STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525441	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Manitowoc LLC	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)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure daily weights were consistently completed or a physician was notified of a significant weight gain for 1 resident (R) (R67) of 6 sampled residents.R67 had a diagnosis of congestive heart failure (CHF). R67 had an order for daily weights and to notify the physician of a weight gain of 3 pounds (lbs) or more in one day. R67 had a significant weight gain of 7.4 lbs (5.96%) from 9/19/25 to 9/20/25. Staff did not consistently complete daily weights or notify the physician of R67's weight gain.Findings include:The facility's Weight Monitoring policy, revised 5/28/25, indicates: Based on the resident's comprehensive assessment, the facility will ensure all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise .6. Weight analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as: a. 5% change in weight in one month (30 days) .7. Documentation: a. The physician should be informed of a significant change in weight and may order nutritional intervention.The facility's Notification of Changes policy, revised 5/28/25, indicates: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification .Compliance guidelines: The facility must inform the resident, consult with the resident's physician, and/or notify the resident's family member or legal representative when there is a change requiring such notification .2. Significant change in the resident's physical, mental, or psychosocial condition, such as deterioration in health, mental, or psychosocial status.3. Circumstances that require a need to alter treatment.From 9/29/25 to 10/1/25, Surveyor reviewed R67's medical record. R67 was admitted to the facility on [DATE] and had diagnoses including chronic diastolic (congestive) heart failure, type 2 diabetes mellitus with ketoacidosis without coma, and dysphagia. A Minimum Data Set (MDS) assessment completed 9/18/25 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R67 was not cognitively impaired. R67's made R67's own medical decisions.A care plan, dated 9/17/25 and revised 9/23/25, indicated R67 had impaired cardiovascular status related to chronic obstructive pulmonary disease (COPD), chronic heart failure, electrolyte imbalances, hypertension, and hyperlipidemia. The care plan contained the following interventions: Diet as ordered; Listen to (R67) when verbalizing concerns over disease symptoms and address issues raised; Medications as ordered by physician. Observe use and effectiveness; Observe for abnormal vital signs and report; Observe for changes in condition.A care plan, dated 9/17/25 and revised 9/25/25, indicated R67 was at risk for skin alteration related to L5 compression fracture, metabolic encephalopathy, diabetes mellitus type 2 with diabetic ketoacidosis, and other comorbidities. The care plan contained the following interventions: Encourage adequate nutrition and fluid intake; Monitor weights as ordered; Ensure good oral health twice daily; Ensure (R67) can swallow safely; Dietitian consult; Maximize nutritional status through adequate protein and calorie intake; Set up and assist with meals as needed.R67 had the following orders:~ Daily weights: Call if 3 lb weight gain in 1 day or 5 lb weight gain in 1 week (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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(dated 9/18/25)~ Consistent controlled carbohydrate diet, regular/non-modified texture, regular (thin) consistency (dated 9/17/25)Surveyor reviewed R67's weights and noted the following:~ 9/22/225 at 10:38 AM - 132.0 lbs (wheelchair) ~ 9/21/25 - there was no weight documented~ 9/20/25 at 2:05 PM - 133.2 lbs (wheelchair) ~ 9/19/25 at 1:01 PM - 125.8 lbs (wheelchair) ~ 9/18/25 at 8:45 AM - 126.6 lbs (wheelchair) ~ 9/17/25 at 2:16 PM - 126.0 lbs (wheelchair) (admission)A Nurse Practitioner (NP) progress note, dated 9/29/25, indicated R67's weights were relatively stable, however, staff had not weighed R67 yet that day. Staff were reminded of the need for a daily AM weight. (R67's medical record indicated R67 was weighed at 1:21 PM on 9/29/25.)On 10/1/25 at 11:47 AM, Surveyor interviewed Registered Nurse (RN)-C who verified R67 had an order for daily weights and to contact the physician for a gain of 3 lbs in 1 day or 5 lbs in 1 week. RN-C indicated Certified Nursing Assistants (CNAs) record a resident's weight on paper and give it to the nurse. RN-C indicated it is the nurse's responsibility to compare weights, document weights in the medical record, and contact the provider for weight loss or gain as ordered during the shift the loss or gain is discovered. RN-C verified the provider should have been contacted on 9/20/25 because R67 had a weight gain of more than 3 lbs in 1 day. On 10/1/25 at 11:17 AM, Surveyor interviewed Director of Nursing (DON)-B who verified R67 had a significant weight gain of 7.4 lbs from 9/19/25 to 9/20/25 and a diagnosis of congestive heart failure. DON-B verified a physician was not notified of R67's weight gain on 9/20/25. DON-B indicated it is the nurse's responsibility to update the physician of a weight gain on the shift the gain is discovered.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not provide services to prevent complications of enteral feeding for 1 resident (R) (R42) of 1 sampled resident with a feeding tube.R42 received medication, nutritional supplements, and hydration via gastrostomy (G)-tube. During an observation of medication administration, Licensed Practical Nurse (LPN)-D did not flush R42's G-tube with 10 cubic centimeters (ccs) of water between medications as ordered.Findings include:The facility's Medication Administration via Enteral Tube policy, dated 2025, indicates: It is the policy of this facility to ensure the safe and effective administration of medication via enteral feeding tube by using best practice guidelines .Each medication will be administered separately .Flush enteral feeding tube with at least 15 milliliters (ml) of water prior to administering medication unless otherwise ordered by the provider .Administer using a clean syringe .Flush tube again with at least 15 ml of water unless otherwise ordered by the physician. Repeat with the next medication.From 9/29/25 to 10/1/25, Surveyor reviewed R42's medical record. R42 was admitted to the facility on [DATE] and had diagnoses including cerebrovascular accident (CVA), anoxic brain damage, and dysphagia (difficulty swallowing). A Minimum Data Set (MDS) assessment completed 9/1/25 indicated R42 had severe cognitive impairment and an abdominal feeding tube. A care plan, dated 9/25/25, indicated R42 required tube feeding related to dysphagia and required total assistance with the tube feeding and water flushes. R42's medical record contained the following orders (dated 8/28/25): ~ Flush G-tube with 10 ccs of water before medication pass. Each medication to be given separately with a 10 cc flush after each medication.~ Simethicone oral tablet chewable, Give 80 milligrams (mg) via G-tube three times daily for gas, bloating.~ Hydralazine HCl oral tablet (Hydralazine HCl), Give 25 mg via G-tube three times daily for hypertension. On 10/1/25 at 11:40 AM, Surveyor observed LPN-D administer hydralazine and simethicone to R42 via G-tube. LPN-D did not flush the tube with 10 ccs of water as ordered between medications. Following the observation, LPN-D verified LPN-D did not flush R42's G-tube between medications. On 10/1/25 at 12:13 PM, Surveyor interviewed Director of Nursing (DON)-B who verified LPN-D should have flushed R42's G-tube with 10 ccs of water between medications per the physician's order.