

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0019771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 03/17/2026
NAME OF PROVIDER OR SUPPLIER STABLE LIVING LLP 325 RAILROAD AVE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 000}	INITIAL COMMENTS On 03/17/2026, Surveyor conducted a standard licensure survey, verification visit, and 2 self-report investigations at Stable Living LLP 325 Railroad Ave. No deficiencies were identified. Census: 3 Under statutory provisions of Wis. Stat. ch. 50, a \$200 revisit fee is being assessed.	{M 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE