STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016530	A. BUILDING: _____ B. WING _____	C 01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE (THE)	330 ARBOR POINT AVE WEST BEND, WI 53095

(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 From 01/02/2024 to 01/03/2024, Surveyor conducted a complaint investigation and self-report review at Cornerstone (The), a CBRF in West Bend. Two deficiencies were identified. The complaint was substantiated. The self-report review resulted in 0 deficiencies. Census: 9	N 000		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 received prompt and adequate treatment after sustaining a left humerus fracture from a fall on 08/21/2023. Findings include: On 01/02/2024, Surveyor conducted a complaint investigation that alleged the facility did not seek proper treatment after a resident sustained a fall. On 01/02/2024 at approximately 9:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 was admitted to the provider's facility on 09/20/2022 with a diagnosis of Alzheimer's disease. Resident 1's record included a fall report	N 353		

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
	0016530	A. BUILDING: _____ B. WING _____	C 01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE (THE)	330 ARBOR POINT AVE WEST BEND, WI 53095

(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 353	Continued From page 1	N 353		

that documented Resident 1 fell on 08/21/2023 at 4:50 p.m. The report documented that Resident 1 complained of pain and discomfort to his/her left elbow. Resident 1's physician orders included an order for Acetaminophen 325 mg (Start Date: 09/20/2022) - "Take 2 tablets every 4 hours as needed for pain/fever." Resident 1's August 2023 Medication Administration Record (MAR) did not document administration of Acetaminophen PRN following Resident 1's fall on 08/21/2023. Resident 1's scheduled medications did not include any pain medications. The fall report documented Resident 1 declined being sent out for evaluation until his/her family member visited. The fall report documented Resident 1's family member was notified of the fall at 7:00 p.m., 2 hours after the fall. Records documented Resident 1's family member visited at approximately 8:15 p.m. at which time the request to have Resident 1 sent out for evaluation was made. A hospital report, dated 08/21/2023, documented Resident 1 was diagnosed with a displaced distal humerus fracture and prescribed Tylenol PRN, Norco PRN and a Lidoderm patch for pain.

On 01/02/2024 at approximately 11:00 a.m., Surveyor interviewed Licensee A regarding Resident 1's 08/21/2023 fall and treatment. Licensee A stated Resident 1's post-fall assessment was completed by Former Nurse C. Licensee A was unable to locate documentation regarding pain control following Resident 1's fall.

On 01/02/2024 at approximately 1:10 p.m., Surveyor interviewed Caregiver D regarding Resident 1's 08/21/2023 fall. Caregiver D stated s/he didn't witness Resident 1's fall but did work that day. Caregiver D stated Resident 1 was in pain, but Former Nurse C completed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016530	A. BUILDING: _____ B. WING _____	C 01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE (THE)	330 ARBOR POINT AVE WEST BEND, WI 53095

(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 353	Continued From page 2 assessment. Caregiver D stated s/he was responsible for medication administration after Former Nurse C left after dinner time. Caregiver D stated s/he did not recall administrating any PRN medications. Caregiver D stated s/he followed management's instructions and had Resident 1 sent out after Resident 1's family member visited. On 01/02/2023 at approximately 3:00 p.m., Surveyor reviewed a paramedic report, dated 08/21/2023. The report documented injury to Resident 1's left elbow was apparent. The report stated, "911 was not called and [Resident 1] was not transported at discretion of the assisted living facility staff and [Resident 1] remained at the facility until approximately 845 when [paramedics] transported [Resident 1] to the hospital ... [Resident 1's] physical exam was performed and [Resident 1] localized their pain to their left elbow by crying out in pain. There was obvious discoloration and deformity at the left elbow." On 01/02/2023 at approximately 4:30 p.m., Surveyor discussed concern with Licensee A that Resident 1 sustained a fall on 08/21/2023 at approximately 4:50 p.m. and exhibited pain to his/her left upper extremity, but was not treated for pain until s/he was sent to the hospital at approximately 8:45 p.m. and diagnosed with a left humerus fracture. Licensee A stated s/he would follow up with staff to discuss pain control.	N 353		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016530	A. BUILDING: _____ B. WING _____	C 01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE (THE)	330 ARBOR POINT AVE WEST BEND, WI 53095

(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 389	Continued From page 3 service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 individual service plans (ISPs) reviewed were updated when there was a change in the resident's physical condition. Resident 1's ISP was not updated to include his/her risk for falls. Findings include: On 01/02/2024 at approximately 9:30 a.m., Surveyor reviewed Resident 1's record. Resident 1 admitted to the provider's facility on 09/20/2022. Resident 1's admission assessment, dated 09/20/2022, identified Resident 1 as a fall risk. Resident 1's record included the following: - Hospital report, dated 11/27/2022, that documented Resident 1 sustained facial fractures following a fall. - Physician fax, dated 03/09/2023, that documented Resident 1 had a fall with no injuries. - Fall report, dated 08/21/2023, that documented Resident 1 had a fall which resulted in a left humerus fracture. *Resident 1 was hospitalized following 08/21/2023 fall and passed away at the hospital	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016530	A. BUILDING: _____ B. WING _____	C 01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE (THE)	330 ARBOR POINT AVE WEST BEND, WI 53095

(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 389	Continued From page 4 on 08/23/2023. Resident 1's ISP, dated 12/13/2022, did not document Resident 1 as a fall risk or identify needs related to being a fall risk. On 01/02/2024 at approximately 11:00 a.m., Surveyor interviewed Licensee A and Administrator B regarding Resident 1's history of falls. Surveyor asked both Licensee A and Administrator B if Resident 1 had an ISP that indicated s/he was a fall risk. Administrator B asked how many falls would indicate a resident was a fall risk. Licensee A replied, "After 1 fall they should be identified as a fall risk." Licensee A reviewed Resident 1's ISP and confirmed the ISP did not include Resident 1's risk for falls. Licensee A explained the facility had already identified areas for quality improvement within the facility and had recently made staffing changes to address the concerns.	N 389		