completion Date: 2/28/26. *Approved 1/8/26*

1 Hartford Drive | Tinton Falls, NJ 07701 | (732) 933-4700

MiraVieSeniorLiving.com

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 55A000 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/8/2026 Y3
NAME OF FACILITY MIRA VIE AT TINTON FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE ONE HARTFORD DRIVE TINTON FALLS, NJ 07701	

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 A0775	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-7.5(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/30/2025	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	
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 10/15/2025		<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		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 55A000 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/8/2026 Y3
NAME OF FACILITY MIRA VIE AT TINTON FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE ONE HARTFORD DRIVE TINTON FALLS, NJ 07701	

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A1249	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:36-17.7	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	02/28/2026	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 _____	
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 10/15/2025		<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		