

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 R-C 10/07/2026
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}	<p>Initial Comments</p> <p>On 10/07/2026, Surveyor conducted a verification visit at Green Bay II AL Operations LLC for Statement of Deficiency (SOD) 8Q9X11 and OEUL11. All deficient practices were verified as corrected, and no new deficient practices were identified.</p> <p>Under statutory provisions, a \$200 revisit fee is being assessed for the follow-up licensing visit.</p> <p>Census: 61</p>	{N 000}		

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

TITLE

(X6) DATE