

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 70A000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/14/2025
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NAME OF PROVIDER OR SUPPLIER MIRA VIE AT WEST MILFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 197 CAHILL CROSS ROAD WEST MILFORD, NJ 07480
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H 000	<p>Initials Comments</p> <p>TYPE OF SURVEY: Complaint COMPLAINT #: NJ00189199 CENSUS: 66 SAMPLE SIZE: 3 SURVEY DATE: 11/11/2025 - 11/14/2025</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, based on this Complaint Survey.</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>	H 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

01/05/26

New Jersey Department of Health

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and facility document and policy review, the Administrator failed to ensure elopement drills were conducted monthly and, on each shift, quarterly per the facility's elopement policy. This deficiency had the potential to affect all residents at risk for elopement.</p> <p>Findings included:</p> <p>A facility policy titled, "Elopement - Missing Person," revised 10/2025, revealed, "Elopement is an event in which a resident leaves the community or Memory Support Environment without the knowledge of community employees." The policy also indicated, "The community is responsible for ensuring effective systems are implemented to reduce the risk of resident elopement." The policy also indicated, "The Executive Director/Designee is the process owner for scheduling, training, managing and follow-up for Elopement Drills. Elopement Drills shall occur monthly and, on each shift, quarterly."</p> <p>The facility's "Logbook Documentation," for "Missing Resident Drill[s]," revealed the facility conducted drills on 03/18/2025 from 3:15 PM to 3:45 PM, on 05/15/2025 from 12:00 AM to 1:00 PM, and on 07/30/2025 from 3:00 PM to 3:30 PM.</p> <p>During an interview on 11/12/2025 at 9:15 AM, the Executive Director (ED) stated they were not following their policy. The ED revealed the policy stated to do monthly elopement drills, but they had only been doing them every other month.</p> <p>During an interview on 11/14/2025 at 11:20 AM,</p>	A 310		

New Jersey Department of Health

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A 310	Continued From page 2 the Assistant Director of Health and Wellness stated they were supposed to do elopement drills every month and schedule the drills alternating the shifts. During an interview on 11/14/2025 at 12:01 PM, the Director of Health and Wellness (DHW) stated that elopement drills were to be done monthly, and the ED and Director of Maintenance (DM) usually did the drills. During an interview on 11/14/2025 at 1:31 PM, the DM stated that prior to this management company they did elopement drills once a year, and they did not get much direction from the new management company on what was expected. The DM stated he had been trying to do the drills about every three months. The DM stated initially he could not find the policy for conducting elopement drills, and then when it was finally found, the policy said to do the drills monthly.	A 310		
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; This REQUIREMENT is not met as evidenced	A 389		

New Jersey Department of Health

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A 389	<p>Continued From page 3</p> <p>by: Complaint #NJ00189199</p> <p>Based on observation, interview, record review, and facility document and policy review, the facility failed to ensure Resident #1 was [redacted] from [redacted]. Specifically, the facility failed to ensure [redacted] was provided for 1 (Resident #1) of 3 sampled residents reviewed for resident safety, and the resident exited the facility's secure [redacted] without staff knowledge on 11/04/2025. Medication Aide (MA) #4, who happened to be outside the facility's building, saw Resident #1 [redacted] and [redacted] the resident [redacted].</p> <p>It was determined the facility's non-compliance with one or more requirements had caused, or was likely to cause, serious injury, harm, impairment, or death to residents.</p> <p>On 11/14/2025 at 5:40 PM, the facility's Executive Director (ED) was verbally informed of the immediacy of the situation involving the failure to provide supervision resulting in the [redacted].</p> <p>Findings included:</p> <p>A facility policy titled, "Elopement - Missing Person," revised 10/2025, revealed, "Elopement is an event in which a resident leaves the community or Memory Support Environment without the knowledge of community employees. This especially applies when residents have impaired decision-making abilities and are not aware of their safety needs. Near Miss Elopement: A near miss elopement is when a resident leaves a community or Memory support residence WITH the knowledge of community employees and the resident remains in visual</p>	A 389		
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A 389	<p>Continued From page 4</p> <p>eyesight." The policy also indicated, "Residents have the right to live at ease, in a safe and secure environment. The community is responsible for ensuring effective systems are implemented to reduce the risk of resident elopement."</p> <p>On 11/13/2025 at 12:25 PM, an observation of the [redacted] revealed all four doors to the unit had working alarms that sounded when the doors were opened. The observation also revealed that when a door alarm was activated, a staff pager (wireless telecommunication device) received notification of the door that was opened.</p> <p>A "Face Sheet" revealed the facility admitted Resident #1 on [redacted]. According to the Face Sheet, the resident had a medical history that included a diagnosis of [redacted].</p> <p>A "DL [Day Life] Master Assessment," dated [redacted], revealed Resident #1 was admitted to the [redacted] unit. The Master Assessment revealed Resident #1 was [redacted] only to [redacted] NJ Exec Order 26.4b1 [redacted], frequently needed [redacted] NJ Exec Order 26.4b1 [redacted], and had a diagnosis of [redacted] NJ Exec Order 26.4b1 [redacted]. The Master Assessment revealed Resident #1 occasionally required redirection to [redacted] NJ Exec Order 26.4b1 [redacted].</p> <p>A "Resident [redacted] NJ Exec Order 26.4b1 [redacted] Assessment," dated [redacted] NJ Exec Order 26.4b1 [redacted] revealed Resident #1 did not have a history of [redacted] NJ Exec Order 26.4b1 [redacted]. The Resident [redacted] NJ Exec Order 26.4b1 [redacted] Assessment revealed Resident #1 scored [redacted] NJ Ex [redacted] on the [redacted] NJ Exec Order 26.4b1 [redacted]) [redacted] NJ Exec Order 26.4b1 [redacted] which indicated the resident had [redacted] NJ Exec Order 26.4b1 [redacted]. The Resident [redacted] NJ Ex Order 26.4(b)(1) [redacted] Assessment revealed Resident #1 had [redacted] NJ Exec Order 26.4b1 [redacted] an [redacted] NJ Exec Order 26.4b1 [redacted] the facility, had [redacted] NJ Exec Order 26.4b1 [redacted] into others' rooms or areas of concern, and had</p>	A 389		
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A 389	<p>Continued From page 5</p> <p>not exhibited any [redacted] and/or [redacted]. The Resident [redacted] Assessment revealed Resident #1 had a [redacted] diagnosis but did not have [redacted] [redacted], was not [redacted], did not have any [redacted], and did not have any [redacted]. The Resident [redacted] Assessment revealed Resident #1 did not experience [redacted] and did not [redacted]. The Resident [redacted] Assessment revealed Resident #1 was admitted to the [redacted] to prevent [redacted]. The Resident [redacted] Assessment revealed Resident #1 was [redacted] and [redacted].</p> <p>Resident #1's "Service Agreement," effective [redacted] included an agreement for [redacted] [redacted] "NJ Exec Order 26.4b1." A section titled, "Notes," revealed, "NJ Exec Order 26.4b1 Provide [redacted] and [redacted] if the resident is [redacted] throughout the common area of the [redacted] [redacted] to [redacted] resident in [redacted] through [redacted] and [redacted]. The community will provide the level of [redacted] necessary to support the resident's optimal level of [redacted] in [redacted]."</p> <p>Resident #1's "Service Agreement," effective [redacted], included an agreement for [redacted] "A section titled, "Notes," revealed, "NJ Exec Order 26.4b1 on the resident status.. Community to [redacted] on resident and address any needs."</p> <p>Resident #1's "Progress Notes," dated [redacted] at 5:12 PM, revealed that on [redacted]</p>	A 389		
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A 389	<p>Continued From page 6</p> <p>NJ Exec Order 26.4b1 at 3:30 PM, the resident was NJ Exec Order 26.4b1 the facility in the NJ Exec Order 26.4b1 and the resident NJ Exec Order 26.4b1. The Progress Note indicated MA #4 observed Resident #1 NJ Exec Order 26.4b1 lot; the resident had just NJ Exec Order 26.4b1 by the NJ Exec Order 26.4b1 and MA #4 saw the resident and NJ Exec Order 26.4b1.</p> <p>Resident #1's "Progress Notes," dated NJ Exec Order 26.4b1 at 6:07 PM, written by the Assistant Director of Health and Wellness (ADHW), revealed staff reported Resident #1 had NJ Exec Order 26.4b1 and the resident was observed outside the NJ Exec Order 26.4b1. The Progress Note revealed Resident #1 NJ Exec Order 26.4b1 on the upstairs door and NJ Exec Order 26.4b1 and out the NJ Exec Order 26.4b1. The Progress Note revealed staff intervened and NJ Exec Order 26.4b1 Resident #1 NJ Exec Order 26.4b1. The Progress Note revealed Resident #1 was NJ Exec Order 26.4b1 and had NJ Exec Order 26.4b1 over the last five days. The Progress Note revealed Resident #1's Family Member/Power of Attorney (POA) was notified of the incident, and the ADHW requested that the family cease using the NJ Exec Order 26.4b1 with the resident. The Progress Note revealed NJ Exec Order 26.4b1 had conducted NJ Exec Order 26.4b1 sessions with the resident in the NJ Exec Order 26.4b1, and a request was made for NJ Exec Order 26.4b1 to use NJ Exec Order 26.4b1.</p> <p>A "Reportable Event Record/Report," record, dated NJ Exec Order 26.4b1 revealed a significant event occurred on NJ Exec Order 26.4b1 at 4:34 PM (in contrast to an event date of NJ Exec Order 26.4b1 as reflected in Resident #1's Progress Notes). The Reportable Event Record/Report indicated on NJ Exec Order 26.4b1 at 4:34 PM Resident #1 was on the second floor of</p>	A 389		
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A 389	<p>Continued From page 7</p> <p>the [redacted] and NJ Exec Order 26.4b1 to the side stairwell, NJ Exec Order 26.4b1, [redacted], down the stairs to the first floor, and NJ Exec Order 26.4b1, where a staff member observed the resident and NJ Exec Order 26.4b1.</p> <p>During an interview on 11/11/2025 at 10:45 AM, the ED clarified that the date reflected on the "Reportable Event Record/Report" was erroneous. The ED confirmed Resident #1's NJ Exec Order 26.4b1 occurred on NJ Exec Order 26.4b1 and provided a copy of email correspondence to the state agency regarding the NJ Exec Order 26.4b1 as confirmation the event occurred in NJ Exec Order 26.4b1.</p> <p>A Director of Memory Support's (DMS) written statement, dated NJ Exec Order 26.4b1 at 5:10 PM, revealed that at 4:35 PM, the DMS directed Resident #1 to sit in a chair next to another resident, and Resident #1 was sitting in the chair when the DMS left the nursing unit. The written statement revealed when the DMS returned to the unit, MA #4 called on the radio and reported that Resident #1 was NJ Exec Order 26.4b1 the DMS looked around and NJ Exec Order 26.4b1 Resident #1 in the chair where the resident had NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1, and, at that time, MA #4 brought Resident #1 NJ Exec Order 26.4b1 via [by way of] the elevator.</p> <p>Care Partner (CP) #3's written statement, dated NJ Exec Order 26.4b1 at 4:59 PM, revealed Resident #1 moved from the chair where the DMS had seated them after the DMS left the area. The written statement indicated CP #3 began talking to another resident when she heard over the radio that Resident #1 was downstairs. The written statement indicated CP #3 did not hear the NJ Exec Order 26.4b1 or the pager sound.</p>	A 389		
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A 389	<p>Continued From page 8</p> <p>CP #2's written statement, dated 11/04/2025, revealed at 4:30 PM he told CP #3 that he was going to use the restroom, he returned at 4:35 PM, and he did not know what happened on the floor during his absence.</p> <p>The ED's written statement, dated 11/05/2025, revealed MA #4 stated she was outside when Resident #1 NJ Exec Order 26.4b1 and she saw the resident as NJ Exec Order 26.4b1 .</p> <p>An undated "Summary and Conclusion," of the event revealed that Resident #1 was on the second floor of the MSU, and at 4:34 PM on NJ Exec Order 26.4b1 the resident NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 . The Summary and Conclusion indicated staff on the unit were assisting other residents or were on another floor. The Summary and Conclusion indicated a staff member watched the resident NJ Exec Order 26.4b1 and returned the resident NJ Exec Order 26.4b1 into the NJ Exec Order 26.4b1 .</p> <p>During an interview on 11/11/2025 at 12:07 PM, the DMS stated that Resident #1 was NJ Exec Order 26.4b1 , and the day Resident #1 NJ Exec Order 26.4b1 they went down the stairs from the second floor. The DMS stated prior to the NJ Exec Order 26.4b1 Resident #1 NJ Exec Order 26.4b1 her to the restroom, so she NJ Exec Order 26.4b1 the resident NJ Exec Order 26.4b1 by another resident and then left. The DMS stated she went to the restroom, and then Resident #1 was NJ Exec Order 26.4b1 The DMS stated, "I was only gone for three minutes." The DMS stated when MA #4 asked over the radio if all the residents were accounted for; she looked at the chair and saw that Resident #1 was NJ Exec Order 26.4b1 The DMS stated CP #3 was the care partner on the floor, and CP #3 stated she did not NJ Exec Order 26.4b1 . The DMS stated Resident #1 had to have NJ Exec Order 26.4b1</p>	A 389		

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A 389	<p>Continued From page 9</p> <p>for [redacted], and it would have [redacted] the whole time.</p> <p>During an interview on 11/11/2025 at 3:03 PM, MA #4 stated she went [redacted] for a phone call, and she [redacted] Resident #1. MA #4 stated the staff on the floor said they did not hear the alarm, but the alarms were loud. MA #4 stated when the door was opened, it had to be pushed for 15 seconds, it alarmed the whole time, but the alarm would shut off when the door closed. MA #4 stated Resident #1 was [redacted] and had been for about a [redacted]</p> <p>During a telephone interview on 11/12/2025 at 1:10 PM, MA #4 stated she was on the first floor passing medications and stepped outside to answer a phone call from a physician since she did not have great cell service in the facility. MA #4 stated Resident #1 [redacted] and [redacted] very quickly as she (MA#4) was only [redacted] or [redacted] and not long at all.</p> <p>During an interview on 11/11/2025 at 3:18 PM, CP #3 stated that she worked on the [redacted] and part of her job was to keep an eye on the residents to make sure they did not [redacted] CP #3 stated the day Resident #1 [redacted] the DMS [redacted] Resident #1 to sit next to another resident by the window. CP #3 stated that she was talking to another resident and the next minute she heard everyone saying that Resident #1 [redacted]. CP #3 stated that the [redacted] that Resident #1 went out [redacted] at all. CP #3 stated she heard nothing until Resident #1 was [redacted] and MA #4 was on the radio. CP #3 stated MA #4 [redacted] Resident #1 [redacted], and it was only a [redacted] from the time when Resident #1 was in the chair and when MA #4</p>	A 389		
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A 389	<p>Continued From page 10</p> <p>radioed to let them know the resident was [redacted] CP #3 stated before shift change, pagers were put in the charger, and most of the time when she arrived on shift, she checked the battery. CP #3 stated she told the DHW that she did not hear the door alarm, so they tested the alarm and all the alarms worked.</p> <p>During an interview on 11/11/2025 at 3:34 PM, CP #1 stated that if the television was on it could be hard to hear the door alarms. CP #1 stated that the pager also notified them that the alarm was going off. CP #1 stated he worked the day that Resident #1 [redacted] his pager was off that day, the pager battery was dead, and he was unaware that it was dead. CP #1 stated he was working a double shift that day, the pager had been working prior to that, and then it died. CP #1 stated he was downstairs working in the kitchenette on the first floor and did not hear the alarm because of where he was. CP #1 stated he should have checked the batteries.</p> <p>During an interview on 11/11/2025 at 3:46 PM, CP #2 stated that his job was to always make sure eyes were on the residents. There were a lot of alarms at the facility, and if the exit door were pushed to go out, the alarm would sound. CP #2 stated they received alarms on the pagers if the alarm on the door was activated. CP #2 stated when Resident #1 [redacted], he was off the unit using the restroom, and when he came back from the restroom, CP #3 told him she was [redacted] Resident #1. CP #2 stated he [redacted] through the resident rooms, and then MA #4 came on the radio saying Resident #1 was [redacted]</p> <p>During an interview on 11/12/2025 at 12:14 PM, the ED stated the staff had their radios and</p>	A 389		

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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
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A 389	<p>Continued From page 11</p> <p>should always be in contact with each other. The ED stated staff should check the pagers and the radios for proper functioning at the start of every shift. The ED stated he expected staff to look at the pagers and radios to make sure they were fully charged. The ED stated it was the staff's responsibility to make sure at the start of the shift that the batteries were charged, and, if there was an issue, staff needed to make sure it was brought to management's attention. The ED stated he was aware prior to Resident #1's admission, that the resident would [redacted]. The ED stated Resident #1 had family in the neighborhood; cameras and alarms watched the resident as the resident [redacted], and family would go to the resident. The ED stated, "At the end of the day, our plans were not adequate enough, because [Resident #1] [redacted] and we should have reevaluated that."</p> <p>During an interview on 11/12/2025 at 12:39 PM, the ADHW stated staff on the floor should be able to physically see the resident when the resident was [redacted] or [redacted]. The ADHW stated there was no designated staff member that supervised the pagers. Per the ADHW, the staff member working on the medication cart directed the floor staff to gather equipment, and then staff should make sure their pagers and radios were charged and working correctly.</p> <p>During an interview on 11/12/2025 at 4:39 PM, the ADHW stated that the expectation was that if the pager went off, staff should look at the pager then follow-up to the physical location indicated by the pager. The ADHS stated if the pager indicated a location on the other floor, they were to radio the other floor staff to check their door. The ADHW stated she did not know if that process happened the day Resident #1 [redacted] the</p>	A 389		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 70A000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/14/2025
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NAME OF PROVIDER OR SUPPLIER MIRA VIE AT WEST MILFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 197 CAHILL CROSS ROAD WEST MILFORD, NJ 07480
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A 389	<p>Continued From page 12</p> <p>NJ Exec Orde The ADHW stated staff should take their pagers with them anytime they left the floor.</p> <p>During an interview on 11/13/2025 at 11:07 AM, the DMS stated that if staff stepped off the unit, they should always keep their radio and pager with them.</p> <p>During an interview on 11/13/2025 at 11:34 AM, the ADHW stated that the CPs should always have eyes on the residents, and the staff were responsible for making sure their equipment was functioning correctly and on the right channel. The ADHW stated they went over the equipment during orientation. The ADHW stated staff were to report any broken or malfunctioning equipment to her; she did not get a lot of reports that the pagers were not working, and none of the staff had told her the batteries were not lasting.</p> <p>During an interview on 11/13/2025 at 2:00 PM, the ED provided the agenda for the in-servicing completed with staff on the day following Resident #1's NJ Exec Order 26.4b1. The ED agreed the agenda did not cover ensuring staff carried their pagers and radios and that the equipment was charged. The ED stated that it was staff error that allowed the resident to leave the building.</p>	A 389		
A1401	<p>8:36-21.1(b)(4) Quality Improvement</p> <p>(b) Quality improvement activities shall include, but not be limited to, the following:</p> <p>4. Evaluation of resident care services, staffing, infection prevention and control, housekeeping, sanitation, safety, maintenance of physical plant and equipment, resident care statistics, and discharge</p>	A1401		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 70A000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/14/2025
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A1401	<p>Continued From page 13</p> <p>planning services;</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and facility policy review, the facility failed to ensure their quality improvement activities included evaluation of staffing needs. This deficiency had the potential to affect all residents.</p> <p>Findings included:</p> <p>A facility policy titled, "Staffing Plan," issued 04/2021, revealed, "Policy: The Community will maintain a staffing plan based on acuity to meet the needs of the residents. Procedure - 1) The Community shall employ sufficient staff to ensure the provision of services necessary to meet the needs of the residents, and shall consider factors including but not limited to: a) services to meet the residents' needs, b) services to be provided under the service plan, and c) services to be provided under the resident agreement."</p> <p>A facility policy titled, "Quality Assurance Program," issued 04/2021, revealed, "Purpose: The focus of a Quality Assurance Program is to ensure that a comprehensive program of services are provided for our residents and that those services are delivered optimally according to the resources of the facility and consistent with Federal and State Licensure requirements." The policy also indicated, "The objectives of this program are to: 1. Establish, maintain, support and document evidence of an Ongoing Quality Assurance Program that included effective mechanisms for monitoring and evaluating utilization of resident services and for the</p>	A1401		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 70A000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/14/2025
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A1401	<p>Continued From page 14</p> <p>appropriate response to adverse finding." The policy also indicated, "Organization/Authority - The Executive Director is responsible for coordinating the Quality Assurance Program. The Executive Director will be the leader of the Quality Assurance Program. A representative from each department will be chosen by the Executive Director to participate in the Quality Assurance Committee." The policy also indicated, "Each department representative will identify service delivery problems or concerns along with a suggested plan of correction to the Quality Assurance Committee."</p> <p>During a telephone interview on 11/14/2025 at 9:19 AM, Care Partner (CP) #5 stated there were times that he had to help staff on the other floor, so that left his assigned residents unattended. CP #5 stated there were some residents who needed more than just him to provide care.</p> <p>During a telephone interview on 11/14/2025 at 9:36 AM, CP #7 stated she worked on both the Assisted Living (AL) and the Memory Support Unit (MSU), and staff worked alone on the floors. CP #7 stated some residents needed the help of more than one staff member, so staff would have to help each other and leave their assigned unit.</p> <p>During a telephone interview on 11/14/2025 at 10:42 AM, CP #8 stated that she worked on both the MSU and the AL. CP #8 stated some residents required both scheduled staff members to help, so staff helped each other and had to leave their assigned floor to help at times.</p> <p>During an interview on 11/14/2025 at 11:20 AM, the Assistant Director of Health and Wellness (ADHW) stated some residents on the MSU required two staff to assist them, and she did not</p>	A1401		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 70A000	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/14/2025
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A1401	<p>Continued From page 15</p> <p>think the nursing ratio was appropriate. The ADHW stated if two staff were assisting a resident, there may be times the other floor was left unattended.</p> <p>During an interview on 11/14/2025 at 12:01 PM, the Director of Health and Wellness (DHW) stated that on the night shift, there were four assigned staff, one on each floor, and there were residents who required two staff for assistance. The DHW stated that at times a floor was unattended while staff helped each other. The DHW stated she did not approve of only one staff member on each floor.</p> <p>During an interview on 11/14/2025 at 1:04 PM, the Executive Director (ED) stated the residents on the MSU should not be left unattended, and he expected residents on the MSU to have staff with them. The ED stated he never felt like they had enough staff, and there were residents who needed more than one person for assistance. The ED stated there could be times when the residents on the MSU would be left unattended, and it was not acceptable to leave the residents on MSU with no staff available. The ED stated there had been issues on all shifts with staffing. The ED stated they had a Quality Assurance Committee, but he did not think anything about staffing was discussed in their meetings.</p> <p>During an interview on 11/14/2025 at 3:25 PM, the ED provided the facility's "Quality Action Plan" form dated 12/21/2021 and stated that they did not specifically discuss the staffing needs of the facility in their meetings.</p>	A1401		

POC #2 received 1/14/26
Accepted 1/14/26



MIRAVIE

AT WEST MILFORD

INDEPENDENT LIVING | ASSISTED LIVING | MEMORY CARE

A310 8:36.4 (A)(1) administration

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
 - Specific resident was not identified.
 - Elopement Drill completed on 11/19/2025 by Director of Plant Ops and Nursing Team.
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.
 - a. Executive Director along with Director of Plant Operations will make sure elopement drills are completed monthly per policy. Effective 11/21/25.
 - b. At the end of each drill staff will be brought together to review elopement policy and go over anything from the drill. The staff will sign off for completion and complete a competency quiz. Effective 11/21/25.
4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
 - a. Complete drills will be kept in log book and will also be entered into our TELS System by Director of Plant Operations monthly. Effective 11/21/25.
 - b. Elopement Drills will be reviewed for completion quarterly by Executive Director and monitored during quarterly QAPI meeting. Next QAPI Meeting: 1/28/26.

Final Completion Dates for all Items 11/21/25



Approved
1/14/26



MIRAVIE

AT WEST MILFORD

A389 8:36-4.1 (a)(16) Resident Rights INDEPENDENT LIVING | ASSISTED LIVING | MEMORY CARE

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
 - a. Following the [redacted] the resident #1 was [redacted] NJ Exec Order 26.4b1 All doors and alarms were checked and noted as operational at time of [redacted] NJ Exec Order 26.4b1 Resident still resides at the community. Service Plan updated on [redacted] NJ Exec Order 26.4b1 to include [redacted] NJ Exec Order 26.4b1 if resident is [redacted] NJ Exec Order 26.4b1 notify supervisor immediately upon [redacted] NJ Exec Order 26.4b1 Engage in activities, conversations, meals, and [redacted] NJ Exec Order 26.4b1 in secure and [redacted] NJ Exec Order 26.4b1 neighborhood.
 - b. Additional alarm was installed onto door post event 11/13/25 where it requires a staff member to manually reset.
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.
 - a. A second door alarm was installed on Nov 13th. New alarm is louder than the original door alarm and will not shut off until manually reset. Door alarms checked monthly by Director of Plant Operations. Effective 11/21/25.
 - b. Employee equipment: staff were educated by Director of Health and Wellness to make sure they are checking their equipment before and during their shift, to confirm everything is charged and working properly and to notify supervisor immediately if it is faulty. Effective 11/21/25.
4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
 - a. Staff are using the equipment log to sign their equipment in and out. Verified by Certified Med Tech or Licensed Nurse on the Medication Cart for that unit. Effective 11/21/25.
 - b. Equipment Log are noted and verified for completion during quarterly QAPI by Director of Health and Wellness. Next QAPI January 1/28/26.
 - c. Door Alarms checked monthly by Director of Plant Operations and logged into TELS. Reported Quarterly during QAPI. Next QAPI January 1/26/28.

Final Completion Date for all elements 11/21/25.



approved 1/14/26

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MIRAVIE

AT WEST MILFORD

INDEPENDENT LIVING | ASSISTED LIVING | MEMORY CARE

A1401 8:36-21(B)(4) Quality Improvement

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
 - No specific residents were identified.

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 by this deficient practice.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
 - a. Education provided to all team members that memory care is never to be left unsupervised for any reason. Unit must have supervision at all times. Education provided by Executive Director and Director of Health and Wellness on 11/21/25.
 - b. Review of all staff assignments to ensure that we are staffing based on Acuity Based Staffing Policy by Executive Director and Director of Health and Wellness on 11/21/25.
 - c. Staffing levels have remained the same based on resident acuity and needs of the Memory Support Neighborhood.
 - 16 Residents reside in Memory Support Neighborhood.
7-3 shift (1) CMA (3) Care Staff, 3-11 (1) CMA (3) Care Staff,
11-7 (2) Care Staff. This does not include additional staff support of a Director of Memory Support of about 40 hours per week and a full-time Activities Assistant.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
 - a. Monthly education and spot checks to entire team to verify process continues to be followed to ensure that Memory Support Unit has supervision at all times.

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AT WEST MILFORD

INDEPENDENT LIVING | ASSISTED LIVING | MEMORY CARE

- b. Completed by Executive Director and Director of Health and Wellness. Effective 11/21/25 and Ongoing.
- c. Quarterly review of all staff assignments to ensure staffing reflects Acuity Based Staffing Policy. Reported on Quarterly QAPI by Director of Health and Wellness and Executive Director. Next QAPI January 1/28/26.

Final Completion Date for all elements 11/21/25.

NJ Exec Order 26.4b1

*approved
1/14/26*

completed by

NJ Exec Order 26.4b1

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 70A000 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/14/2026 Y3
NAME OF FACILITY MIRA VIE AT WEST MILFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 197 CAHILL CROSS ROAD WEST MILFORD, NJ 07480	

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 A0389	Correction	ID Prefix A1401	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-21.1(b)(4)	Completed
LSC	11/21/2025	LSC	11/21/2025	LSC	11/21/2025
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 11/14/2025		<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 70A000 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/14/2026 Y3
NAME OF FACILITY MIRA VIE AT WEST MILFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 197 CAHILL CROSS ROAD WEST MILFORD, NJ 07480

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 A0389	Correction	ID Prefix A1401	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-21.1(b)(4)	Completed
LSC	11/21/2025	LSC	11/21/2025	LSC	11/21/2025
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 11/14/2025		<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		