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	0019771	A. BUILDING: _____ B. WING _____	C 11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STABLE LIVING LLP 325 RAILROAD AVE	325 E RAILROAD AVE FALL CREEK, WI 54742

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M 000	INITIAL COMMENTS On 11/20/2024, Surveyor conducted a complaint investigation at Stable Living LLP 325 Railroad Ave. Data collection continued through 11/27/2024. The complaint was substantiated. Two deficiencies were identified. Census: 4	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the Department was notified within 24 hours when a resident's whereabouts were unknown. Resident 1 eloped on 05/12/2024. Findings include: On 05/14/2024, the department received a complaint alleging a resident eloped.	M 134		

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

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The provider is licensed to serve up to 4 ambulatory residents within the client groups of correctional clients, developmentally disabled, emotionally disturbed/mental illness, traumatic brain injury, and alcohol/drug dependent.

On 11/20/2024 at 10:42 AM, Surveyor interviewed Assistant Program Manager (APM) A. APM A indicated Resident 1 had a history of attempting to elope.

On 11/20/2024 at 11:20 AM, Surveyor requested Resident 1's record from Executive Director (ED) B and Integrator C. A deadline for documents was given for 11/21/2024 at 5:00 PM, due to technology issues.

On 11/22/2024 at 1:00 PM, Surveyor reviewed Resident 1's record, including face sheet, Individual Service Plan (ISP), and incident reports. Resident 1 was admitted to the provider on 11/22/2023. The ISP dated 11/22/2023, indicated Resident 1 was on protective placement by Adult Protective Services (APS) and had a guardian. Surveyor did not receive any incident reports for elopement by Resident 1.

A staff progress note dated 05/12/2024 to 05/13/2024, 8:00 AM to 8:00 AM, written by Caregiver D, read, in part, "[Resident 1] has completely refused to come inside with a few exceptions ...[Resident 1] wants to walk around but I told [him/her] that the hard and fast rule is that [s/he] needs to be where I can see [him/her]. I've still had to remind [him/her] 40 times so far today and chase [him/her] down two or three. I did tell [him/her] that the next time [s/he's] 'missing' I'm just going to call on-call and the police. Mostly because [s/he] is spending all of [his/her] energy in people's back yards trying to

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M 134	Continued From page 2	M 134		

find things [s/he] can use as a weapon ... [Resident 1] spent entirety of the day outside, refusing sunblock, hat, food, drink, etc. .... [Resident 1] refused to come into the house until staff had called on call [sic] was ready to contact non-emergency police then [s/he] came in but went in and out every 60 seconds or less until well past midnight. In the middle of the night, staff found [him/her] wandering around in neighbor's [sic] yards, barefoot ...and got [him/her] to take a PRN (as needed) for anxiety."

A police report dated 05/12/2024, indicated at 10:31 PM, police were dispatched to the provider for a missing person. The report read, in part, "Dispatch advised [Resident 1] had left the residence wearing blue pants and a windbreaker ...As I neared the area I observed [Resident 1] walking from the [store] across the street to the credit union. I stepped out with [him/her] and observed [him/her] to be extremely sweaty and have vomit on the front of [his/her] shirt. [Resident 1] was talking rapidly and stated people were out to harm [him/her] ...The group home employees, [Caregiver D] and [Assistant Program Manager (APM) E] were contacted and informed on [sic] [his/her] whereabouts ...[Caregiver D] then told me [s/he] could see [Resident 1] by the [store] Store in [town] and was yelling at [him/her] to come back ...After a period of time, Northwest Connections determined a safety plan would be put in place for [Resident 1] to return to the group home with [Caregiver D]."

The provider's elopement policy read, in part, "Elopement - Any resident who requires 24/7 supervision that leaves the facility without being accompanied by a staff member or any resident who is allowed to leave without supervision but fails to notify staff."

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M 134	Continued From page 3 On 11/25/2024 at 3:57 PM, Surveyor received an email from ED B. The email read, in part, "[Program Manager (PM) F] said [Resident 1] did not have any elopements from the facility." On 11/26/2024 at 1:09 PM, Surveyor interviewed APM E. APM E confirmed s/he was on-call on 05/12/2024 and responded to Resident 1's elopement. APM E stated s/he recommended Caregiver D call non-emergency police to help assist if Resident 1's behavior escalated. APM E stated that when s/he arrived at the facility, s/he helped Caregiver D look around the facility and property for Resident 1. APM E stated Caregiver D did not initially know where Resident 1 was. APM E stated s/he thought Resident 1 was missing for a maximum of 10 minutes. On 11/26/2024 at 1:18 PM, Surveyor interviewed PM F. PM F stated Resident 1's self-supervision was suspended after s/he was admitted for inpatient psychiatric services on 04/23/2024. PM F stated Caregiver D was aware on 05/12/2024 that Resident 1 had walked away from the facility across the railroad tracks to the gas station. PM F stated Caregiver D was the only staff to supervise all 4 residents within the building and had to call the on-call staff, who was 20-minutes away. PM F stated Caregiver D then called non-emergency police to help respond sooner. On 11/27/2024 at 11:00 AM, Surveyor received an email from Guardian G. The email read, in part, "We were not notified of elopement until later." The provider did not ensure the Department was notified within 24 hours, when a resident's whereabouts were unknown. On 05/12/2024, Resident 1 eloped and went across the railroad	M 134		

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M 134	Continued From page 4 tracks to a local gas station. On-call staff and police responded to the incident. Cross Reference M0218 DHS 88.04(2)(b) Awake Staff For Continuous Care	M 134		
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 at all times. Resident 1 required continuous care when s/he started to experience increased mental health behaviors and staff did not stay present or awake at all times. Findings include: On 05/14/2024, the department received a complaint related to staff supervision of residents. The provider is licensed to serve up to 4 ambulatory residents within the client groups of correctional clients, developmentally disabled, emotionally disturbed/mental illness, traumatic brain injury, and alcohol/drug dependent. Wis Admin Code § DHS 88.02(9) defines continuous care as: "The need for supervision,	M 218		

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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."

On 11/20/2024 at 10:42 AM, Surveyor interviewed Assistant Program Manager (APM) A. APM A stated Resident 1 started to have a mental health exacerbation in April 2024, with behaviors of hiding knives, making knives out of homemade items, increased paranoia, hiding in the company van, breaking into medication and sharps, cabinets, multiple police interventions, and sitting outside all day. APM A stated staffing during April and May 2024 was one staff per 4 residents for all shifts and overnight staff were asleep. APM A stated staffing on weekends consisted of one staff working from Friday night through Monday morning.

On 11/20/2024 at approximately 11:00 AM, Surveyor observed the provider had two separately licensed Adult Family Homes (AFHs) within a duplex building.

On 11/20/2024 at 11:20 AM, Surveyor requested Resident 1's record from Executive Director (ED) B and Integrator C. A deadline for documents was given for 11/21/2024 at 5:00 PM, due to technology issues.

On 11/21/2024 at 9:30 AM, Surveyor received an email from ED B, which included staff schedules for April and May 2024. The staff schedule confirmed one staff worked per shift and staff would work a whole weekend at a time from Friday night to Monday morning.

On 11/22/2024 at 1:00 PM, Surveyor reviewed

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M 218	Continued From page 6 Resident 1's record, including face sheet, Individual Service Plan (ISP), and incident reports. Resident 1 was admitted to the provider on 11/22/2023. The admission agreement, dated 11/23/2023, read, in part, "Resident will have 24/7 staff supervision. Supervision in the home and out in the community will be 1:4." The ISP dated 11/22/2023, indicated Resident 1 was protectively placed by Adult Protective Services (APS) and had a guardian. The ISP indicated Resident 1 experienced delusions and struggled with anxiety. Resident 1 was followed by psychiatry to manage his/her mental health and related medications. The ISP read, in part, " ...[Resident 1] is to be under 24-hour supervision of care staff and requires overnight care. [Resident 1] is allowed to go on walks and stay at home alone if [s/he] chooses not to ride with staff on appointments or errands for up to 2 hours ... [Resident 1] will have 1:4 staffing ratio supervision from the hours of 7am-11pm [sic]. Staff are allowed to sleep at the facility from the hours of 11pm-7am [sic] with the expectation that they are able to respond to residents even within that time frame if needed ...[Resident 1] is allowed to be out of eyesight of care staff when out in the community but needs to let care staff know what [s/he] is doing to ensure [his/her] safety ...In time of distress, returning from an elopement, or other emergency situations, staff will place [Resident 1] on timed checks (such as 15-minute checks) or line of sight to ensure [his/her] safety and well-being ...In situations that staff feel they are not able to provide appropriate support/supervision, they may contact local authorities for additional support."	M 218		

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M 218	Continued From page 7 The ISP, updated 05/10/2024, indicated Resident 1 would be establishing a new psychiatric provider on 05/28/2024, and a referral for counseling services was made. Resident 1's level of supervision remained unchanged from the 11/22/2023 ISP. A staffing form for the 6-month ISP review, dated 05/10/2024, read, in part, "Discussed giving a 30 day [sic] as we are not staffed enough to provide enough 1 on 1. The safety of [Resident 1] being left home alone was discussed ..." Between 04/09/2024 and 05/15/2024, Resident 1 had approximately 6 incidents related to escalated mental health and behaviors. Between 04/23/2024 and 05/13/2024, Resident 1 had approximately 6 incidents that needed police intervention related to escalated mental health and behaviors. Staff progress notes, dated 04/01/2024 to 05/15/2024, indicated the following related to Resident 1's supervision: 04/19/2024 8:00 AM to 5:00 PM - "[Resident 1] admitted to picking the lock on the med (medicine) cabinet again and also refused to go with staff to appointments. Staff asked [Resident 1] to go next door if [s/he] wasn't going to ride with since [Resident 1's] guardian would not like [Resident 1] to be able to self-supervise anymore. [Resident 1] refused to go next door for appointments and also refused to go with staff." 04/19/2024 5:00 PM to 9:00 AM - "Staff attempted to get [Resident 1] to ride with to go to a movie or to go next door so the rest of the house could, but [Resident 1] would refuse."	M 218		

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M 218	Continued From page 8 04/20/2024 8:00 AM to 8:00 AM - "[Resident 1] was agreeable today of going next door so [Resident 2] and I could go and check out some of the local thrift sales." 04/22/2024 5:00 PM to 8:00 AM - "It is hard to get the [residents] out of the house since [Resident 1] continues to refuse to ride anywhere or go next door." 04/23/2024 8:00 AM to 5:00 PM - "At around 3:30p [sic], while staff was transporting peers of [Resident 1] to an appointment, next door staff conducting 30-minute checks on [Resident 1] since [s/he] refused to ride with them [sic]discovered a knife in the garage of [facility]. Next door staff immediately locked it up with the rest of the knifes [sic], but while doing so, [Resident 1] came next door with a butter knife. [Resident 1] admitted picking the lock where the knives were kept. [Resident 1] then called 911 and they arrived to [sic] the house ..." Resident 1 did not meet inpatient criteria but was considered [sic] suicide risk. Staff were instructed to lock up anything in Resident 1's room that could be harmful. When Resident 1's room was being searched s/he grabbed a lava lamp and smashed it [sic] threatening staff with a glass shard. Law enforcement was contacted and Resident 1 was admitted inpatient for a psychiatric hold. 05/07/2024 5:00 PM to 8:00 AM - "Next door staff kept an eye on [Resident 1] while we shopped." 05/09/2024 8:00 AM to 5:00 PM - "[Resident 1] spent most of the day at [provider next door]." 05/09/2024 5:00 PM to 8:00 AM - "[Resident 1] had a very rough night. Very delusional all day,	M 218		

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spent most of the time at [provider next door]."

05/12/2024 to 05/13/2024 8:00 AM to 8:00 AM - "[Resident 1] has completely refused to come inside with a few exceptions ...[Resident 1] wants to walk around but I told [him/her] that the hard and fast rule is that [s/he] needs to be where I can see [him/her]. I've still had to remind [him/her] 40 times so far today and chase [him/her] down two or three. I did tell [him/her] that the next time [s/he's] 'missing' I'm just going to call on-call and the police. Mostly because [s/he] is spending all of [his/her] energy in people's back yards trying to find things [s/he] can use as a weapon ... [Resident 1] spent entirety of the day outside, refusing sunblock [sic], hat, food, drink, etc. ...In the middle of the night, staff found [him/her] wandering around in neighbor's yards, barefoot ...and got [him/her] to take a PRN (medication as needed) for anxiety."

05/14/2024 5:00 PM to 8:00 AM - "[Resident 1] stayed outside until about 10:55 [sic]. I was woken [sic] up multiple times in the night because [Resident 1] was either outside or being loud enough to wake everyone else up."

05/15/2024 8:00 AM to 5:00 PM - "[Resident 1] was unresponsive with staff and police this morning. [Resident 1] is now in the hospital and has been chaptered."

A 30-day discharge notice was given to Resident 1 and Guardian G on 05/14/2024 due to the provider being unable to meet Resident 1's needs and safety concerns.

A discharge summary indicated Resident 1 discharged from the facility on 05/15/2024 and read in part, "because [his/her] needs could no

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longer be met by the facility and because [s/he] was becoming an increased danger to [him/herself] and others in the house. [Resident 1] became very delusional and began thinking staff and [his/her] peers were out to get [him/her] and cause harm to [him/her]. [Resident 1] began stockpiling house knives, silverware and makeshift weapons to protect [him/herself] around the house ...There was an incident where [Resident 1] broke the glass to [his/her] lava lamp with the intention of inflicting harm to [him/herself] and anyone who tried to stop him/her. [Resident 1] went inpatient ...several times due to [him/her] stating that [s/he] was not safe or because [s/he] was suicidal ...Upon admission back from [inpatient], the delusional think [sic] continued with [Resident 1] refusing to come inside during the day. This resulted with [Resident 1] becoming severely sunburnt [sic] on the top of [his/her] head and the rest of [his/her] body exposed to the sun. [Resident 1] would refuse any prompts to come inside and would also refuse solutions ...When [Resident 1] would barricade [him/herself] inside of [his/her] room with [his/her] dresser or bed frame. [Resident 1's] delusions got to the point where law enforcement had to be involved due to barricading [him/herself] in [his/her] room and suicidal ideation. On the day of discharge 5/15/24, law enforcement had to breach [Resident 1's] room to get [him/her] out and [s/he] was placed on a chapter 51 hold and transported to [emergency room] for a psych evaluation. [Resident 1] was admitted to the hospital. [S/he] was discharged from [provider] as a result. [Resident 1's] team was in agreement that [s/he] needed more care and supervision than what the [provider] could provide."

The provider's program statement read, in part under services, "There will be 24-hour care with

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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."

On 11/26/2024 at 1:18 PM, Surveyor interviewed Program Manager (PM) F. PM F confirmed Resident 1's self-supervision was suspended per Guardian G's request after Resident 1 returned from inpatient psychiatric care and his/her escalated behaviors continued. PM F stated Resident 1 also had delusional and paranoia thinking, along with suicidal ideation. PM F also confirmed that once Resident 1 refused to leave the home with staff, s/he initially would go over to the other provider for supervision. Eventually s/he refused to go to the other provider and was causing issues with those residents. After this, staff from the other provider had to do frequent checks on Resident 1 within his/her home. PM F stated 30-minute checks were done when Resident 1 was having suicidal ideations but were not documented by staff. This information was passed on verbally and written vaguely in the daily observation notes as a task completed. PM F confirmed overnight staff were allowed to sleep on their shift when Resident 1 was having escalated behaviors and suicidal ideations.

On 11/26/2024 at 1:56 PM, Surveyor interviewed ex-Assistant Program Manager (APM) H. APM H stated that when Resident 1 was having escalated mental health behaviors in April and May 2024, Resident 1 had to go over to the other provider next door for supervision. APM H stated that when Resident 1 started upsetting the residents of the other provider, s/he would stay in the home and the other provider's staff would do checks on him/her instead or sit with Resident 1, leaving their residents to self-supervise. APM H

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STABLE LIVING LLP 325 RAILROAD AVE	325 E RAILROAD AVE FALL CREEK, WI 54742

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 218	Continued From page 12 stated that at times in the afternoon, all 4 residents were home when Resident 1 would go over to the other provider, causing their census to be greater than what they were licensed for. On 11/27/2024 at 11:00 AM, Surveyor received an email from Guardian G. Guardian G's email read, in part, "I believe that [the provider] was trying their best but are [sic] not trained to deal with [Resident 1's] level of mental health." Resident 1 required continuous care based on his/her mental health exacerbation and had self-supervision suspended after the 04/23/2024 incident that resulted in Resident 1 receiving inpatient psychiatric care. Staff did not stay present and awake in the home at all times after Resident 1 returned from a week of inpatient psychiatric care and his/her escalated behaviors continued until discharge on 05/15/2024. Cross Reference M0134 DHS 88.03(5)(e)1 Significant Change To The Resident	M 218		