STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020319	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STABLE LIVING LLP 1202 GRAND AVE	1202 GRAND AVE SUPERIOR, WI 54880

(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 02/10/2025, Surveyor conducted a self-report investigation at Stable Living LLP 1202 Grand Ave. Data was collected through 02/13/2025. One violation 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 a service provider was present and awake for residents in need of continuous care. Resident 1 eloped on 12/03/2024 while staff were asleep. Findings include: On 12/0/4/2024, the Department received a self-report from the provider indicating Resident 1 eloped sometime during overnight hours on 12/03/2024 and 12/04/2024. The self-report read, "This facility is an asleep overnight facility. Staff sleep from the hours of 11pm-7am unless there is an emergency or a resident needs something... Resident 1 has a long history of stealing, eloping, and manipulating. Resident 1 was just release [sic] from a 7 day PO (probation) hold on the 27th of November... Upon the House Manager arriving at 8am they noticed Resident 1 was not downstairs, House Manger asked staff where	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		

Resident 1 was, [Caregiver B] stated [Resident 1] was still sleeping. At 8:35am House Manager went to wake Resident 1 up to take [his/her] medication...House Manager immediately called [Caregiver B] who was working the previous shift and asked [him/her] when the last time they had seen Resident 1 was, [sic] [Caregiver B] stated they saw [him/her] at 11pm go to [his/her] bedroom to go to bed." Later the same day, Resident 2 reported missing over $900 from his/her bank account. It was determined that Resident 1 stole and activated Resident 2's new debit card. The report indicated Resident 1 was located by police and arrested on 12/04/2024 at 1:00 AM for obstructing an officer, giving a false name, and theft of over $500.

On 02/10/2025 at 10:13 AM, Surveyor interviewed Owner A. Owner A stated the provider was familiar with Resident 1. Resident 1 had lived at another location owned by the licensee for about 1 1/2 years prior to coming to the Superior location in September 2024.

Owner A 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 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.

On 02/11/2025, Surveyor reviewed Resident 1's record. Resident 1's assessment, dated 09/25/2024, read, "[Resident 1] does have a

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M 218	Continued From page 2 history of eloping. This usually happens when... out in the community unsupervised or in the middle of the night when staff do not have eyes on. [Resident 1] requires supervision and redirection from staff to prevent elopement episodes... [Resident 1] has a much higher change of eloping when [his/her] mental health is not stable. Staff should also sleep in common area to ensure [Resident 1] does not elope in the middle of the night." According to incident reports, Resident 1 was jailed from 11/20/2024 through 11/27/2024, for violating his/her rules of probation. Specifically, Resident 1 went across state lines, sold the provider's PS4, and used the money to purchase methamphetamine. On 02/13/2025 at 2:30 PM, Surveyor interviewed Owner A. Surveyor asked Owner A if s/he was aware of the need to have staff present and awake for continuous care residents. Owner A asked for clarification on the definition of continuous care. Owner A stated the provider received a violation for this same situation at their Eau Claire location recently. Owner A discussed concern that placing agencies would not pay for an awake overnight staff member.	M 218		