

Wisconsin Department of Health Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0016530</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>07/25/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CORNERSTONE (THE)</b> |                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>330 ARBOR POINT AVE<br/>WEST BEND, WI 53095</b> |                                                                                                                          |                                                                |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                       |
| {N 000}                                                      | <p>Initial Comments</p> <p>On 07/25/2023, Surveyor conducted a verification visit and one (1) complaint investigation at Cornerstone (The). As a result of the survey, previous deficiency was corrected, one complaint was unsubstantiated and no new deficiencies were identified.</p> <p>Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed.</p> <p>Census: 10</p> | {N 000}                                                                                     |                                                                                                                          |                                                                |

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

TITLE

(X6) DATE