STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315247	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at West Caldwell LLC	165 Fairfield Ave West Caldwell, NJ 07006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and review of pertinent facility documents on [DATE], it was determined that the facility failed to complete and thoroughly investigate the fall incident of a cognitively impaired resident (Resident #5) to rule out abuse and neglect. On [DATE] the resident was found unresponsive on the floor next to their bed with their head in the trash bin lined with clear plastic bag. The facility called 911 and police came. The resident was pronounced dead by EMS [emergency medical services] at bedside. This deficient practice was identified for 1 of 5 residents reviewed and was evidenced by the following:The surveyor reviewed the medical record for Resident #5. A review of the facility's Reportable Event Record (RER), a document submitted by the facility to the New Jersey Department of Health (NJDOH), with an event date of [DATE] and an event time of 12:57 AM was reported by the facility's Previous Administrator. Under Type of Incident reported was Unexpected Death. The Narrative indicated that at approximately 1:00 AM, Certified Nursing Assistant (CNA) #1 was assisting another patient when they heard a sound coming from Resident #5's room. When CNA entered the room, Resident #5 was on the floor next to their bed. Upon checking, Resident #5 was observed to be non-responsive. CNA immediately notified the nurse and registered nurse (RN) Supervisor. RN Supervisor called 911 while nurses and CNAs retrieved the AED and Code cart. As soon as the nurses began implementing emergency response measures. When the police arrived, approximately 2 minutes later, they took the lead on emergency response. The facility did not submit an Investigation, Summary, and Conclusion (ISC) to the NJDOH, as requested by the department. A review of the admission Record (AR) face sheet (an admission summary), revealed that Resident #5 was admitted to the facility with diagnoses which included but were not limited to: generalized idiopathic epilepsy and epileptic syndromes (sudden uncontrollable jerking, stiffening movements caused by various factors including genetic, structural, metabolic, and autoimmune factors), developmental disorder of scholastic skills, generalized osteoarthritis (degeneration of joint cartilage and the underlying bone affecting multiple joints, causing widespread pain, stiffness, and swelling), muscle weakness, and difficulty walking. A review of the Minimum Data Set (MDS), an assessment tool dated [DATE], indicated Resident #5 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating Resident #5 had severely impaired cognition. The MDS further revealed that the resident required assistance from staff in the completion of their activities of daily living (ADLs)).A review of Resident #5's individual comprehensive care plan (ICCP) included a focus area dated [DATE] that the resident had a seizure disorder r/t [related to] Epilepsy. Interventions included but were not limited to give medications as ordered, monitor labs and report any sub therapeutic or toxic results to MD [medical doctor], post seizure treatment, seizure documentation, and seizure precautions. The IICP as included a [DATE] that the resident was moderate risk for falls r/t gait/balance problems, poor communication/comprehension, seizure disorder and history of falls. Interventions included but were not limited to anticipate and meet the resident's needs, be sure the resident's call light was within reach, and the resident needs a safe environment (even floors, free from spills or clutter, adequate light, working and reachable call light, bed in low position at night, side rails as ordered, personal items within reach).On [DATE] at 12:16 PM, the surveyor requested for the facility's ISC, investigation report and documents for the [DATE] incident involving Resident #5. The LNHA provided the surveyor with Resident #5's investigation documents (ID). The surveyor was not able to find the ISC in the investigation documents. The LNHA stated that she started to work as the LNHA in the facility in June of 2025 and she was not aware of or if an ISC was made and submitted by the previous administrator who resigned from the facility before June of 2025. The surveyor reviewed the facility's ID. There was no facility ISC nor staff statements in the documents received by the surveyor. Statements received by the surveyor were VWSs taken by the local police.On [DATE] at 1:16 PM, the LNHA provided the surveyor of a document titled, Summary of Investigation (SOI). The SOI indicated under Issue/Concern: On [DATE] at approximately 120 [1:20 am] [Resident #5] was found lying next to [their] bed with a garbage pail at the top of her head. Under Action/Intervention: Staff immediately began CPR [cardiopulmonary resuscitation] and called 911.Under Conclusion/Plan: There is no evidence of abuse or neglect .Team has concluded .It is most likely the resident [Resident #5] suffered a fatal seizure and rolled off the bed onto the floor and [their] head hit the bedside garbage pail.A review of the facility's Abuse, Neglect, and Exploitation with a Reviewed/Revised date of [DATE] revealed under Policy Explanation and Compliance Guidelines: 1. The facility will develop and implement written policies and procedures that, b. Establish policies and