STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020201	A. BUILDING: _____ B. WING _____	C 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STABLE LIVING LLP 2601 KANE RD	**3540 JEFFERS 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 2601 Kane Rd. Data collection continued through 12/19/2024. The complaint was substantiated. One deficiency was identified. Census: 3	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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M 218	Continued From page 1	M 218		

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 typically 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. When asked about the residents in the home, ED A stated Resident 2 was on house arrest. 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 approximately 2:40 PM, Surveyor interviewed Caregiver D. Caregiver D stated the program had a lot of issues with staffing. Caregiver D stated Resident 2 was on house arrest and staff would often coordinate with the staff at the other licensed home that was connected to the same building. The other home was owned by the same licensee. Caregiver D stated residents would ride together for appointments in order to remain in ratio. Caregiver D discussed 2 staff members that had caused issues in the home and stated they

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M 218	Continued From page 2	M 218		

no longer worked for the provider. Caregiver D stated s/he did not feel the staff were bad but that the residents were challenging.

At 6:16 PM, Surveyor received an email with staff schedules for October 2024-December 2024.

Staff were often scheduled in block shifts of various lengths, including having 1 staff scheduled alone for approximately 40 consecutive hours over the weekends in October through December. It appeared 1 staff per shift was the typical staffing pattern.

On 12/12/2024, at 1:00 PM, Surveyor requested records for Resident 1 and Resident 2 via email from ED A.

At 2:31 PM, Surveyor received an email from ED A with records for Resident 1.

Resident 1 was admitted on 07/26/2024. Resident 1 had a corporate guardian. Resident 1's Individual Service Plan, dated 07/11/2024, included a section titled, "Supervision." The box for "24-hour supervision" was selected. Under a "Wandering Risk" section, it stated, "Staff will follow all Elopement Procedures that are defined in the [Provider] Elopement Policy." Under the "Frequency of Service and Service Performed" section, it stated, "Elopement Risk. 4x Every Day And As Needed." Under the "Resident's Desired Goals and Outcomes" section, it stated, "To have proper precautions and redirection techniques in place to prevent elopement." Under the "Service Providers Responsibilities" section, it stated, "Staff." Resident 1's service agreement stated, "Residents will have 24/7 staff supervision. Supervision in the home and out in the community will be 1:4." A handwritten

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M 218	Continued From page 3	M 218		

assessment, dated 06/17/2024, stated Resident 1 was a sex offender. The document also read, in part, " ...has to be reported to registry w/ (with) any internet accounts ...understands law. Enticement of a child ...Behaviors: likes to be nosey. Sometimes thinks [s/he] is staff. Sometimes has temper, is impatient."

Surveyor accessed the online Wisconsin Department of Corrections Sex Offender Registry and noted Resident 1 was identified as a registered sex offender. The report stated registration began on 05/02/2018 and would end on 05/02/2038. The offense code referenced was 948.07 with an offense of Child Enticement.

At 2:58 PM, Surveyor received an email from ED A with records for Resident 2.

Resident 2 was admitted on 07/01/2024. Resident 2 had a corporate guardian. Resident 2's ISP, dated 07/01/2024, included a section titled, "Supervision." The box for "24-hour supervision" was selected. Under a section titled, "Leisure Time Activities," it read, in part, "Needs to go to other [Provider] homes for any outing or activities in the community per court order." Under a "Community Contacts" section, it read, "Has no contacts within the community." Under a "Vocational Skills" section, it read, in part, "Per court order [Resident 2] is not able to gain employment at this time. If and when [Resident 2] is able to gain employment, vocational services will need to be required." Under a "Public Transportation" section, it stated, " ...staff must transport [Resident 2] to all appointments and other [Provider] homes. [Resident 2] must be with/transported by staff at all times." Resident 2's service agreement stated, "Residents will have 24/7 staff supervision. Supervision in the home

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M 218	Continued From page 4 and out in the community will be 1:4." Resident 2's record included a signature bond court order from the State of Wisconsin Circuit Court filed on 07/17/2023. It included multiple conditions, including Resident 2 shall neither directly nor indirectly threaten, harass, intimidate, or otherwise interfere with victims or witnesses and shall have no contact with any minor children. Resident 2's record included a signature bond court order from the State of Wisconsin Circuit Court filed on 09/26/2022. It included multiple conditions, including Resident 2 shall neither directly or indirectly threaten, harass, intimidate, or otherwise interfere with victims or witnesses and may not leave supervised home. An email from ED A regarding Resident 2 stated, in part, "When [s/he] was admitted, [his/her] case manager/ guardian made it known that they want [his/her] bond to be treated as a house arrest, therefore that is our language in the ISP. In the first bond, it does state not to leave the facility. Due to [his/her] need to avoid all contact with children. [S/he] is allowed to leave to go to [his/her] medical appointments and court and that is with supervision of our staff." On 12/17/2024, Surveyor accessed the provider's department file and reviewed the following self-reports submitted to the department by the provider: -A self-report, dated 09/30/2024, detailed a probation violation for Resident 3. It was determined Resident 3 had consumed alcohol and would be taken to jail. Resident 3 was no longer residing with the provider. -A self-report, dated 09/30/2024, detailed a probation violation for Resident 4. It was noted	M 218		

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M 218	Continued From page 5	M 218		

staff took Resident 4 to a gas station after an appointment and Resident 4 purchased alcohol. Resident 4 was taken to jail on a probation violation.
-A self-report, dated 10/07/2024, detailed a probation violation for Resident 4. A resident from the neighboring home reported to staff that Resident 4 had taken a screwdriver to a parked vehicle's ignition and dash. The vehicle had been parked near the provider's garage. Resident 4 attempted to try to start the vehicle. Resident 4 was taken to jail. Resident 4 no longer resided with the provider.

On 12/17/2024, at 3:00 PM, Surveyor interviewed ED A, Operations B, and Licensee C via a 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 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 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 ask staff to be aware even if residents do not have a history of elopement. ED A stated the overnight sleep

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M 218	Continued From page 6 position was appropriate based on their recent experiences with the residents. Surveyor reviewed the provider's program statement. Under the "Services" section, it read, "Everyone at [Provider] will have their 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."	M 218		