STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018872	A. BUILDING: _____ B. WING _____	C 05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPPING STONE GROUP HOME LLC	111 WEST HIGHLAND DRIVE GRAFTON, WI 53024

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M 000	INITIAL COMMENTS On 05/06/2025, Surveyor conducted a standard survey and one (1) complaint investigation. Additional information was gathered through 05/12/2025. As a result of the survey, six (6) deficiencies were identified, 1 complaint was unsubstantiated. Census: 3	M 000		
M 290	88.05(3)(e)2.b INSPECTIONS-GAS FURNACE A gas furnace shall be inspected and serviced every 3 years by a heating contractor or local utility company. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the gas furnace was inspected by a heating contractor or local utility company at least every 3 years for 1 of 1 furnace. Findings include: On 05/06/2025 at 10:30 AM, Surveyor requested to review facility's most recent furnace inspection. Caregiver A stated Surveyor would need to request this from Licensee B. On 05/06/2025 at approximately 10:45 AM, Admin Assistant (AA) C stated s/he would have Licensee B send the furnace inspection to Surveyor. On 05/06/2025 at 4:45 PM, Surveyor received an email from Licensee B. Surveyor observed a Heating System sheet, however there was no date on this sheet. Surveyor reviewed the facility folder and observed the identical sheet in the	M 290		

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

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M 290	Continued From page 1 facility folder with an invoice from 12/30/2021. On 05/07/2025 at 1:38 PM, Surveyor emailed Licensee B requesting documentation a furnace inspection had been completed in 2024. On 05/07/2025 at 2:17 PM, Surveyor received an email from Licensee B stating, "I can't seem to locate the bill or anything else with a date. I will just find someone to come out asap to do another one for us." The provider did not ensure the gas furnace was inspected by a heating contractor of local utility company at least every 3 years.	M 290		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the licensee did not ensure there was a smoke detector on the ceiling of each sleeping room and in the	M 334		

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M 334	Continued From page 2 basement. Findings include: The provider is licensed to provide care for up to 4 ambulatory residents that may be emotionally disturbed/mental illness, traumatic brain injury, developmentally disabled, advanced age and/or irreversible dementia/Alzheimer's. On 05/06/2025 at 10:00 AM, Surveyor toured the home and observed there was no smoke detector in the hallway and the basement did not have a smoke detector on the ceiling. On 05/12/2025 at 2:43 PM, Surveyor interviewed Licensee B. Licensee B stated s/he will install a smoke detector in the hallway and on the ceiling in the basement.	M 334		
M 344	88.05(4)(d)2.a FIRE SAFETY EVACUATION PLAN REVIEW The licensee shall review the fire safety evacuation plan with each new resident immediately following placement and shall evaluate the resident using a form provided by the department to determine whether the resident is able to evacuate the home without any help within 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed (Resident 3) was evaluated within 3 days of admission for evacuation time, using the	M 344		

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M 344	Continued From page 3 Department's form. Findings include: On 05/06/2025, Surveyors reviewed Resident 3's record and identified the following: Resident 3 was admitted to the facility on 04/04/2023. Resident 3 did not have evidence of a fire safety evacuation plan completed within 3 days of admission. Surveyor observed an evacuation plan form in his/her record to be blank. On 05/06/2025 at approximately 10:30 AM, Surveyors interviewed Caregiver A. Caregiver A acknowledged the form had not been completed within 3 days of admission. On 05/12/2025 at 2:43 PM, Surveyor interviewed Licensee B. Licensee B stated s/he will do a new packet for all residents to ensure all documentation is complete. The provider did not ensure the fire safety evacuation plan was completed within 3 days of admission.	M 344		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes.	M 346		

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M 346	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 3 residents were evaluated annually for evacuation capabilities. Findings include: On 05/06/2025, Surveyor reviewed Resident 1, Resident 2 and Resident 3's record. Resident 1 was admitted on 02/02/2022. Surveyor observed Resident 1 had a completed evacuation form in his/her record dated 01/31/2022. Resident 2 was admitted on 02/02/2022. Surveyor observed Resident 2 had a completed evacuation form in his/her record dated 01/31/2022. Resident 3 was admitted on 04/04/2023. Surveyor did not observe Resident 3 to have a completed evacuation form in his/her record. On 05/06/2025 at 10:45 AM, Surveyor interviewed Admin Assistant (AA) C. AA C stated s/he was unaware evacuation forms needed to be completed annually. AA C stated s/he will talk to Licensee B. On 05/12/2025 at 2:43 PM, Surveyor interviewed Licensee B. Licensee B stated s/he was unaware the evacuation form had to be completed annually if residents had no change. Licensee B stated s/he will do a new packet for all residents to ensure all documentation is complete.	M 346		

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M 424	Continued From page 5	M 424		
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 3 of 3 individual service plans (ISPs) reviewed were updated at least once every 6 months. Findings include: On 5/06/2025 at approximately 10:00 AM, Surveyor reviewed resident ISPs: Resident 1 was admitted on 02/02/2022. Surveyor observed Resident 1's record included an ISP dated March 2024, there were no signatures or date completed on the form, and no additional ISPs since March 2024.	M 424		

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M 424	Continued From page 6 Resident 2 was admitted on 02/02/2022. Surveyor observed Resident 2's record included an ISP dated March 2024, there were no signatures or date completed on the form. Surveyor observed an ISP from May 2023, signed by Licensee B on 05/18/2023. Resident 3 was admitted on 04/04/2023. Surveyor observed Resident 3's record included an ISP dated March 2024, there were no signatures or date completed on the form. Surveyor observed an ISP from May 2023, signed by Licensee B on 05/18/2023. On 05/12/2025 at approximately 2:43 PM, Surveyor interviewed Licensee B. Licensee B stated s/he does update ISPs but acknowledged s/he did not have all parties' sign. Licensee B stated s/he thought the ISPs had been updated. Licensee B stated s/he will do a new packet for all residents to ensure all documentation is complete. The provider did not ensure 3 of 3 ISPs reviewed were updated at least once every 6 months.	M 424		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident	M 570		

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M 570	Continued From page 7 because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not safeguard residents who cannot fully guard themselves from environmental hazards. The provider did not ensure the dryer vent was made of rigid venting. Findings include: The provider is licensed to provide care for up to 4 ambulatory residents that may be emotionally disturbed/mental illness, traumatic brain injury, developmentally disabled, advanced age and/or irreversible dementia/Alzheimer's. According to FEMA (Federal Emergency Management Agency), "Facts about home clothes dryer fires...2,900 home clothes dryer fires are reported each year and cause an estimated 5 deaths, 100 injuries, and $35 million in property loss...Maintenance-Inspect the venting system behind the dryer to ensure it is not damaged or restricted. Put a covering on outside wall dampers to keep out rain, snow and dirt. Make sure the outdoor vent covering opens when the dryer is on. Replace coiled-wire foil or plastic venting with rigid, non-ribbed metal duct. (Source: https://www.usfa.fema.gov/prevention/outreach/clothes_dryers.html (Retrieval date 11/18/2024))" On 05/06/2025 at 10:00 AM, Surveyor toured the provider's home and observed the venting to the home's dryer was made of semi-rigid material, creating a safety hazard. Caregiver A stated Surveyor would need to talk to Licensee B.	M 570		

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M 570	Continued From page 8 On 05/12/2025 at 2:43 PM, Surveyor interviewed Licensee B and shared the code. Licensee B acknowledged the rigid metal requirement and s/he will have it fixed.	M 570		