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	0020184	A. BUILDING: _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STABLE LIVING LLP 2603 KANE RD	**2603 KANE RD EAU CLAIRE, WI 54703**

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M 000	INITIAL COMMENTS On 12/10/2024, Surveyor conducted a complaint investigation at Stable Living LLP 2603 Kane Rd. Data collection continued through 12/19/2024. The complaint was substantiated. One deficiency was identified. Census: 4	M 000		
M 218	88.04(2)(b) AWAKE STAFF FOR CONTINUOUS CARE The licensee shall ensure that he or she or a service provider is present and awake at all times if any resident is in need of continuous care. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure awake staff was provided at night for continuous care residents. Findings include: The provider is licensed to care for 4 residents from the following client groups: traumatic brain injury, developmentally disabled, alcohol/drug dependent, emotionally disturbed/mental illness, and correctional clients. DHS 88 defines continuous care as "The need for supervision, intervention or services on a 24-hour basis to prevent, control and ameliorate a constant or intermittent mental or physical condition which may break out or become critical during any time of the day or night. Note: Examples of persons who need continuous care	M 218		

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

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are wanderers, persons with irreversible dementia, persons who are self abusive or who become agitated or emotionally upset and persons whose changing or unstable health condition requires monitoring."

On 10/17/2024, the department received a complaint related to staff supervision of residents.

On 12/10/2024, at approximately 1:40 PM, Surveyor interviewed Executive Director (ED) A. When asked about staffing ratios, ED A stated the provider had 1 staff per shift. ED A stated the daytime shift was typically 9:00 AM to 5:00 PM and the overnight shift was typically 5:00 PM to 9:00 AM. ED A stated the overnight shift allowed for staff to sleep. ED A stated the provider had a lot of staffing issues in October 2024 and had multiple staff resign around the same time. ED A stated they had staff work overtime and management would step in when needed.

At approximately 1:50 PM, Surveyor requested staff schedules from ED A. ED A stated s/he had to contact their Human Resources representative as staff schedules were maintained electronically.

At 2:06 PM, Surveyor interviewed Resident 3. When asked if staff were always available when needed, Resident 3 stated there was 1 time when s/he woke from a nap and realized nobody was in the home. Resident 3 stated staff had to go pick up a resident that lived next door. The home was connected to another adult family home owned by the same licensee. Resident 3 stated s/he realized it when s/he noticed the vehicle was gone. When asked if Resident 3 had any concerns, Resident 3 stated s/he sometimes felt threatened and intimidated by Resident 2.

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M 218	Continued From page 2 At approximately 2:15 PM, Surveyor interviewed ED A. ED A stated the provider had disgruntled staff who were not happy about certain residents. ED A stated it did not end well, and multiple staff resigned at the same time. ED A stated they let go of House Manager (HM) D around that time. ED A stated HM D received write-ups for his/her performance issues. When asked about Resident 3's report of staff being unavailable due to a next-door resident's transportation needs, ED A stated Resident 3 might not have noticed staff. When asked about Resident 3's concerns about Resident 2, ED A stated Resident 2 could sometimes appear intimidating. ED A stated Resident 3 moved in recently and had not gotten comfortable yet. At approximately 2:30 PM, Surveyor interviewed Program Manager (PM) E. PM E stated s/he had started his/her position last week. When asked how staffing was between programs, PM E stated 1 staff would provide transportation and residents from the home where that staff was being utilized would spend time in the other home so that staff ratios were met. At approximately 2:40 PM, Surveyor interviewed Caregiver F. Caregiver F stated Resident 1 moved out about 1 month ago. Caregiver F stated staff did not know how to de-escalate challenging situations and some staff had caused unnecessary confrontation. Caregiver F stated they spoke with Resident 1's family member and Resident 1 was now receiving 2:1 care. Caregiver F stated Resident 1 would benefit from more supervision based on his/her behavioral needs. At 6:16 PM, Surveyor received an email with staff schedules for October 2024-December 2024.	M 218		

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M 218	Continued From page 3 Staff were often scheduled in block shifts of various lengths, including having 1 staff scheduled alone for approximately 72 consecutive hours over a weekend in October. Staff was scheduled alone in block shifts of approximately 81 consecutive hours over weekends in November and 39 hours in December. It appeared 1 staff per shift was the typical staffing pattern. On 12/11/2024, Surveyor received an email from ED A with staff records and records for Resident 1. Resident 1 was admitted on 06/17/24 and discharged on 11/2/24. Resident 1 had a guardian. Resident 1's face sheet identified s/he was a fall risk. Resident 1's records included a handwritten assessment, dated 03/07/2024. The assessment stated Resident 1 had a history of calling 911 and was protectively placed with the county. The assessment included the following statements: "4 Bed AFH (Adult Family Home) 2:4 staffing; awake overnight staff." The assessment also read, in part, " ...will have behaviors, will get upset over staff. Behaviors = verbal, hit, kick, bite, yells and hx (history) of property damage..stay out of way when [s/he] has behaviors ...Property damage - broke window of staff car, wripped [sic] cords out of wall/tv. Threaten to hurt people, staff has to be on guard with [him/her]." Resident 1's Individual Service Plan (ISP), dated 08/07/2024, included a section titled, "Supervision." The box for "24-hour supervision" was selected. Under a section titled, "Wandering Risk," it stated, "Requires supervision and redirection from staff to prevent elopement episodes. Exit-seeking and requires checks throughout day/night." Under a section titled,	M 218		

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"Destructive/Abusive," it stated, "Requires supervision and monitoring to help manage/redirect destructive/abusive behaviors." Under a section titled, "Evacuation," it stated, "Requires assistance to evacuate building. Physical assistance and/or verbal cues and prompting provided as needed." Under a section titled, "Physical Disabilities," it stated, "[Resident 1] has been diagnosed with Cerebral Palsy. With this disability, [Resident 1] at times will need help with walking on uneven surfaces and stairs." Under a section titled, "Aggressive/Combative," it stated, "Requires supervision and monitoring to help manage/redirect aggressive/combative behaviors. [Resident 1] will show increase in anger by yelling, throwing objects, slamming doors, hitting, kicking."

Resident 1's behavior support plan (BSP), signed on 08/07/2024, stated Resident 1 required 24/7 supervision beginning at approximately 17 years old. The BSP indicated Resident 1's behaviors were problematic in the home and in the community. Resident 1 had the following diagnoses: Intellectual Disabilities, Generalized Anxiety Disorder, Cerebral Palsy, Microcephaly, Seizure Disorder, and vision loss in left eye. Under a "History of Behaviors" section, it read, in part, "It is especially important that staff stay consistent from one shift to the next and to follow [Resident 1's] support plan. It is also important for staff to work as a team with [Resident 1.] If the staff does not stay consistent [Resident 1] will take advantage of the inconsistencies and will use them to [his/her] advantage. Staff need to keep [Resident 1] as active as possible." Under a section titled, "Stealing," it read, in part, "[Resident 1] will steal the staff's personal belongings and try to take them to [his/her] room to prevent a particular member of staff from

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leaving. This usually occurs with [sex] staff. Staff should make sure their belongings are out of reach of [Resident 1.] Under a section titled, "Elopement," it stated, in part, "[Resident 1] will attempt/threaten to elope from the home when [s/he] is perseverating, over a particular staff. Staff need to remain calm and attempt to redirect [Resident 1] back home ...staff must know where [Resident 1] is. Staff will follow all elopement procedures established in [Provider.]" Under a section titled, "Property Destruction," it read, in part, "[Resident 1] has a history of breaking items/objects and throwing object/items across the room. [S/he] has a history of breaking appliances (destroying/cutting cords, breaking door off) and cutting cords on the TV/cable hook up. Damage to staff vehicles when [s/he] does not get the answer or attention [s/he] seeks." Under a "Physical Aggression" section, it stated, "[Resident 1] has a history of physical aggression towards others. [Resident 1] will hit, kick, slap, and throw items. [S/he] has a history of seeking out items to cause harm to others. (Knives, forks, scissors, and screw drivers.)" Under a section titled, "Self-Abusive Behavior," it read, "[Resident 1] will repeatedly hit walls and the floor when [s/he] is agitated. [S/he] will threaten harm to [his/herself.]"

An incident report, dated 10/03/2024, indicated Resident 1 required police intervention to support with a behavioral episode. Resident 1 had gotten upset and began yelling and screaming at staff. Resident 1 entered a staff's vehicle and began ripping items out of staff's car. Resident 1 was threatening staff. Resident 1 later directed his/her attention towards a peer and bit one of his/her peers. Law enforcement arrived and Resident 1 was taken to jail.

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M 218	Continued From page 6 On 12/12/2024, Surveyor requested additional records for Resident 2 and Resident 3 via email from ED A. At 3:31 PM, Surveyor received additional resident records from ED A via email. Resident 2 was admitted on 06/24/2024. Resident 2 had a guardian and multiple diagnoses including: attention-deficit hyperactivity disorder, conduct disorder, disruptive mood dysregulation disorder, epilepsy, hallucinations, post-traumatic stress disorder, schizoaffective disorder, and sleepwalking (somnambulism.) Resident 2's ISP, signed on 08/23/2024, included a section titled, "Supervision." The box for "24-hour supervision" was selected. Under a section titled, "Wandering Risk," it read, in part, "[Resident 2] has a history of elopement. [Resident 2] tends to elope when [s/he] has funds on person or when [s/he] is upset. Staff should have eyesight on [Resident 2] hourly...[Resident 2] tends to elope when [s/he] wants [name] products. When [Resident 2] is frustrated or seeking, [s/he] will walk off from the home however with staff encouragement to make the right choice and a reminder of [his/her] court order [Resident 2] will turn back around or walk around the block and come back..." Under a section titled, "Self-Abusive Behavior," it read, in part, "When [Resident 2] is in a rage or having a behavior, [s/he] has in the past cut [his/her] arm, threatens to drink paint/chemicals. [Resident 2] will make comments about self-harm. Staff should make sure [Resident 2] does not have any sharp objects in [his/her] room or access to chemicals. [Resident 2] tends to access the basement by [his/her] room to find objects that could be used for self-harm. Staff should try to communicate with [Resident 2] and encourage	M 218		

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coping skills ..." Under a section titled, "Destructive/Abusive," it read, in part, "[Resident 2] is a high level for destructive behaviors. [Resident 2] often defers to slamming and breaking things, punching holes in walls, destroying personal and [Provider] property, completely destroying a wall, throw out food items, break windows, break items downstairs, turn off water/lights/furnace, breaking/damage to vehicles, and breaking doors. [Resident 2] has been physical with members and staff. [Resident 2] will instigate and provoke other peers. [Resident 2] will also use threating [sic]/intimidation tactics such as invading personal space, screaming/cussing/yelling, pushing, manufacturing homemade weapons, theft, stealing others property, and threating [sic] comments of harm to others ...[Resident 2] has in the past and may need Police assistance ..." Under a "Chronic Illnesses" section, it read, in part, "Has chronic illness (es) that require proper treatment and management. [Resident 2] is diagnosed with Fetal alcohol syndrome [sic]. [Resident 2] is also diagnosed with mental health needs. [Resident 2] tends to seek out drugs and alcohol to help cope with these illnesses." Under a section titled, "Aggressive/Combative," it read, in part, "Requires supervision and monitoring to help manage/redirect aggressive/combative behaviors. [Resident 2] has a history of verbal aggression and physical aggression to staff and peers. [Resident 2] at this time has charged filed with [County] and is currently on bond for this ..." Under a section titled, "Maturation," it read, in part, "[Resident 2] struggles with controlling [his/her] emotions and making good choices. [Resident 2] tends to make choices out of impulse and what [s/he] wants in the moment without thinking of the outcome ...Staff should make themselves available for one-on-one

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conversations with [Resident 2] if [s/he] is expressing, [s/he] needs to talk..." Resident 2's service agreement stated, "Residents will have 24/7 staff supervision. Supervision in the home and out in the community will be 1:4."

An employee disciplinary report, dated 11/21/2024, was written for HM D. It indicated HM D was underperforming in his/her role and incidents were not being reported timely. It read, in part, "[Resident 2] had eloped from the facility and gotten in a cab to go sell [his/her] Xbox and buy alcohol and they were not notified right away ..."

On 12/17/2024, Surveyor accessed the provider's department file and reviewed the following self-report submitted to the department by the provider:

-On 09/03/2024, a resident altercation was reported involving Resident 2. Resident 2 was noted to have punched another resident in the face 5 to 6 times. The resident was taken to the hospital by ambulance and Resident 2 was taken to jail.

On 12/17/2024, at 3:00 PM, Surveyor interviewed ED A, Operations B and Licensee C via Microsoft Teams meeting. Surveyor asked about staff supervision and stated resident ISPs indicated a need for 24-hour supervision. ED A stated staff were in the home 24/7. ED A stated the home implemented a sleep overnight staff position and it was always designated as such. ED A stated that if a resident needed to be awake for a colonoscopy preparation or something that required overnight assistance, they would pay for awake hours during that time. ED A stated it changed upon resident needs. Operations B

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stated that when entering information into their electronic system, it did not always let them recreate the template, and supervision requirements on the ISP might not be 100% accurate. ED A stated staff sleep in the living room and if a resident were to leave, staff would probably be aware of it. ED A stated that identifying residents as needing 24-hour supervision and as an elopement risk was their process to get to know the residents, even though that may not have happened yet. ED A stated they asked staff to be aware even if residents do not have a history of elopement. ED A stated the overnight sleep position was appropriate based on their recent experiences with the residents. When asked about Resident 2's incident referenced in the employee disciplinary letter, ED A stated Resident 2 did leave and sold his/her Xbox. ED A later stated Resident 2 did not actually elope, s/he went out of his/her bedroom window to meet someone s/he connected with on Facebook to sell his/her Xbox. ED A stated Resident 2 met someone on the property and staff was at home. ED A did not clarify if staff were aware Resident 2 exited the home through his/her bedroom window to meet someone s/he met online.

Surveyor reviewed the provider's program statement. Under the "Services" section, it read, "Everyone at [Provider] will have their own service plan tailored to them. These documents will be described in their Individual Service Plan. There will be 24-hour care with one staff member on duty during day hours and one staff member on duty during night hours. The amount of staffing can increase based on residents' needs."