STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525608	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Ridgewood LLC	3205 Wood Rd Racine, WI 53406

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and facility policy review, the facility failed to monitor fluids offered and consumed by a resident to ensure fluid intake was in accordance with a physician order for a 1500 milliliter (ml) fluid restriction for 1 (R4) of 2 sampled residents reviewed for dehydration.Findings included:A facility policy titled, Fluid Restriction, dated 2025, revealed It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to (sic) physicians' orders. Policy Explanation: Fluid restrictions are basically the restriction of fluid intake. This may be due to underlying medical conditions that may cause fluid buildup such as congestive heart failure or end stage renal disease (ESRD), in addition to electrolyte imbalance disorders such as hyponatremia. Fluid restrictions amounts can vary according to the resident's condition and the physician's judgment.An admission Record indicated the facility admitted R4 on 10/03/2025. According to the admission Record, the resident had a medical history that included a diagnoses of chronic kidney disease and acute on chronic diastolic (congestive) heart failure. R4's Care Plan Report included a focus area initiated 10/03/2025, that indicated the resident was at nutritional risk. Interventions directed the staff to monitor meal intake percentage of food and fluids (initiated 10/04/2025) and provide a consistent carbohydrate diet with a 1500 milliliter (ml) fluid restriction (initiated 10/06/2025). R4's Order Summary Report for active orders as of 10/14/2025, revealed an order dated 10/03/2025, for a 1500 ml fluid restriction every shift.R4's Treatment Administration Record [TAR] for the timeframe 10/01/2025 - 10/31/2025, revealed documentation to indicate the resident consumed 910 ml of fluids on 10/05/2025, 1020 ml of fluids on 10/07/2025, 960 ml of fluids on 10/08/2025, 970 ml of fluids on 10/11/2025, and 1220 ml of fluids on 10/12/2025.R4's Meal Intake for the timeframe 10/03/2025 - 10/13/2025, revealed documentation to indicate the resident consumed 800 ml of fluids on 10/05/2025, 680 ml of 10/07/2025, 960 ml on 10/08/2025, 620 ml on 10/11/2025, and 620 ml on 10/12/2025.According to the R4's TAR and Meal Intake for 10/2025, the resident consumed 1710 ml of fluids on 10/05/2025, 1700 ml of fluids on 10/07/2025, 1920 ml of fluids on 10/08/2025, 1590 ml of fluids on 10/11/2025, and 1840 ml of fluids on 10/12/2025.During an interview on 10/14/2025 at 4:02 PM, the Registered Dietitian (RD) stated R4 admitted to the facility with a physician's order for a fluid restriction. The RD stated she calculated how much fluids nursing and dietary would provide. According to the RD, nursing would provide 780 ml per day and dietary would provide 720 ml per day. The RD stated she did not calculate or monitor the amount of fluids nursing provided but expected the nursing staff to monitor what they provided to the resident and make any necessary adjustments based on what the dietary staff provided. During an interview on 10/14/2025 at 5:17 PM, Registered Nurse Q stated she was aware R4 was on a fluid restriction, and she recorded what the resident received from nursing to include what the nurse aides reported to her the resident consumed during meals. During an interview on 10/15/2025 at 10:27 AM, Registered Nurse Unit Manager (RN UM) F stated when she administered medication during the day shift for residents on a fluid restriction, she documented the amount of fluids given to the resident on the resident's TAR. During an interview on 10/15/2025 at 11:59 AM, Licensed Practical Nurse (LPN) G stated when a resident was on a fluid restriction, she divided the total fluids allowed by three so that she would know how many ml of fluids could be provided per shift and recorded the amount of fluid provided during medication administration on the resident's TAR. LPN G stated she reminded the nurse aides to follow the fluids allowed as recorded on the resident's meal ticket. During an interview on 10/15/2025 at 1:15 PM, RN UM R stated for residents with fluid restrictions, the nurse was responsible for documenting on the resident's TAR the fluids given. RN UM R stated that he had not added up the total amount of fluids provided to R4 from medication administration and meals to make sure the fluid restriction was being followed. RN UM R stated he only monitored fluids a resident consumed if there was a change in the resident's condition, and his review only included the documentation on the TAR recorded by the nurse. RN UM R acknowledged his review did not include the documentation by the nurse aides of how much fluids the resident consumed during meals. During an interview on 10/15/2025 at 2:23 PM, the Director of Nursing (DON) stated because of the inconsistency and lack of monitoring, it was difficult to determine if staff provided R4 fluids per the physician's order. According to the DON, the nurse should monitor a resident's fluid intake to ensure their fluid needs were met per the physician's order.During a telephone interview on 10/14/2025 at 4:58 PM, the Medical Director (MD) stated R4 admitted to the facility with a physician's order for a 1500 ml fluid restriction. The MD stated based on the resident's medical history, he would not be concerned about the amount of fluids the resident consumed over the 1500 ml limit unless the resident had