

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Manitowoc LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2021 S Alverno Rd Manitowoc, WI 54220	

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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure a medical record contained complete and accurate information for 1 resident (R) (R5) of 10 sampled residents. On 6/28/25, Registered Nurse (RN)-C assessed R5 for stroke symptoms after receiving a concern from R5's friend. RN-C did not document the neurological assessment in R5's medical record after it was completed. Findings include: The facility's Documentation in the Medical Record policy, revised 10/2024, indicates: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress. Licensed staff and Interdisciplinary Team members shall document all assessments, observations, and services provided in the resident's medical record. Documentation shall be completed at the time of service. On 7/7/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including stroke, chronic kidney disease, type 2 diabetes, and atrial fibrillation. R5's most recent Minimum Data Set (MDS) assessment, dated 6/2/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had intact cognition. R5 was R5's own decision maker. A progress note, dated 6/29/25, indicated R5's friend called 911 for R5. When staff went to R5's room, R5 stated R5 did not feel right and R5's tongue felt thick. R5 had slightly slurred speech and questionable left facial droop. Staff completed a neurological assessment and R5 was sent to the hospital for suspicion of a stroke. On 7/7/25 as of 12:15 PM, Surveyor noted R5's medical record did not contain any neurological assessments prior to 6/29/25. On 7/7/25 at 12:20 PM, Surveyor interviewed RN-C regarding neurological assessments and stroke concerns for R5. RN-C indicated RN-C spoke with R5's friend on the 6/28/25 PM shift who had concerns that R5 was having a stroke with symptoms of slurred speech and facial droop. RN-C went to R5's room and conducted a stroke/neurological assessment. RN-C confirmed RN-C completed the assessment but did not document the assessment in R5's medical record until 7/7/25 at 12:18 PM upon request from Director of Nursing (DON)-B. On 7/7/25 at 12:30 PM, Surveyor reviewed R5's medical record again and noted a progress note from RN-C, dated 6/28/25 at 5:30 PM, that indicated R5's friend called RN-C on the charge phone and requested a stroke assessment. R5's friend was on a video call with R5 and noticed R5 was talking funny, had slurred speech, and had left facial droop. RN-C went to R5's room at that time and determined R5 was not having symptoms of slurred speech or facial droop. R5's hand grasps were equal with full strength, mentation was at baseline, pupils were equal, and vital signs were stable. R5 stated, I feel fine. (Surveyor noted the progress note was entered in R5's medical record on 7/7/25 at 12:18 PM after Surveyor asked several staff about R5 having signs and symptoms of a stroke prior to 6/29/25.) On 7/7/25 at 12:53 PM, Surveyor interviewed DON-B who verified RN-C did not document the neurological assessment in R5's medical record until DON-B asked RN-C to do so on 7/7/25. DON-B verified RN-C should have documented the assessment on the date it was completed.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 525441
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