STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	70A000	A. BUILDING: _____ B. WING _____	C 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIRA VIE AT WEST MILFORD	197 CAHILL CROSS ROAD WEST MILFORD, NJ 07480

(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 #: NJ00175885 CENSUS: 57 SAMPLE SIZE: 1 SURVEY DATE: 02/06/2025 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; This REQUIREMENT is not met as evidenced	A 389		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 389	Continued From page 1 by: #NJ175885 Based on record review, interview, and facility document and policy review, the facility failed to ensure each resident's right to be free from [NJ Exec Order 26] was honored, as evidenced by a failure to prevent [NJ Exec Order 26.4b1] which affected 1 (Resident #1) of 1 resident reviewed for [NJ Exec Order 26.4b1] Specifically, Resident #1 [NJ Exec Order 26] from the facility's [NJ Exec Order 26.4b1] on [NJ Exec Order 26.4b1] and on [NJ Exec Order 26.4b1]. Findings included: A facility policy titled, "Ensuring Resident Rights and Dignity," dated 04/2021, revealed, "7) Residents will not be mistreated or mishandled in any way (see abuse and neglect)." A facility policy titled, "Elder Abuse/Neglect," dated 04/2021, revealed, "4) Upon the notice of reported observed, suspected, or at imminent risk of abuse or exploitation: a) Immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is being conducted." A facility document titled, "Missing Resident-Elopement Prevention Program," dated 04/2021, 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 and 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	A 389		

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A 389	Continued From page 2 resident remains in visual eyesight." 1. Resident #1's "[Facility name] Service Plan," dated NJ Exec Order 26.4b1, indicated the resident resided on the NJ Ex Order 26. 4B1 unit, and the earliest services that were initiated in the service plan were dated NJ Exec Order 26.4b1. According to the service plan, the resident had a medical history that included a diagnosis of NJ Exec Order 26.4b1 The service plan indicated that the resident required a NJ Ex Order 26. 4B1 Resident #1's "Resident NJ Ex Order 26. 4B1 Assessment," dated NJ Exec Order 26.4b1, indicated the resident did not have a history of NJ Ex Order 26. 4B1 . The Resident NJ Ex Order 26. 4B1 Assessment indicated the "Current interventions" at that time were 'NJ Ex Order 26. 4B1 ." A "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 to the state survey agency. Per the report, on NJ Exec Order 26.4b1 at 3:40 PM, Resident #1 took the NJ Ex Order 26. 4B1 unit's elevator from the NJ Ex Order 26. 4B1 . The report indicated that when the resident was unable to go NJ Ex Order 26. 4B1, they pushed the NJ Exec Order 26.4b1 leading to the NJ Ex Order 26. 4B1 of the facility until they opened, then walked through the back hallway on the NJ Ex Order 26. 4B1 of the facility to a dining room. Per the document, once in the dining room, Resident #1 NJ Exec Order 26.4b to the NJ Ex Order 26. 4B1 . The document indicated that a staff member saw the resident and sat with them until the NJ Ex Order 26. 4B1 the resident. The document indicated Resident #1 NJ Exec Order 26.4b to the NJ Ex Order 26. 4B1	A 389		

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A 389	Continued From page 3 NJ Ex Orde unit at 3:50 PM and was assessed with NJ Exe. The Reportable Event Record/Report indicated that, following the NJ Ex Order 26. 4B1 the facility planned to install keypads to the NJ Ex Order 26. 4B1 elevator so that the residents could not freely use the elevator and that, while the keypads were being installed, staff would count the residents at the start and end of their shifts and at mealtimes. Resident #1's "Resident NJ Ex Order 26. 4B1 Assessment," dated NJ Exec Order 26.4b1, indicated the "Current interventions" at that time were NJ Ex Order 26. 4B1 ," and new interventions implemented included NJ Ex Order 26. 4B1 with activities and NJ Exec Order 26.4b1 the resident, and allowing the resident time to NJ Exec Order 26.4b1 a day to NJ Exec Ord on the NJ Exec Orde During an interview on 02/06/2025 at 2:10 PM, Licensed Practical Nurse (LPN) #3, who worked on NJ Exec Order 26.4b1, stated she was administering medications when Resident #1 NJ Ex Order 26. 4. She stated she went to the NJ Exec Order 26.4b1 noticed Resident #1 was NJ Ex Order 26. 4B1, and did not hear a NJ Exec Or so she went back to the NJ Exec Order 26 floor and counted the residents, then called staff on the NJ Ex Order 26. 4B1 of the facility to NJ Ex Order 26. 4B1 the resident. During an interview on 02/06/2025 at 11:30 AM, the Executive Director stated Resident #1 had resided on the NJ Ex Order 26. 4B1 of the facility in the past, so the resident thought they were going through NJ Ex Order 26. 4B1 of going to read. 2. A "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, indicated that the facility reported an NJ Exec Order 26.4b1 to the state survey agency. Per the report, on NJ Exec Order 26.4b1 at 5:40 PM, Resident #1	A 389		

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A 389	Continued From page 4	A 389		

took the NJ Ex Order 26. 4B1 elevator from the NJ Exec Order 26. floor to the NJ Exec O floor. The report indicated Resident #1 tried to NJ Ex Order 26. 4B1 and then went to the NJ Exec Order 26.4b1 to the NJ Ex Order 26. 4B1 of the facility and tried to open them. Per the report, a staff member from the kitchen NJ Ex Order 26. 4B1 for the resident. The report indicated Resident #1 then walked through the back hallway on the NJ Ex Order 26. 4B1 of the facility to the dining room. The report indicated that once in the dining room, waitstaff notified nursing staff, who NJ Ex Order 26. 4B1 Resident #1 to NJ Ex Order 26. 4B1 . The report indicated that the resident was back on the NJ Ex Order 26. 4B1 unit at 5:50 PM. The Reportable Event Record/Report indicated that, following the NJ Ex Order 26. 4B1 , in addition to keypads being installed, the facility staff were to provide NJ Ex Order 26. 4B1 for Resident #1 and a NJ Exec Order 26.4b1 was NJ Exec Order 26.4b on Resident #1's NJ Exec Order 26.4b1 to alert staff when Resident #1 NJ Ex Order 26. 4B1 .

Resident #'s "[facility name] Service Plan," dated NJ Exec Order 26.4b1 revealed instructions for staff to take Resident #1 NJ Ex Order 26. 4B1 unit's NJ Exec Ord multiple times throughout the day. The service plan indicated that Resident #1 needed an NJ Ex Order 26. 4B1 (initiated NJ Exec Order 26.4b1 .

Resident #1's "Resident NJ Ex Order 26. 4B1 Assessment," dated NJ Exec Order 26.4b1 indicated that the resident now had a NJ Ex Order 26. 4B1 . The Resident NJ Ex Order 26. 4B1 Assessment indicated the 'NJ Ex Order 26. 4B1 " at that time were 'NJ Ex Order 26. 4B1 ," NJ Ex Order 26. 4B1 with activities, and offering the resident time to NJ Exec Order 26.4b1 a day to NJ Exec Orde The assessment identified a new

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A 389	Continued From page 5 intervention, dated [NJ Exec Order 26.4b1], that indicated a [NJ Exec Order 26.4b1] was added to the resident's [NJ Ex Order 26. 4B1] to alert staff when the resident [NJ Ex Order 26. 4B1]. During an interview on 02/06/2025 at 11:30 AM, the Executive Director stated that the [NJ Ex Order 26. 4B1] on [NJ Exec Order 26.4b1] involved a staff member from the kitchen who helped Resident #1 [NJ Ex Order 26. 4B1], thinking he was helping the resident. He stated that the staff member knew the difference between the [NJ Ex Order 26. 4B1] of the facility, but did not know who lived on which side. He stated that the resident did not go [NJ Ex Order 26. 4B] but made it to the dining area when staff saw them.	A 389		

4/11/25

New Jersey Department of Health

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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		

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

MIRA VIE
AT WEST MILFORD
INDEPENDENT LIVING | ASSISTED LIVING | MEMORY CARE

A 389 8:36-4.1(a)(16) Resident Rights

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
   - Resident 1 found to be affected by the deficient practice was [NJ Exec Order 26.4b1] in this incident. Moving forward, the Executive Director and the entire team at the community will follow the community policy and procedure to identify residents at risk. This deficient practice was corrected immediately.
2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
   - The community will identify other residents that have the potential to be affected by the same deficient practice by following the community policy and procedure for investigating alarms when they sound. When an alarm sounds, community policy will immediately be followed.
   - Elopement Risk Assessments will continue to be completed on admission, every 6 months, and/or change in condition.
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
   - All team members have been in-serviced on Elopement/Missing Resident procedures on [NJ Exec Order 26.4b1] that include the differences between [NJ Exec Order 2] and [NJ Exec Orde]
   - Keypad installed into [NJ Exec Orde] Elevator so that the elevator will not open unless a code is entered. This was completed on 10/9/2024.
   - [NJ Exec Order 26.4b1] installed on *NJ Ex Order 26. 4B1* . This was completed on [NJ Exec Order 26.4b1]
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.
   - Executive Director or designee will include this corrective measure in its Quarterly QA Program to ensure compliance. This measure was added in meetings 8/26/24.
   - Community will follow P&P for Monthly Elopement Drills and Staff Education. Effective: 8/15/24.

NJ Ex Order 26. 4B1