

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0020319	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/10/2025
NAME OF PROVIDER OR SUPPLIER STABLE LIVING LLP 1202 GRAND AVE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 12/08/2025, Surveyor began a verification visit at Stable Living 1202 Grand Ave. Data was collected through 12/10/2025. One violation was identified. This is a repeat violation. See Statement of Deficiencies (SOD) W61E11, dated 02/13/2025. A \$200 revisit fee is being assessed. 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 interview and record review, the provider did not ensure staff was present and awake at all times for residents in need of continuous care. This is a repeat violation. See Statement of Deficiency (SOD) W51E11, dated 02/13/2025. Findings include: According to Department of Health Services (DHS) administrative code DHS 88.02(9), "Continuous care" means 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	{M 218}		

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

TITLE

(X6) DATE

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{M 218}	Continued From page 1 during any time of the day or night." On 12/08/2025, at approximately 12:00 PM, Surveyor interviewed House Manager (HM) A. HM A stated the staffing schedule at the adult family home consisted of 1 staff on duty during the day from 8:00 AM to 5:00 or 6:00 PM and 1 staff on duty overnight from 5:00 or 6:00 PM to 8:00 AM. HM A stated staff were allowed to sleep during the night from the hours of 11:00 PM to 6:00 AM. HM A stated there was a slight elopement risk for 1 of 4 residents. At approximately 12:08 PM, Program Manager (PM) B arrived on-site. Surveyor interviewed both PM B and HM A. HM A stated Resident 1 had not eloped since early 2025, but that s/he had eloped in the past. PM B stated residents occasionally got up to use the bathroom or smoke throughout the night. PM B stated Resident 1 and Resident 2 liked to be up at night. PM B stated staff would perform checks on residents at 11:00 PM, 6:00 AM, and 8:00 AM. PM B stated residents occasionally did not get along with one another, and that law enforcement had come to the house for a resident-to-resident altercation. HM A stated Resident 1 had eloped frequently from his/her previous home prior to his/her placement at the adult family home in January of 2025. HM A stated there had been no elopement issues since February of 2025, and that staff had started implementing 1 hour of "alone time" for Resident 1, which had resolved the elopements. Surveyor reviewed Resident 1's and Resident 2's records. Resident 1's individual service plan (ISP), last	{M 218}		

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{M 218}	Continued From page 2 assessed on 08/21/2025, indicated and/or read, in part: - "24-hour supervision" needed. - "ELOPEMENT RISK...Provide supervision and redirection to avoid and prevent elopement. Provide checks throughout day/night and document whereabouts...[Resident 1] has a history of elopement. [Resident 1] tends to elope when [s/he] is upset. Staff should have an [sic] eyesight on [Resident 1] hourly ...Staff will provide monitoring for [Resident 1] during the hours of 7 am- 11 pm. Overnight asleep staff will provide awake hours and follow elopement procedure in the even [sic] of recent elopement ..." - "SELF ABUSIVE ...Provide supervision and monitoring to help manage/redirect self-abusive behavior ...[Resident 1] has a history of using random household items to self-harm ..." - "SUICIDAL TENDENCIES ...[Resident 1] has made comments about killing [himself/herself] and others. When [Resident 1] is angry, [s/he] will become verbally aggressive and make comments in detail about killing [himself/herself]..." - "AGGRESSIVE/COMBATIVE ...Requires supervision and monitoring to help manage/redirect aggressive/combatative behaviors. [Resident 1] has a history of verbal and physical aggression towards others ...If staff are not able to redirect [Resident 1], they should give [him/her] space, but monitor [him/her] from a distance due to elopement history ..." A document titled, "Police Safety Plan" read, in part: - "...[Resident 1] ...has a history of multiple police contacts due to aggression issues and elopement from the program ...[Resident 1] has	{M 218}		

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{M 218}	Continued From page 3 24/7 supervision provided by [facility] ..." - "...Elopement: walks in the middle of the road will [sic] not avoid dangerous things that could harm [him/her]..." Resident 1's admission agreement read, in part: - "...Residents will have 24/7 staff supervision ...The facility will maintain awake staffing from 7am- 11pm [sic] and from 11pm- 7am the staff on duty will be permitted to sleep. Should there be a situation that causes the staff to need to attend to residents' needs, the staff member will be expected to be awake to attend to these needs ..." Resident 1's behavioral support plan (BSP) indicated an elopement concern. Resident 2's ISP, last assessed on 08/21/2025, indicated and/or read, in part: - "ELOPEMENT RISK...provide supervision and redirection to avoid and prevent elopement. Provide checks throughout day/night and document whereabouts...Requires supervision and redirection from staff to prevent elopement episodes. Exit-seeking and requires checks throughout the day/night..." - "SELF ABUSIVE...Provide supervision and monitoring to help manage/redirect self-abusive behavior...Requires supervision and monitoring to help manage/redirect self-abusive behavior. [Resident 2] when upset can self-harm include hitting [his/her] head on something, scratching [himself/herself] and throwing [himself/herself] on the ground. [Resident 2] struggles with being able to communicate what [s/he] is exactly feeling and can resort to self harm in [sic] the means to cope..."	{M 218}		

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{M 218}	Continued From page 4 - "DESTRUCTIVE/ABUSIVE...Requires supervision and monitoring to help manage/redirect destructive/abusive behaviors..." Surveyor reviewed incident reports for all elopements in 2025. An incident report, dated 01/24/2025, indicated the following information: - Resident 1 had a history of suicidal ideations and thoughts. - Resident 1 had moved into the adult family home on 01/22/2025. - On 01/24/2025, at 7:15 PM, law enforcement were called to the home after receiving multiple calls from the home. Resident 1 told the police s/he was going to harm himself/herself when they attempted to make contact with him/her. - Resident 1 asked to smoke a cigarette, waited for police to leave, and then eloped. - Law enforcement were called back and located Resident 1 in the community. An incident report, dated 02/18/2025, indicated the following information: - Resident 1 had a history of elopements. - Resident 1 got upset with a staff member on 02/18/2025 at 11:16 PM, and left the home. Resident 1 told staff, "Good luck finding me." - Staff gave resident until 11:38 PM to return, then called the police when s/he did not. - Resident 1 returned on his/her own at 12:10 AM. On 12/10/2025, at approximately 10:34 AM, Surveyor interviewed Resident 1's managed care worker (MCW) and his/her MCW's supervisor. MCW C stated Resident 1 was able to come and go from the home, but that Resident 1 engaged in	{M 218}		

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{M 218}	Continued From page 5 criminal activity when s/he left the home. MCW C stated Resident 1 was arrested on 12/09/2025 for stealing items from a neighbor's camper. MCW C stated s/he had concerns that Resident 1 would leave during the night. MCW C stated the best level of service the home could provide would be to have awake-staff during the overnight hours. MCW C stated the second best thing they could do would be to have a door alarm so that sleep-staff would hear if Resident 1 left the home at night. MCW C stated Resident 1 needed more supervision than what s/he was getting at the home. MCW C stated Resident 1's cognitive issues made him/her vulnerable, which added to MCW C's concern about Resident 1's criminal activity. Managed Care Supervisor (MCS) D stated Resident 1 was not at a setting that was appropriate to the level of supervision s/he needed. MCS D stated Resident 1 needed elevated supervision. Both MCW C and MCS D expressed concern with Resident 1 leaving during the night. The licensee did not ensure a service provider was awake at all times for residents in need of continuous care.	{M 218}		