

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/25/2026
NAME OF PROVIDER OR SUPPLIER GREEN BAY II AL OPERATIONS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 289 E SAINT JOSEPH ST GREEN BAY, WI 54301		
(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
N 000	Initial Comments On 06/19/2026, with information gathered through 06/25/2026, Surveyors conducted 5 complaint investigations at Green Bay II AL Operations in Green Bay. Two (2) of 5 complaints were substantiated. As a result of the survey, 2 deficiencies will be issued. Census: 57	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure injuries of unknown origin were investigated for Resident 2 and Resident 3. Resident 2 and Resident 3 both had injuries of unknown origin and did not have a complete investigation or documentation of an investigation. Findings include: On 06/02/2026, the Department received a complaint alleging the provider was not investigating resident injuries.	N 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 161	Continued From page 1 Resident 2 On 06/19/2026, Surveyor reviewed Resident 2's records including his/her Face sheet, Individual Service Plan (ISP) dated 05/07/2026, facility Care Notes (CN,) Medication Administration Record (MAR,) and Hospice Notes (HN.) Resident 2 was admitted to the facility on 04/08/2025 with diagnoses including dementia and osteoporosis. The ISP noted Resident 2 had limited ability to communicate, a history of falls, and was on hospice services. On 06/19/2026 at 11:00 AM, Surveyor interviewed Administrator A and Regional RN B. Administrator A described Resident 2 as frail, weighing 97 Lbs., and with limited ability to communicate. Administrator A stated Resident 2 sustained a broken hip some time between the evening of 05/30/2026 and morning of 05/31/2026. Administrator A stated Memory Care Director of Wellness (MCDW C) was responsible for conducting an investigation into the injury of unknown origin. Surveyor asked to review the documentation of the investigation. Administrator A did not provide Surveyor with a copy of an investigation but instead had MCDW C join the interview at 11:30 AM. On 06/19/2026 at 11:30 AM, Surveyor interviewed MCDW C, with Administrator A and Regional RN B present. When asked for a copy of the investigation into the injury of unknown origin for Resident 2, MCDW C stated no investigation was completed and therefore there was no documentation of an investigation to review. MCDW C stated s/he was aware injuries of unknown origin required an investigation to be completed but offered no explanation for why it was not done.	N 161		

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N 161	Continued From page 2 MCDW C recalled the events and stated the provider noticed a change in Resident 2's overall condition on 05/28/2026 and the hospice provider assessed the resident as beginning to transition to actively dying. MCDW C stated s/he was made aware by Caregiver E on 06/01/2026 that the hospice nurse who visited the morning of 05/31/2026 discovered Resident 2 to be in significant pain and ordered an x-ray which was completed on 06/01/2026, and confirmed Resident 2's had a left hip fracture. MCDW C stated s/he spoke with HR Director D who worked the evening before on 05/30/2026 and stated HR Director D told him/her no pain was noted on 05/30/2026 when Resident 2 was put to bed. MCDW C stated the resident's pain was first noticed by the hospice nurse the morning of 05/31/2026. MCDW C stated s/he did not interview the caregivers that worked overnight between 05/30/2026 and the morning of 05/31/2026. The provider had an incomplete investigation into Resident 2's injury of unknown origin, and did not document the investigation. Resident 3 On 06/19/2026, Surveyor reviewed Resident 3's records including his/her Face sheet, Individual Service Plan (ISP) dated 01/27/2026, facility Care Notes (CN,) Medication Administration Record (MAR,) and Hospice Notes (HN.) Resident 3 was admitted to the facility on 12/28/2023 with diagnoses including Neurocognitive disorder with lewy bodies. On 06/19/2026 at 11:00 AM, Surveyor interviewed Administrator A and Regional RN B. Administrator A described Resident 3 as being nonverbal with limited ability to communicate. Administrator A	N 161		

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N 161	Continued From page 3 stated it was noticed by hospice that Resident 3 had pain and swollen right wrist on 05/26/2026. Administrator A stated MCDW C was responsible for conducting an investigation into the injury of unknown origin. Surveyor asked to review the documentation of the investigation. Administrator A did not provide Surveyor with a copy of an investigation but instead had MCDW C join the interview at 11:30 AM. On 06/19/2026 at 11:30 AM, Surveyor interviewed MCDW C, with Administrator A and Regional RN B present. When asked for a copy of the investigation into the injury of unknown origin for Resident 3, MCDW C stated no investigation was completed and therefore there was no documentation of an investigation to review. MCDW C stated s/he was aware injuries of unknown origin required an investigation to be completed but offered no explanation for why it was not done. MCDW C recalled the events and stated s/he noticed Resident 3 had extreme upper body pain the morning of 05/26/2026 and called the hospice provider to assess the resident. On 05/25/2026 the hospice nurse noted in the HN that Resident 3 was in extreme pain and guarding his/her right wrist which was swollen. MCDW C stated s/he spoke with Caregiver E who worked the morning of 05/26/2026 but did not interview the caregivers that worked the previous pm shift on 05/25/2026 and overnight shift from 05/25/2026 into 05/26/2026. The provider did not complete an investigation into Resident 3's injury of unknown origin, and did not document an investigation. On 06/19/2026 at 12:00 PM, MCDW C,	N 161		

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N 161	Continued From page 4 Administrator A and Regional RN B all acknowledged the requirement for the provider to investigate the circumstances surrounding injuries of unknown origin and the need to promptly retroactively investigate and document the event surrounding Resident 2 and Resident 3's injuries to ensure current residents safety. The administrators stated they would take immediate steps to correct the deficient practice, and would investigate and submit any findings as required. On 06/25/2026 at 11:00 AM, Surveyor interviewed Regional RN B. When asked if the investigations were completed Regional RN B stated s/he would follow-up with MCDW C. On 06/25/2026 Surveyor received an e-mail from Regional RN B with MCDW C's statement regarding the status of the required retroactive investigations. MCDW C noted s/he started the investigation paperwork and was still in the process of gathering staff interviews.	N 161			
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received his/her medication as prescribed by his/her physician. the provider did not promptly address the antibiotic when it was entered into their system creating a delay of receiving the	N 352			

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N 352	Continued From page 5 medication of 3 days. The provider gave the resident 8/14 doses, stopped giving the medication for 3.5 days, and then resumed administering the medication without consulting the Resident's physician. The resident received 12 of the 14 total doses. The resident was admitted to the hospital with sepsis 3 days after the antibiotic was resumed. Findings include: Antibiotic Resistance - StatPearls - NCBI Bookshelf https://www.ncbi.nlm.nih.gov/books/NBK513277/ (Retrieval date, 06/25/2026) "Clinical Significance Antibiotic resistance has profound clinical and public health implications. Infections caused by resistant organisms often last longer, require second-line (or more toxic) therapies, prolong hospitalization, and result in higher mortality rates than infections caused by susceptible strains..." Antibiotics: Are you misusing them? - Mayo Clinic https://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/antibiotics/art-20045720 (Retrieval date, 06/25/2026) " ...you need to take the full treatment to kill the disease-causing bacteria. If you don't take an antibiotic as prescribed, you may need to start treatment again later. If you stop taking it, it can also promote the spread of antibiotic-resistant properties among harmful bacteria. ...Bacteria that survive an antibiotic treatment can multiply and pass on resistant properties. Also, some bacteria can pass on their drug-resistant properties to other bacteria.	N 352		

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N 352	Continued From page 6 -Use antibiotics only as prescribed by your health care provider. Take the prescribed daily amount. Complete the entire treatment. Tell your health care provider if you have any side effects. -Never take leftover antibiotics for a later illness. They may not be the correct antibiotic. And they likely don't include a full treatment course..." The Department received a complaint on 05/13/2026 that alleged a resident did not receive medication as prescribed. On 06/19/2026, Surveyor reviewed Resident 1's record and noted Resident 1 was admitted to the facility on 04/15/2021 with diagnoses including: type 2 diabetes with diabetic chronic kidney disease, heart failure, hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, stage 3 urinary tract infection and other bacterial infections of unspecified site. Surveyor reviewed an order from the pharmacy that was entered into the provider's electronic Medical Administrator Record (MAR) on 04/27/2026 and the order faxed to the provider on 04/30/2026. The order was from Resident 1's dentist dated 04/27/2026, for an oral antibiotic to be given 2 times daily for 7 days (14 doses) for an oral infection. On 06/19/2026 at 11:30 AM, Surveyor interviewed Administrator A and Regional RN B. Administrator A stated Resident 1 went to the dentist on 4/27/2026 and s/he believed upon return Resident 1 did not provide any follow-up discharge instructions or inform the provider that they should be expecting an order for an antibiotics from the dentist visit. Administrator A stated they received a fax from the pharmacy on 04/30/2026 and administered the first dose of the medication during the PM medication pass on	N 352		

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N 352	Continued From page 7 04/30/2026. On 06/25/2026 at 8:30 AM, Surveyor interviewed Resident 1. Resident 1 stated s/he returned from the dentist (unable to recall the exact date) and spoke with a staff member (unable to recall the staff person's name) telling them an antibiotic was ordered and gave them his/her discharge paperwork from the dentist office which noted s/he was ordered an antibiotic. Resident 1 said s/he was upset because it was a few days before the provider gave him/her his/her medication. Resident 1 said his/her doctor informed him/her that oral bacteria can cause infection in other areas of the body and with his/her chronic kidney disease the doctor was "shocked" s/he hadn't been on an antibiotic. Resident 1 stated the provider gave him/her a few doses of the antibiotic and then stopped. Resident 1 said s/he asked a staff member (unable to recall the staff person's name) and didn't get a clear answer as to why the medication stopped but was told something about the medication not being entered in or available to administer. Resident 1 stated a few days later s/he was given the medication again but by this time (05/8/2026-05/10/2026) s/he was "really feeling awful" and was admitted to the hospital for urosepsis. Resident 1 expressed great emotion stating his/her fear and that it was the sickest s/he had ever been. Resident 1 was admitted to the hospital on 05/10/2026 and as of 06/25/2026 is residing in a skilled nursing facility for rehabilitation with no plans of being able to return to the facility. On 06/24/2026, Surveyor received Resident 1's MAR. Surveyor noted the MAR showed the medication was given starting on the PM medication pass on 04/30/2026 and ended on the	N 352		

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N 352	Continued From page 8 PM medication pass on 05/04/2026, totaling 8/14 doses received (the AM dose on 04/01/2026 was marked with a "5" which per the MAR chart code indicated "Hold/ See progress notes." Surveyor reviewed Resident 1's progress notes and found no note related to why the medication was held) The MAR show the medication was stopped for 3.5 days and then resumed on the PM med pass of 05/08/2026 through the AM med pass on 05/10/2026 totaling 4 additional doses given prior to Resident 1 being admitted to the hospital for sepsis. Resident 1 received 12/14 doses total and with a gap in administration between the 8th and 9th dose of 3.5 days. On 06/25/2026 at 1:02 PM, Regional RN B e-mailed Surveyor regarding the timeline of administration of Resident 1's ordered antibiotics (ABX.): " ... In speaking with the team, here is the timeline on [Resident 1's] ABX 4/27- order sent to pharmacy and pushed into the MAR/delivered. Facility did not receive a copy of this order at the time. 4/30- pharmacy contacted to request the order THEY had received. Order was sent, received, and approved. However, the original start date the pharmacy put on the medication was next changed. So, they [sic] medication was to be for 7 days, but wasn't started until 4/30/26 actually, but was still set to end after the original 7 day supply was exhausted. This left several days of the medications remaining. 5/8/26- staff noted there were several ABX left and the med was no longer in the MAR. The order was manually entered into the MAR by [Assistant Director of Wellness X] to finish the supply of the medication. The doctor was not	N 352		

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N 352	Continued From page 9 contacted regarding this."	N 352			