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	0019562	A. BUILDING: _____ B. WING _____	06/05/2025

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M 000	INITIAL COMMENTS On 05/27/2025, Surveyor conducted a self-report investigation (x2) and licensure survey at Stable Living LLP - 3120 Kohlhepp Rd. Data collection continued through 06/05/2025. Three deficiencies were 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 a service provider was present and awake for residents in need of continuous care. Resident 1 and Resident 2 were on 15-minute checks each after eloping in 2024, and staff would discontinue the 15-minute checks during sleep hours. Findings include: On 05/27/2025 at 9:38 AM, Surveyor interviewed Program Manager (PM) C. PM C described the provider's staffing schedule as follows: - One staff member was on site and awake from 8:00 AM to 5:00 PM, Monday through Friday. - One staff member was on site from 5:00 PM to 8:00 AM, Monday through Thursday. This shift was allowed to sleep between the hours of 11:00	M 218		

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

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PM and 7:00 AM.
- The provider had a weekend shift where 1 staff was on site from Friday at 5:00 PM to Monday at 8:00 AM. Staff were allowed to sleep between the hours of 11:00 PM and 7:00 AM.

RECORD REVIEW

Resident 1

On 05/08/2024, the Department received a self-report from the provider indicating Resident 1 eloped around 1:45 PM on 05/07/2024. The report indicated Resident 1 was upset that morning due to his/her family refusing to visit the day before. The self-report read, in part, "Later in the day [Guardian G] contacted the [PM H] about [Resident 1] threatening to harm [him/herself]. Then [PM H] contacted the house staff and asked them to start the 15-minute checks ...At 1:45 PM, the staff checked on [Resident 1], [s/he] was not in [his/her] room."

Once staff returned from searching for Resident 1, they searched the house again and found a letter left by Resident 1. Approximately 2.5 hours later, Resident 1 was picked up by police and returned to the provider. The report read, in part, "When at that time the police were informed of the letter. [sic] They reached out to DHS (Department of Health Services) and [Guardian G] about a 24-hour hold. It was decided at that time that [Resident 1] remain at the house." The report indicated Resident 1 would remain on 15-minute checks and have his/her self-supervision discontinued until determined by his/her team.

On 05/27/2025 at approximately 10:30 AM, Surveyor requested and reviewed Resident 1's

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record. Resident 1 was admitted to the provider on 07/19/2023 and had a guardian. Resident 1 had diagnoses that included anxiety disorder, depression, schizoaffective disorder (bi-polar type), suicidal ideations, and type 2 diabetes mellitus with diabetic chronic kidney disease.

Resident 1's individualized service plan (ISP), dated 01/12/2024, indicated Resident 1 was 1:4 supervision from 7:00 AM to 11:00 PM during the day and then sleep overnight staff from 11:00 PM to 7:00 AM. The ISP indicated Resident 1 could self-supervise when staff were transporting other residents. The ISP indicated Resident 1 would remain within eyesight when out in the community. The ISP indicated Resident 1 had a history of elopement and self-harm (cutting).

Resident 1's behavioral support plan (BSP), dated 01/12/2024, indicated Resident 1 was at an increased risk of elopement and self-harm when things were not going well for him/her.

Staff progress notes, dated 05/07/2024, indicated Resident 1 was put on 15-minute checks on 05/07/2024 due to vocalizing suicidal thoughts to Guardian G on the phone.

Resident 1's 15-minute check charting indicated Resident 1 was on 15-minute checks on 05/07/2024 at 11:45 AM and eloped sometime after the 1:30 PM check. The charting indicated Resident 1 was brought back to the provider at 6:45 PM (gone approximately 5 hours). The charting indicated 15-minute checks were discontinued during staff sleeping hours from approximately 11:00 PM to 7:00 AM when staff would resume 15-minute checks for the day. This was observed in the charting from the night of the elopement on 05/07/2024 to at least 05/15/2024.

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The police report, dated 05/07/2024, indicated Resident 1 had left a suicide note prior to his/her elopement on 05/07/2024. The report read, in part, "The note explained [Resident 1] was unhappy at the group home and wished [s/he] could hang [him/herself] or use a gun to kill [him/herself]. I asked [Resident 1] about the note and [s/he] explained that [s/he] was upset due to a bad phone call with [his/her] family and a change in [his/her] [Managed Care Organization (MCO) worker]. I asked if [s/he] had any set plans or means of carrying out those plans. [Resident 1] said no and everything in [his/her] note was just written in anger. [Resident 1] indicated [s/he] was not suicidal." Due to the note, police had Resident 1 evaluated and it was concluded Resident 1 was safe to be at the provider with additional precautions put in place.

Resident 2

On 12/09/2024, the Department received a self-report from the provider indicating Resident 2 eloped around 1:45 PM on 12/07/2024. The report indicated Resident 2 was witnessed entering the unsecured staff office and confronted about it. Staff stepped away to call the on-call manager and when they came back, Resident 2 had left a note stating s/he went for a walk. Staff witnessed Resident 2 walking away from the provider down the block until s/he was out of eyesight. Around 4:30 PM, staff were notified that Resident 2 was found at another company home. The self-report read, in part, "After law enforcement left, [Resident 2] returned to the house with on-call and was placed on 15-minute checks for the remainder of the weekend."

On 01/23/2024, the Department received a

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self-report from the provider indicating Resident 2 had eloped on 01/22/2024, hitchhiked with a stranger to his/her parents' home, and was found 2 days later without his/her parents being aware s/he was there. The report indicated alarms were placed on the provider's doors of the home and Resident 2 was placed on 30-minute checks.

On 05/27/2025 at approximately 10:30 AM, Surveyor requested and reviewed Resident 2's record. Resident 2 was admitted to the provider on 06/06/2023 and had a guardian. Resident 2 had diagnoses that included bipolar II disorder, post-traumatic stress disorder, impulse disorder, and mild intellectual disabilities.

Resident 2's individualized service plan (ISP), dated 07/11/2024, indicated Resident 2 had an elopement history and required supervision (checks throughout day/night) and redirection from staff to prevent elopement episodes. The ISP indicated Resident 2 required monitoring to help manage/redirect self-abusive behavior, such as hitting his/her head, scratching him/herself, and picking at sores on his/her skin.

Resident 2's 15-minute check charting indicated Resident 2 resumed 15-minute checks on 12/07/2024 at 6:30 AM and eloped sometime after the 2:45 PM check. The charting indicated Resident 2 was brought back to the provider at 4:00 PM (gone approximately 1 hour). The charting indicated 15-minute checks were discontinued during staff sleeping hours from approximately 11:00 PM to 7:00 AM, when staff would resume 15-minute checks for the day. This was observed in the charting from 12/08/2024 to at least 12/15/2024. Occasionally, staff charted one check on Resident 2 during sleep hours.

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M 218	Continued From page 5 INTERVIEWS On 05/27/2025 at 11:36 AM, Surveyor interviewed ED B again and asked about staff discontinuing 15-minute checks during sleep hours. ED B stated it depended upon the situation for staff to not complete the 15-minute checks during sleep hours. ED B stated that sometimes staff would change the checks to every 3 to 4 hours overnight. On 05/30/2025 at 1:08 PM, Surveyor interviewed Managed Care Organization (MCO) Nurse I. MCO Nurse I stated s/he was unsure when Resident 2's 15-minute checks were discontinued after his/her elopement on 12/07/2024. MCO Nurse I stated s/he was unsure of the expectation of 15-minute checks for Resident 2 overnight and commented Resident 2 usually had behaviors during the day and not overnight. MCO Nurse I stated they probably would be okay with staff sleeping on the overnight shift if they checked on Resident 2 every so often. On 06/02/2025 at 10:44 AM, Surveyor received an email from the provider, which read, in part, "The staff on duty reports to On Call or the PM if there are concerns about a resident. If the resident is showing signs of wanting to hurt self, others, or is an elopement risk, either the On Call or PM staff will decide to put the resident on a 15-minute check. It ensures extra eyes and opportunities to provide assurance to the resident or intervention for behaviors. If a resident is on 15-minute checks, we ask the staff to verify the resident is sleeping before they themselves go to bed. We assess if the resident has a history of behaviors on the overnight. If the resident sleeps through the night, does not have a history of concerns on the overnight, the manager	M 218		

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M 218	Continued From page 6 discusses with the staff if we require the staff to stay awake all night to monitor the resident, if we want to break up the night and just do a few checks while the resident is asleep, or if we have the staff sleep as they would on a normal night." On 06/05/2025 at 8:54 AM, Surveyor interviewed Guardian G. Guardian G stated Resident 1 was not a good fit from day one at the facility due to staffing ratio and frequent staffing turnover. Guardian G stated Resident 1 was found 3 miles from the provider on 05/07/2024, after eloping. Guardian G stated 15-minute checks were implemented until Guardian G felt Resident 1 was safe to be off them and would notify the provider. Guardian G stated his/her expectations of 15-minute checks were for staff to visually observe Resident 1 and for staff to check on Resident 1 every 15 minutes, including during sleep hours. Guardian G stated s/he did not trust the door alarms and Resident 1 had a history of self-harm. On 06/05/2024 at 3:00 PM, Surveyor interviewed Integrator A, ED B, and PM C. Integrator A stated it would be a discussion with the care team to discontinue the 15-minute safety checks for a resident. ED B confirmed staff should have continued 15-minute safety checks after both incidents during staff sleep hours. ED B stated that with their newly implemented change of condition policy and procedure in early 2025, s/he would now expect staff to be awake and conduct the 15-minute safety checks during staff sleep hours.	M 218		
M 234	88.04(2)(g)2 COMMUNICABLE DISEASE The licensee shall ensure that no one	M 234		

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who has a communicable disease reportable under ch. HSS 145 may work in a position in the adult family home where the disease would present a significant risk to the health or safety of the residents.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure each service provider was screened for illness detrimental to residents, including tuberculosis (TB), by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service, for 3 of 3 caregivers (Caregiver D, Caregiver E, and Caregiver F) reviewed.

Findings include:

This facility is licensed to serve up to 4 residents in the client groups alcohol/drug dependent, correctional clients, traumatic brain injury, developmentally disabled, and emotionally disturbed/mental illness.

On 05/27/2025 at 9:40 AM, Surveyor requested to review employee records for Caregiver D, Caregiver E, and Caregiver F.

Caregiver D had a hire date of 08/14/2025. Caregiver D's record contained a communicable disease and TB screening, dated 08/14/2025, which had no signature by a physician, a registered nurse or a physician's assistant. Caregiver D's record did not contain documentation of TB test results.

Caregiver E had a hire date of 10/28/2024. Caregiver E's record contained a communicable

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M 234	Continued From page 8 disease and TB screening, dated 10/28/2024, which had no signature by a physician, a registered nurse or a physician's assistant. Caregiver E's record did not contain documentation of TB test results. Caregiver F had a hire date of 12/05/2023. Caregiver F's record contained a communicable disease and TB screening, dated 12/05/2023, which had no signature by a physician, a registered nurse or a physician's assistant. Caregiver F's record did not contain documentation of TB test results. At 10:25 AM, Surveyor interviewed Integrator A. Integrator A stated s/he did not know they needed to do a TB test on all their caregivers within 90 days before the start of providing service and confirmed this was not being done company wide. Integrator A stated the health screening form (which screened for communicable disease and TB) was completed by their human resources staff and confirmed this staff was not a physician, a registered nurse or a physician's assistant. The provider did not ensure each service provider was screened for illness detrimental to residents, including TB, by a physician, a registered nurse or a physician's assistant, within 90 days before the start of providing service, when 3 out of 3 caregivers reviewed did not have a completed TB test in their record and the health screening was signed by the human resources staff that was not a physician, a registered nurse or a physician's assistant.	M 234		
M 570	88.10(3)(l) Safe Physical Environment	M 570		

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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 because of the resident's condition or disability.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the provider did not ensure 4 of 4 residents were safeguarded from environmental hazards, when the home's water temperature exceeded 120 degrees Fahrenheit (F) at 3 of 3 faucets tested and the dryer vent did not consist of rigid metal.

Findings include:

Water Temperature

Exposure to hot water is a potential environmental danger for clients. Elderly clients and clients with mental and physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances, skin does not return to normal and forms scar tissue upon healing. These burns may lead to permanent disability. (DQA publication P-01942, Hot Water

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M 570	Continued From page 10 Temperatures in Adult Family Homes, 08/2017). This facility is licensed to serve up to 4 residents in the client groups alcohol/drug dependent, correctional clients, traumatic brain injury, developmentally disabled, and emotionally disturbed/mental illness. On 05/27/2025, from 11:55 AM to 12:15 PM, Surveyor checked water temperatures at 3 faucets used by residents and staff. The water temperature at the kitchen sink registered at 129.9 degrees F. The water temperature at the upstairs bathroom sink registered at 137.1 degrees F. The water temperature at the downstairs bathroom sink registered at 142.7 degrees F. At approximately 12:30 PM, Surveyor interviewed Integrator A. Integrator A stated s/he had already contacted maintenance to come and reset the water temperature today and agreed the water temperature was "alarmingly high." Integrator A stated s/he could not find the provider's thermometer. Integrator A stated the water temperatures were checked monthly and showed Surveyor the 2025 log. Surveyor observed the water temperature checks were dated and marked as checked monthly, but the actual water temperature was not recorded on the log. At 3:00 PM, Surveyor received an email from Integrator A which read, in part, "We did check it with our thermometer and it was high. Maintenance was able to reset the water and we rechecked it again. It's within the correct temperature now."	M 570		

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M 570	Continued From page 11 Dryer Vent "House fires caused by dryers are more common than many people realize, based on statistics from the National Fire Protection Agency and the Consumer Product Safety Commission, which cite that around 15,000 fires each year can be attributed to improper lint cleanup and maintenance of the home's clothes dryer. Fortunately, these fires are very easy to prevent. The recommendations outlined below reflect International Residential Code (IRC) SECTION M1502 CLOTHES DRYER EXHAUST guidelines: M1502.5 Duct construction. Exhaust ducts shall be constructed of minimum 0.016-inch-thick (0.4 mm) rigid metal ducts, having smooth interior surfaces, with joints running in the direction of air flow. Exhaust ducts shall not be connected with sheet-metal screws or fastening means which extend into the duct. This means that the flexible, ribbed vents used in the past should no longer be used. They should be noted as a potential fire hazard if observed during an inspection." (Retrieved on 04/02/2025 from the International Association of Certified Home Inspectors web page at https://www.nachi.org/dryer-vent-safety.htm). On 05/27/2025 at 12:05 PM, Surveyor observed a flexible dryer vent in use. At 12:10 PM, Surveyor interviewed Integrator A. Integrator A stated the dryer vent was recently replaced at the end of March 2025 and s/he had not checked back to make sure it was in compliance.	M 570		

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M 570	Continued From page 12 At 2:11 PM, Surveyor received an email from Integrator A which read, in part, "Here is the receipt for the dryer. I just wanted to show it hasn't been that long since we've had this installed and we will replace the dryer vent connection very quickly." Attached to the email was an invoice from a service company, dated 04/15/2025, which indicated a new dryer was installed. At 2:47 PM, Surveyor received an email from Integrator A indicating the current dryer vent had been replaced with a ridged vent. A picture was attached to confirm this was corrected. The provider did not ensure 4 of 4 residents were safeguarded from environmental hazards when the home's water temperature reached 142.7 degrees F and the dryer vent did not consist of rigid metal.	M 570		