STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017256	A. BUILDING: _____ B. WING _____	C 01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARATON COMMONS GREEN BAY 2	655 WOODSIDE RD GREEN BAY, WI 54311

(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 10/16/2024 with additional information obtained through 01/03/2025, Surveyor conducted 2 complaint investigations and 1 self-report at Caraton Commons Green Bay II. As a result, 2 complaints were unsubstantiated, and 1 deficiency was identified. Census: 14	N 000		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure there were employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. Findings include: The provider is licensed as a Class CNA (non-ambulatory) CBRF to provide care for residents who may be physically disabled, terminally ill, advanced age and/or have irreversible dementia/Alzheimer's disease. At the time of survey, 12 residents resided at the facility. On 05/15/2024, the department received a self-report indicating the facility was left unattended for 2 hours and 20 minutes. On 10/16/2024, at approximately 10:45 AM, Surveyor interviewed Director A. Director A reported on 05/12/2024, Caregiver C worked until 10:20 PM and left the facility before confirming	N 396		

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
	0017256	A. BUILDING: _____ B. WING _____	C 01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARATON COMMONS GREEN BAY 2	655 WOODSIDE RD GREEN BAY, WI 54311

(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 396	Continued From page 1	N 396		

the presence of an overnight staff. Director A stated Resident 1 heard call alarms not being attended to. Resident 1 confirmed there was no overnight staff onsite and notified Caregiver G at the sister facility at 12:01 AM on 05/13/2024. Caregiver G called Assistant Director B (AD-B) immediately to notify him/her no overnight staff were present at the sister facility.

On 10/16/2024, at approximately 10:55 AM, Surveyor interviewed Assistant Director B (AD-B). AD-B explained s/he received a phone call from Caregiver G notifying him/her no overnight staff were present at the sister facility at approximately 12:01 AM on 05/13/2024. AD-B stated s/he arrived at the facility at 12:40 AM on 05/13/2024. AD-B stated s/he completed rounds to ensure all residents were cared for appropriately, including toileting, repositioning, and medication needs. AD-B remained at the facility until the morning caregiver arrived for his/her shift.

On 01/03/2025, Surveyor reviewed residents' Individual Service Plans (ISP) and Care Plans and noted 4 of 12 residents have needs that required the presence of an overnight staff.

RESIDENT 2:
On 01/03/2025, at 9:03 AM, Surveyor reviewed Resident 2's ISP dated 04/05/2024 and Care Plan updated 11/19/2024. The Care Plan specified the following diagnosis: Hemiplegia and hemiparesis (medical condition that causes paralysis or weakness on one side of the body) following cerebral infarction (also known as an ischemic stroke, is a serious condition that occurs when blood flow to the brain is blocked, causing an area of tissue death in the brain) affecting right side, Muscle wasting and atrophy, (decrease in muscle mass and strength) Muscle weakness

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017256	A. BUILDING: _____ B. WING _____	C 01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARATON COMMONS GREEN BAY 2	655 WOODSIDE RD GREEN BAY, WI 54311

(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 396	Continued From page 2 (generalized), Other abnormalities of gait and mobility, Unspecified mood affective disorder, and Restless legs syndrome. The ISP further noted Resident 2 uses a wheelchair for mobility and 1 to 2 staff assist with a gait belt for transfers. Additionally, Resident 2 is at risk for falls due to his/her diagnoses, impaired mobility, and fall history. RESIDENT 3: On 01/03/2025, at 9:20 AM, Surveyor reviewed Resident 3's ISP dated 11/19/2024 and Care Plan updated 11/19/2024. The Care Plan specified the following diagnosis: Hemiplegia and hemiparesis (medical condition that causes paralysis or weakness on one side of the body) following cerebral infarction (also known as an ischemic stroke, is a serious condition that occurs when blood flow to the brain is blocked, causing an area of tissue death in the brain) affecting left non-dominant side, Monoplegia (a condition characterized by paralysis or weakness in only one limb) of upper limb affecting right dominant side, Muscle weakness (generalized), Unsteadiness on feet, Difficulty in walking, not elsewhere classified. The ISP further noted Resident 3 uses a wheelchair for mobility and 2 Staff assist using a Hoyer for all transfers. Additionally, Resident 3 is at risk for falls due to his/her diagnoses and impaired mobility. RESIDENT 4: On 01/03/2025, at 9:40 AM, Surveyor reviewed Resident 4's ISP dated 03/25/2024 and Care Plan updated 05/13/2024. The Care Plan specified the following diagnosis: Cognitive communication deficit, history of falling, other abnormalities of gait and mobility, unspecified dementia with behavioral disturbance, unspecified psychosis not due to a substance or known physiological	N 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017256	A. BUILDING: _____ B. WING _____	C 01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARATON COMMONS GREEN BAY 2	655 WOODSIDE RD GREEN BAY, WI 54311

(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 396	Continued From page 3	N 396		

condition, and muscle weakness. The ISP further noted Resident 4 uses a broad chair for mobility requiring staff assistance and 2 Staff assist using a Hoyer for all transfers. Additionally, Resident 4 is at risk for falls due to his/her diagnoses, medications, and impaired mobility.

RESIDENT 5:
On 01/03/2025, at 10:20 AM, Surveyor reviewed Resident 5's ISP dated 01/18/2024 and Care Plan updated 01/31/2024. The Care Plan specified the following diagnosis: Difficulty in walking, not elsewhere classified, muscle weakness (generalized), spinal stenosis, (narrowing of the spinal canal that compresses the spinal cord and nerve roots, causing pain, numbness, or weakness in the arms or legs), need for assistance with personal care, and Psychophysiologic insomnia (a sleep disorder that involves a combination of heightened arousal and learned associations that make it difficult to fall asleep). The ISP further noted Resident 5 uses a motorized wheelchair for mobility and 2 staff assist using a Hoyer for all transfers. Additionally, Resident 5 is at risk for falls due to his/her diagnoses, medications, and impaired mobility.

On 10/17/2024, at approximately 7:55 AM, Surveyor reviewed the facility's caregiver schedule. The schedule indicated the following: Caregiver C scheduled from 2:00 PM - 10:00 PM on 05/12/2024. Caregiver D scheduled from 10:00 PM -11:59 PM on 05/12/2024 and 12:00 AM - 6:00 AM on 05/13/2024. Caregiver E scheduled as a float to assist between both sister facilities from 10:00 PM -11:59 PM on 05/12/2024 and 12:00 AM - 6:00 AM on 05/13/2024.

On 01/03/2025, at 2:52 PM, Surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017256	A. BUILDING: _____ B. WING _____	C 01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARATON COMMONS GREEN BAY 2	655 WOODSIDE RD GREEN BAY, WI 54311

(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 396	Continued From page 4 Director of Operations F (DOO-F) DOO-F confirmed on 05/12/2024, Caregiver E was scheduled to work as a float between both facilities for the overnight shift, but Caregiver E called in sick prior to his/her shift. Caregiver C worked from 2:00 PM - 10:00 PM, left the facility at 10:20 PM, prior to confirming staff had arrived for the overnight shift. Caregiver C's employment was terminated on 05/13/2024 and the incident was reported to the Office of Caregiver Quality. DOO-F explained Caregiver D was not scheduled for the overnight shift as the schedule indicated. DOO-F explained no replacement staff was scheduled for the float staff who called in sick and no staff was scheduled for the overnight shift. DOO-F stated Management scheduled a staff meeting to re-educate all staff on resident abuse, neglect, and expectations of resident care to ensure there are always 3 caregivers on every shift to manage the two facilities.	N 396		