

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012525	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER CORNERSTONE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1521 W 2ND AVE PORT WASHINGTON, WI 53074		
(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 08/12/2024 with additional information gathered through 08/13/2024, Surveyor conducted an abbreviated survey at Cornerstone Group Home. One deficiency was identified. Census: 8	N 000		
N 406	83.37(1)(g) Disposition of medications. Disposition of medications. 1. When a resident is discharged, the resident ' s medications shall be sent with the resident. 2. If a resident ' s medication has been changed or discontinued, the CBRF may retain a resident ' s medication for no more than 30 days unless an order by a physician or a request by a pharmacist is written every 30 days to retain the medication. 3. The CBRF shall develop and implement a policy for disposing unused, discontinued, outdated, or recalled medications in compliance with federal, state and local standards or laws. The CBRF shall arrange for the stored medications to be destroyed in compliance with standard practices. Medications that cannot be returned to the pharmacy shall be separated from other medication in current use in the facility and stored in a locked area, with access limited to the administrator or designee. The administrator or designee and one other employee shall witness, sign, and date the record of destruction. The record shall include the medication name, strength and amount. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure outdated medications for 4 sampled residents were	N 406		

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

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012525	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER CORNERSTONE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1521 W 2ND AVE PORT WASHINGTON, WI 53074		
(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 406	Continued From page 1 separated from other medications in current use in the facility. Findings include: On 08/12/2024 at approximately 11:40 AM, Surveyor observed the facility medication cart and Resident 1, Resident 2, Resident 3, and Resident 4's medications. Surveyor observed the following 8 medications that possessed a "Use By" date prior to 08/12/2024: Resident 1 One medication card containing 12 half tablets of Clonazepam 0.5 MG that expired on 03/08/2024. On 08/14/2024, Surveyor reviewed Resident 1's medication administration record (MAR) provided by Program Manager B. Surveyor found evidence that expired Clonazepam 0.5 MG half tablet was administered to Resident 1 on 03/18/2024 and 04/16/2024. Resident 2 One medication card containing 7 tablets of Acetaminophen 500 MG that expired on 06/27/2024. On 08/14/2024, Surveyor reviewed Resident 2's MAR. Surveyor found evidence that expired Acetaminophen 500 MG was administered to Resident 2 on 06/28/2024. Resident 3 Two bottles of Fluticasone 50 MCG nasal spray that expired on 06/07/2023 and 07/13/2024. One medication card containing 30 capsules of Benzonatate 200 MG that expired on 12/22/2023. One medication card containing 20 tablets of Acetaminophen 500 MG that expired on 12/19/2023. One bottle of Olopatadine 0.1% DRO eye drops that expired on 08/02/2024.	N 406		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0012525	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER CORNERSTONE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1521 W 2ND AVE PORT WASHINGTON, WI 53074		
(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 406	Continued From page 2 On 08/14/2024, Surveyor reviewed Resident 3's MAR and found evidence that expired Benzonatate 200 MG was administered to Resident 3 on 08/12/2024. Resident 4 One medication card containing 20 tablets of Acetaminophen 500 MG that expired on 06/13/2024. On 08/12/2024 at approximately 12:40 PM, Surveyor interviewed Program Director B. Program Director B acknowledged the expired medications observed in the medication cart. On 08/12/2024 at approximately 12:45 PM, Surveyor interviewed House Manager A. House Manager A acknowledged the expired medications in the medication cart and stated s/he would ensure the medications were removed and destroyed promptly.	N 406		