STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016564	A. BUILDING: _____ B. WING _____	R-C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOTS RESIDENTIAL ADULT FAMILY HOME L	1936 FRANKLIN RACINE, WI 53403

(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 01/16/2025, Surveyors concluded a verification visit and two complaint investigations at Roots Residential Adult Family Home LLC. As a result, two deficient practices were identified. Two complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 3	{M 000}		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the	M 424		

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

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M 424	Continued From page 1	M 424		

provider did not ensure each resident's Individual Service Plan (ISP) was updated with changes for 1 of 1 resident. Resident 2's individual service plan (ISP) did not include a description of the safety plan to address self-injurious behaviors/self-mutilation behaviors. Resident 2 received 1:1 staffing due to a self-injurious behaviors/self-mutilation. Resident 2 had repeated incidents of self-harm, emergency visits and hospitalizations despite having 1:1 care.

Resident 2's ISP was not updated to address additional interventions for 1:1 staff and caregivers when behaviors occurred.

Findings include:

On 10/31/2024, the Department received two complaints alleging a resident required 1:1 staffing and they were not provided appropriate supervision. A resident had repeated incidents of self-harm, emergency visits, and hospitalizations despite having the intervention of a 1:1 staff to resident ratio.

On 01/14/2025 at 9:30 a.m., Surveyors requested the complete file for Resident 2. Surveyors reviewed Resident 2's record. The following was identified:

Resident 2 was admitted 12/30/2022 with diagnoses including borderline personality disorder, gender dysphoria, mood instability, depression, and self-injurious behaviors/self-mutilation. Resident 2 was his/her own guardian. Resident 2 moved out on 10/22/2024.

Resident 2's ISP, dated 07/18/2024, identified the following:

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M 424	Continued From page 2 -Needs 24-hour supervision -There is a risk as s/he has self-harmed 14 times at current placement. -Resident 2 has self-harmed 14 times at current placement. Staff will monitor all behaviors and redirect as needed. Staff will also work with Resident 2 on coping skills to prevent self-harming thoughts. Goal/Outcome: "To remain free from self-harm." -Wandering: There is no elopement risk currently. 24-hour awake staff to redirect. -Poses suicidal tendencies currently. Staff will monitor all behaviors and redirect as needed. Staff will also work with Resident 2 on coping skills to prevent self-harming thoughts. -Service provider responsible: "RRAFH (Roots Residential Adult Family Home), LLC." Resident 2's ISP, dated 10/14/2024, identified the following: Resident 2's ISP form was divided into the following categories: personal care, behavior patterns, mental and emotional health, social participation, and independent living skills. -Supervision: 24-hour supervision -Behavior patterns. Self-Abusive Behavior -Current Status: "There is a risk as s/he has self-harmed numerous times at current placement." -Frequency of Service and Services Provided: "Staff will monitor all behaviors and redirect as needed. Staff will also work with [Resident 2] on coping skills to prevent self-harming thoughts. There was no description of the coping skills Resident 2 required to prevent self-harm. -Goal/Outcome: "To remain free from self-harm." -Service provider responsible: "RRAFH, LLC."	M 424		

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M 424	Continued From page 3 Stapled to the back page of Resident 2's ISP, Surveyor read page titled, "DHS 88.06(3D)." The page read, "1. A description of the services the licensee will provide to meet the assessed need: supervision, redirection, prompts, medication management, assist in daily living skills, keto diet management [sic] 2. Identification of the level of supervision required in the home and community: 1:1 staffing all shifts [sic] 24/hrs. [sic] 3. Description of services provided by outside agencies: LGBTQ meetings Racine County, Psych (Tele psych) 4. Identification of who will monitor plan: Care team (staff, leadership, county) 5. Making the environment safe ... History ... Description of Challenging or Dangerous "Target" Behaviors 1. Continued risk of self-harm 2. Severe symptoms affecting functioning 3. Triggered by others behavior 4. Staff manipulation 5. False accusations [sic] Staff will keep cleaning supplies locked and will not clean while member is woken [sic] staff will complete checks of members pocket, shoes and hoodie upon entering the home from outside as member has self-harmed. All sharps in the home will remain locked up and out of reach of member. Staff will keep all coloring, pens, markers locked up unless you utilized in front of staff. Staff will continue to work with member on DBT (dialectical behavior therapy) skills and coping skills to prevent self-harming behaviors. Staff will take member for a walk and get them out of the home when another member may be in behavior." Surveyor noted 6 incidents requiring emergency room visits or hospitalizations that occurred before Resident 2's ISP was updated, on 10/14/2024, documented as follows:	M 424		

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M 424	Continued From page 4 Resident 2's Behavioral Incident Reports -On 08/17/2024, at 2:20 p.m., Resident 2 took a cup and dipped it into the mop water that contained bleach and drank it. Staff transported Resident 2 to the hospital. -On 08/31/2024, at 5:30 p.m., Resident 2's incident report indicated Resident 2 inserted objects into his/her arm. Resident was taken to emergency room (ER). Hospital staff was able to remove items. Resident 2 returned to facility. -On 08/31/2024 at 5:30 p.m., Resident 2's incident report indicated Resident 2 placed staples in his/her arm. Staff inquired where the staples came from, Resident 2 stated that s/he took them out of his/her crafts book. Staff transported Resident 2 to the hospital, where they were able to remove the staples from Resident 2's arm. -On 09/07/2024 at 7:00 p.m., Resident 2 inserted a zipper into his/her arm and reopened a wound. S/He was transported to the hospital to have it removed. -On 10/09/2024 at 7:00 p.m., Resident 2 was outside with staff. Resident 2 found a pen outside, went into the AFH and swallowed the pen while not being supervised in his/her bedroom. Resident 2 was transported to the hospital to have the pen surgically removed. -On 10/13/2024 at 1:00 pm., Resident 2 was in the restroom, took apart the soap dispenser and swallowed pieces. S/He also went into his/her room and retrieved a nail from the floor, cut his/her arm open and placed the nail into his/her arm. Staff transported Resident 2 to the hospital. Interviews On 01/14/2025 at 9:55 a.m., Surveyor interviewed	M 424		

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M 424	Continued From page 5 Human Resource Officer (HR) B, who stated after Resident 2 drank the bleach at the facility, "We stopped cleaning when s/he was awake. Everything was removed. Chemicals, hand soap, toothpaste. Everything." HR B confirmed Resident 2 had 1:1 staffing. HR B added, "There were gaps. We can't go in the bathroom with him/her. S/He gets to go in his/her room. Resident 2 was to be within eyesight." HR B stated after Resident 2 swallowed the ink pen, the staff began doing a clothing, shoe, and body check. Surveyor asked when all of these interventions were assessed and added to Resident 2's ISP. HR B stated, "It's all been added and signed by [Resident 2]." On 01/14/2025 at 12:43 p.m., Surveyor interviewed HR B, who stated the provider did not do a new assessment for Resident 2 after all the self-harm incidents; however, they did update the ISP on 10/14/2024. On 01/15/2025 at 3:50 p.m., Surveyor interviewed Licensee J. Surveyor asked what new interventions were tried after each behavioral incident to protect the safety and wellbeing of Resident 2. Licensee J stated, "We have the same interventions. We cannot do anything. If someone wants to self-harm, they are going to self-harm." Cross Reference: N0436 DHS 88.07(2)(a) Services	M 424		
M 436	88.07(2)(a) SERVICES The licensee shall provide or arrange for the provision of individualized services specified in a resident's	M 436		

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M 436	Continued From page 6 individual service plan that are the licensee's responsibility. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure services specified in 1 of 1 resident's individual service plan (ISP) were provided. Resident 2 had a history of self-injurious behavior/self-mutilation. Resident 2 had a 1:1 staff member 24 hours a day. Resident 2 had 6 occurrences of self-mutilation/self-injurious behaviors that resulted in hospital visits, while on 1:1 care. On 08/17/2024 at 2:20 p.m., Resident 2 drank bleach. Staff transported Resident 2 to the hospital. On 08/31/2024 at 5:30 p.m., Resident 2's incident report indicated s/he inserted objects into his/her arm. Resident 2 was taken to emergency room (ER). Hospital staff was able to remove items. Resident 2 returned to facility. On 08/31/2024 at 5:30 p.m., Resident 2's incident report indicated s/he placed staples in his/her arm. Staff inquired where the staples came from, Resident 2 stated that s/he took them out of his/her crafts book. Staff transported Resident 2 to the hospital, where they were able to remove the staples from Resident 2's arm. On 09/07/2024 at 7:00 p.m., Resident 2 inserted a zipper into his/her arm and reopened a wound. S/He was transported to the hospital to have it removed.	M 436		

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M 436	Continued From page 7 On 10/09/2024 at 7:00 p.m., Resident 2 was outside with staff. Resident 2 found a pen outside, went into the AFH and swallowed the pen while not being supervised in his/her bedroom. Resident 2 was transported to the hospital to have the pen surgically removed. On 10/13/2024 at 1:00 pm., Resident 2 was in the restroom, took apart the soap dispenser and swallowed pieces. S/He also went into his/her room and retrieved a nail from the floor, cut his/her arm open and placed the nail into his/her arm. Staff transported Resident 2 to the hospital. Findings include: On 10/31/2024, the Department received two complaints alleging a resident required 1:1 staffing and they were not provided appropriate supervision. A resident had repeated incidents of self-harm, emergency visits, and hospitalizations despite having the intervention of a 1:1 staff to resident ratio. On 01/14/2025 at 9:30 a.m., Surveyors requested complete file for Resident 2. Surveyors reviewed Resident 2's record. The following was identified: -Resident 2 was admitted 12/30/2022 with diagnoses including borderline personality disorder, gender dysphoria, mood instability, depression, and self-injurious behaviors/self-mutilation. Resident 2 was his/her own guardian. Resident 2 moved out on 10/22/2024. Resident 2's physical intake assessment, dated 01/04/2023, under mood and behavioral patterns, read, "Resident does display sadness or anxiety."	M 436		

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M 436	Continued From page 8 Under socially inappropriate/disruptive behavior: self-abusive acts ...sexual behavior, etc., "Behavior not exhibited recently or ever." Resident 2's ISP, dated 07/18/2024 identified the following: -Needs 24-hour supervision. Resident 2's ISP, dated 10/14/2024, identified the following: Resident 2's ISP form was divided into the following categories: personal care, behavior patterns, mental and emotional health, social participation, and independent living skills. -Supervision: 24-hour supervision. Resident 2's Self Reports On 08/17/2024 at 2:20 p.m., while staff was cleaning the kitchen, Resident 2 took a cup and dipped it into the mop water. Staff attempted to redirect Resident 2, but s/he drank the cup of mop water which had bleach in it. Staff transported Resident 2 to the hospital. Action taken to ensure residents health safety and well-being: "Resident 2 was kept at the hospital for an evaluation." On 10/09/2024 at 7:00 p.m., Resident 2 was outside with staff. Resident 2 found a pen outside, went into the AFH and swallowed the pen while not being supervised in his/her bedroom. Resident 2 was transported to the hospital to have the pen surgically removed. Action taken to ensure residents health safety and well-being: "Staff will continue to complete checks once Resident 2 leaves the home and returns. Staff will also continue to work with Resident 2 on noticing triggers prior to self-harming."	M 436		

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M 436	Continued From page 9 On 10/13/2024 at 1:00 pm., "[Resident 2] had gone to the bathroom and came out and went back in their room. Member came out of their room and state [sic] that they had swallowed the bathroom soap dispenser and stuck a nail from the piece of the floor they broke." Staff transported Resident 2 to the hospital. Action taken to ensure residents health safety and well-being: "Staff have added removal and lock up of all soaps until distributed by staff to the ISP for member. Maintenance has been made aware of the floor in [sic] which member damaged so that it could be repaired again." Emergency Room/Hospital Reports On 08/17/2024, Resident 2 was seen at Ascension All Saints Hospital. His/her admission paperwork read, "[Resident 2] presents from his/her group home after s/he intentionally ingested about 1/2 bottle of bleach around 1430 this afternoon. Resident 2 reports that s/he drank the bleach in an attempt to kill himself/herself... Of note, [Resident 2] was seen in the emergency room department on 7/19/24 after s/he intentionally inserted two small zip ties into his/her left forearm which were removed." On 10/16/2024, Winnebago Mental Health Institutes admission note read, "Chief complaint: [Resident 2] is on a civil commitment through Pierce County and placed at a group home in Racine County. S/He is being returned on a commitment based on clinical judgment do to self-injurious behavior exhibited while in group home. [Resident 2] has been engaging in self-harm by biting his/her arms, embedding foreign objects into the wound, and ingesting craft supplies. From 10/9 to 10/11 [Resident 2] was medically admitted to the hospital after ingesting	M 436		

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M 436	Continued From page 10 a pen ink cartridge and spring. On 10/13, [Resident 2] was again medically admitted after s/he ingested a piece of soap dispenser and imbedded a rusty nail in his/her arm." On 01/14/2025 at 12:43 p.m., Surveyor interviewed HR B, who stated the facility did not do a new assessment for Resident 2 after all the self-harm incidents. However, the facility did update the ISP on 10/14/2024. On 01/15/2025 at 9:35 a.m., Surveyor reviewed Managed Care Organization (MCO) documentation. The following was identified: -Initial screen, dated 08/15/2024, identified under additional supports, Resident 2 needed 'the continuous presence of another person.' The notes read, "Due to safety concerns, [Resident 2] lives in a home with 24/7 awake staff." -10 day initial assessment worksheet dated 09/12/2024, Care Manager (CM) G wrote, "[Resident 2] self-harms ...[Resident 2] frequents [sic] the emergency department due to self-harm." - Long term care target group audit information report, dated 10/07/2024, read, "[Resident 2] is currently living in a group home through a commitment order related to ongoing self-harm and the need for supervision to keep [Resident 2] safe ... Due to cognitive impairments, [Resident 2] exhibits behaviors of self-harm including eating and drinking nonfood items such as bleach and cutting and biting himself/herself to the point of requiring medical attention and violent and offensive behaviors of pushing and hitting staff due to internally motivated factors that are unpredictable. [Resident 2] requires a formal	M 436		

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behavior plan with five+ interventions during the day and night of line-of-sight supervision, 1:1 staffing, locking up sharps, cleaning up any other sharp objects such as chicken bones, locking up cleaning chemicals, weekly talk therapy sessions and calling [Family I] when s/he is upset."

On 01/16/2025 at 1:30 p.m., Surveyor reviewed Resident 2's MCO critical incident notes. The following was identified:

On 09/08/2024, Family Care Supervisor (FC S) K noted Resident 2 presented to emergency department because s/he, "bit a chunk out of my arm" to hurt himself/herself. Resident 2 then inserted a zipper into his/her arm and reopened a wound. S/He was transported to the hospital to have it removed again. FC S K wrote, "Staff were not in-line of sight during the incident."

On 10/09/2024, FC S K noted Resident 2 presented to emergency department for swallowing foreign object to intentionally harm himself/herself. Resident 2 swallowed a pen spring and a pen ink cartridge with metal tip attached. "[Resident 2] is to have 1:1 staff 24/7."

On 10/13/2024 FC S K noted Resident 2 presented to emergency department for swallowing a soap pump straw and inserting a rusty nail into his/her arm. Resident 2 required surgical intervention for removal. FC S K noted, "In reading the reports, it states the staff went to check on the [Resident 2]. It does not appear [Resident 2] was actually receiving 1:1 as s/he should have."

On 01/16/2025 at 11:30 a.m., Surveyor interviewed Nurse Care Manager (RN CM) H and Care Manager (CM) G. RN CM H explained the

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critical incidents for the MCO were defined as any injury of suspicious nature that resulted in a hospitalization. Typically, the critical incident reports were written up with the resident's care team. RN CM H, CM G and Family Care Supervisor (FCS) K all worked on the writing of the incident reports. RN CM H confirmed the content of the critical incident reports that were submitted by his/her Supervisor, FCS K.

Adult Protective Services

On 01/15/2025 at 9:35 a.m., Surveyor reviewed APS investigation notes. The following was identified:

On 09/09/2024, Adult Protective Services (APS) E interviewed County Behavioral Health (BH) F. Resident 2's room and board at the AFH was paid for by County Behavior Health (CBH). BH F confirmed CBH paid for Resident 2 to be on 1:1 care. BH F reported on one occasion, [Resident 2] reported that s/he was supposed to fill up a mop bucket and the cabinet was left unlocked. [Resident 2] got a hold of the bleach and drank it. S/He also reported that the staff is no longer his/her 1:1.

On 09/11/2024, APS E spoke with Human Resource Officer (HR) B, who supplied incidents reports to APS E regarding incidents that had taken place at the facility with Resident 2. The following was identified in the forwarded paperwork:

-08/17/2024 - Resident 2 took a cup and dipped it into the mop water that contained bleach and drank it. This required Resident 2 to go to the hospital.
-8/31/2024 - Resident 2 obtained and inserted a

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	0016564	A. BUILDING: _____ B. WING _____	R-C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOTS RESIDENTIAL ADULT FAMILY HOME L	1936 FRANKLIN RACINE, WI 53403

(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 436	Continued From page 13	M 436		

foreign object into his/her arm and hospital had to remove the foreign object.
-09/07/2024 - Resident 2 inserted a zipper into his/her arm and reopened his/her wound and had to go to the hospital to have it removed again.
-10/09/2024 - Resident 2 found a pen outside and went into the AFH and swallowed it while not being supervised. Resident 2 had to go to the hospital and have it surgically removed.
-10/13/2024 - Resident 2 was in the restroom took apart the soap dispenser and swallowed pieces, then went to Resident 2's room and retrieved a nail from the floor, cut his/her arm open and placed the nail into Resident 2's arm.

On 10/16/2024, APS E spoke with Family Care, Care Manager (FC CM) G, who stated they were attempting to find Resident 2 new placement, but were having difficulty getting, "advanced services." FC CM G stated Resident 2 recently went into the bathroom, came out and informed staff that s/he had swallowed the straw to the soap dispenser, then went into his/her room and managed to pry a rusty nail up from his/her floor and self-injure. FC CM G also noted that on 10/10/2024, Resident 2 was hospitalized again for swallowing the ink straw from a pen and had to have it removed.

On 01/16/2025 at 9:50 a.m., Surveyor interviewed APS E, who confirmed the findings in his/her report, that concluded on 10/28/2024.

Pierce County Behavioral Health and Human Services.

On 09/09/2024 at 11:33 a.m., Community Support Worker (CSW) F emailed Community Health Manager (CHM) O to inform, "[Resident 2] bit a hole in his/her arm and inserted a zipper

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ROOTS RESIDENTIAL ADULT FAMILY HOME L	1936 FRANKLIN RACINE, WI 53403

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M 436	Continued From page 14 yesterday. She was brought to the emergency room." On 10/15/2024 at 10:56 a.m., CSW F emailed Community Health Manager (CHM) O to inform, "[Resident 2] is now placed in inpatient due to swallowing the soap dispenser and nail from the flooring." On 01/15/2025 at 11:42 a.m., Community Health Manager (CHM) P emailed HR B to confirm if the $650 rate is for 2:1 staffing or 1:1 staffing. On 01/15/2024 at 11:56 a.m., HR B confirmed, "1:1 behavioral clients [sic]." Interviews On 01/14/2025 at 9:11 a.m., Surveyor interviewed Caregiver L who stated Resident 2 would, "self-harm himself/herself right in front of us. S/He was trying to get attention. We couldn't stop him/her." On 01/14/2025 at 9:19 a.m., Surveyor interviewed Caregiver M, who stated Resident 2 would self-harm himself/herself with anything. "[Resident 2] was the highest level of self-harm I've ever worked with. S/He was a 1:1." On 01/16/2025 at 11:25 a.m., Surveyor interviewed RN CM H, who confirmed Resident 2 required 24/7 care including 1:1 supervision, while s/he was at facility. RM CM H stated, "[Resident 2] was at that facility for almost two years S/He had enhanced services, or 1:1 care, for the whole stay. Even when s/he transferred from County Behavioral Health to the MCO, since 1:1 care was already in place, we would have kept it in place and reevaluated it in 30-days. It remained active."	M 436		

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M 436	Continued From page 15 On 01/16/2025 at 11:30 a.m., Surveyor interviewed CM G, who stated when s/he went on a home visit, the staff was sitting in the kitchen on their phones. [Resident 2] was in his/her room with the door shut. That was concerning because it was not within eye-view." Cross Reference: N0424 DHS 88.06(3)(f) Review of ISP	M 436		