STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0009779	A. BUILDING: _____ B. WING _____	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIL STONE RIDGE	504 NIKKI LN FORT ATKINSON, WI 53538

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M 000	INITIAL COMMENTS On 03/18/2025, with information gathered through 03/20/2025, Surveyor conducted an abbreviated licensure survey. Four deficiencies were identified. Census: 3	M 000		
M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the adult family home's physical environment was safe, well maintained, and appropriate to provide a homelike environment to residents. Findings include: On 03/18/2025, at approximately 11:45 AM, Surveyor toured the home with Service Coordinator A and Direct Support Supervisor B. Surveyor observed in the hallway, to the resident bedrooms, 5 circular holes in the wall material. Three of the holes appeared to be approximately 12 inches in diameter and 2 appeared to be approximately 6 inches in diameter. Service Coordinator A explained that Resident 3 had created the holes during moments of displaying aggressive behavior. Service Coordinator A stated that Resident 3 had moved out of the	M 276		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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M 276	Continued From page 1 home in 12/2024. Service Coordinator A stated the wall material was going to be replaced with a heavier material, so that it was not easily damaged, but s/he was not sure when maintenance would be making those repairs.	M 276		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 resident's (Resident 1, Resident 2) Individual Service Plan (ISP) were reviewed at least once every six months by the provider, the resident and/or resident's guardian, and/or the placing agency. Findings include:	M 424		

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M 424	Continued From page 2 On 03/18/2025, Surveyor reviewed Resident 1's and Resident 2's record. Resident 1 moved into the home on 08/24/2022. Resident 1's record contained an ISP dated 08/21/2024. Resident 1's record was due to be reviewed in 02/2025. Resident 2 moved into the home on 01/31/2022. Resident 2's record contained an ISP dated 05/09/2024. Resident 2's record was due to be reviewed in 11/2024. On 03/18/2025, at approximately 12:00 PM, Surveyor reviewed Resident 1's and Resident 2's ISPs with Service Coordinator A. Service Coordinator A stated the ISPs should have been reviewed every 6 months.	M 424		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it. This Rule is not met as evidenced by:	M 556		

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M 556	Continued From page 3	M 556		

Based on observation, record review, and interview, the provider did not ensure the right to freedom of choice for 2 of 2 residents in the home.

Resident 1's and Resident 2's bedroom windows were covered with a plexiglass frame to prevent full access to the opening of the window, and cranks were not available for residents to open the windows.

Findings include:

The provider is licensed to care for up to 4 residents in the client groups developmentally disabled and emotionally disturbed/mental illness.

On 03/18/2025, at approximately 12:00 PM, Surveyor toured the provider's home with Service Coordinator A and Direct Support Supervisor B. Surveyor observed that Resident 1's and Resident 2's rooms had 2 windows, which were covered with a plexiglass frame that left approximately a 12-inch section, from the bottom of the window frame, that allowed air to travel through, if the windows were open. The windows required cranks for opening. The cranks were not present on the windows. Direct Support Supervisor B stated the residents often took the cranks off the windows and additional cranks could be ordered. Surveyor asked if a waiver had been filed with the department regarding limited access to the resident's windows. Service Coordinator A stated s/he was unsure and would need to follow up with the corporate office.

On 03/18/2025, Surveyor reviewed Resident 1's and Resident 2's record.

Resident 1 moved into the home 08/24/2022.

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Resident 1's "Individual Service Plan (ISP)," dated 08/21/2024, documented:
"Capacity for self direction: Needs assistance."
"Physical Disabilities: [Resident 1] has no physical disabilities."
"Restrictive Measures: [Resident 1] has no current restrictive measures."
"Wandering/Elopement: [Resident 1] does not have a history of wandering or elopement away from home."
"Destructive of Property or Self, Physically or Mentally Abusive: Behaviors are dependent on [his/her] mood. At times [s/he] is content and other times [s/he] is "go, go, go." [Resident 1] can be aggressive and non-compliant with cares, at times."

Resident 2 moved into the home 01/31/2022.
Resident 2's ISP, dated 05/09/2024, documented:
"Capacity for self direction: Makes Needs Known."
"Restrictive Measures: [Resident 2] has no current restrictive measures."
"Wandering/Elopement: [Resident 2] has a history of eloping when [s/he] becomes agitated and needs to be supervised while in the community for safety concerns. [Resident 2's] current eloping is that [s/he] will go out and sit in the driveway or will go sit on the next door front door chair."
"Self-Abusive Behavior: [Resident 2] will pound on windows, walls, doors or anything [s/he] chooses."
"Destructive of Property or Self, Physically or Mentally Abusive: [Resident 2] may be physically aggressive to objects and people when agitated or looking for attention."
"Aggressive/Combative: [Resident 2] may become aggressive and combative when [s/he] is agitated, frustrated, or over stimulated."

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M 556	Continued From page 5 Resident 1's and Resident 2's ISPs did not document concerns regarding the window cranks being placed on the windows or the requirement for Plexi material to cover a portion of the window. On 03/18/2025, Surveyor reviewed the department's facility folder and did not observe a waiver for limited window access in resident rooms.	M 556		
M 574	88.10(3)(n)1 Freedom From Seclusion and Restraints Except as provided in subd. 2, to be free from seclusion and from all physical and chemical restraints, including the use of an as-necessary (PRN) order for controlling acute, episodic behavior. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 3 of 3 residents were provided the ability to make decisions related to care and activities. The exit doors were controlled with a mag locking system which blocked residents from leaving the facility. Findings include: On 03/18/2025, at approximately 11:30 AM, Surveyor toured the home with Resident Aide C. Resident Aide C pointed out that the exit doors were controlled with a magnetic locking system due to resident behaviors.	M 574		

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M 574	Continued From page 6 On 03/18/2025, at approximately 12:00 PM, Surveyor interviewed Service Coordinator A and Direct Support Supervisor B and asked if the provider had a waiver for the mag locking system. Service Coordinator A stated s/he would need to contact the corporate office. Service Coordinator A stated the residents in the home had been approved for a magnetic locking system from their supporting mental health program. Service Coordinator A stated a waiver had not been submitted. "A magnetic door strike relies on two parts: a magnet that is mounted to the door, and an armature door lock strike plate that is mounted to the door frame. With an electric field energizing the magnet in the door lock, a magnetic field is created that secures the armature lock and magnet in place. The magnetic door strike must be de-energized to open the door and fire the magnetic release latch, which breaks the field and moves the plate away from the mechanic. This can be achieved by a variety of methods including a card reader, keypad, or key fob. (Source: Avigilon website, Guide to Electromagnetic Door Locks and Comparing Magnetic vs. Electric Strikes, 2024, https://www.avigilon.com/blog/electric-vs-magnetic-strike-locks (retrieval date - March 18, 2025).) On 03/18/2025, Surveyor reviewed Resident 1's and Resident 2's record. Resident 1 moved into the home on 08/24/2022. Resident 1's "Protocol - Utilization of Magnetic Exit Locks," undated, documented: "Use this protocol if [Resident 1] demonstrates the need for a locked environment to maintain health and safety. This protocol will address [Resident 1's] safety and criteria for the use of a	M 574		

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magnetic lock system. ... Preventative interventions will be utilized until [Resident 1] poses a significant risk of harm to [him/herself] or others. ... Elopement with the intent to injure self as determined by known historical actions or body language would indicate the intent to harm. ... When only one staff is in the house and they are using the restroom they will engage the magnetic locks for the duration of time they are in the restroom. The magnetic locks will be used at all times when staff are using the restroom to ensure [Resident 1] does not leave the home while staff are using the restroom."

Resident 2 moved into the home on 01/31/2022. Resident 2's "Protocol - Utilization of Magnetic Exit Locks," undated, documented:
"Use this protocol if [Resident 2] demonstrates the need for a locked environment to maintain health and safety. This protocol will address [Resident 1's] safety and criteria for the use of a magnetic lock system. ... Preventative interventions will be utilized until the individual poses a significant risk of harm or [s/he] is attempting to elope from the home without safety awareness or in search of alcohol or other drugs. ... When only one staff is in the house staff will magnetically lock the house when utilizing the restroom."

On 03/18/2025, at approximately 12:30 PM, Surveyor interviewed Service Coordinator A. Service Coordinator A stated Resident 1 and Resident 2 did not require a mag locking system and removed the remote controller for the system from the resident aide's house keys.

On 03/18/2025, Surveyor reviewed the department facility files and did not observe a waiver for a magnetic locking system.

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