STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016034	A. BUILDING: _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOTS RESIDENTIAL ADULT FAMILY HOMES	1715 LASALLE STREET UPPER RACINE, WI 53402

(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 07/17/2024, Surveyor completed 2 complaint investigations at Roots Residential Adult Family Homes LLC-Lower. As a result, 7 deficiencies were identified. Two complaints were substantiated. Census: 4	M 000		
M 216	88.04(2)(a) RESPONSIBILITIES The licensee shall ensure that the home and its operation comply with this chapter and with all other laws governing the home and its operation. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the home and its operation complied with this chapter and all the other laws governing the home and its operation. Surveyor conducted 2 complaint investigations, and 7 deficiencies were identified during the investigation. Two of 2 complaints were substantiated. Findings include: The home was licensed as an ambulatory adult family home caring for up to 4 residents in the client groups of traumatic brain injury, correctional clients, developmentally disabled, alcohol/drug dependent, irreversible dementia/Alzheimer's, physically disabled, advanced age, terminally ill, and emotionally disturbed/mental illness. On 05/29/2024 through 09/11/2024, Surveyor conducted 2 complaint investigations. The following 7 violations, which includes this	M 216		

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

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M 216	Continued From page 1 violation, were identified: 88.04(2)(a) - Responsibilities 88.05(3)(a) - Home Environment 88.06(3)(d) - Individual Service Plan 88.06(3)(d)1 - Description of Services 88.07(3)(a) - Prescription Medications 88.10(3)(e) - Self-Direction 50.065(2)(bb) - Determine Final Disposition of Charge On 06/11/2024, at 12:36 PM, Surveyor interviewed Licensee A. Licensee A reported Surveyor's findings were not accurate, the residents were well cared for by trained staff, and resident rights violations did not exist in the home. Licensee A reported s/he would be having a conversation with Human Resource Director B regarding paperwork and the hiring process.	M 216		
M 276	88.05(3)(a) HOME ENVIRONMENT An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure the adult family home (AFH) was safe, clean, well-maintained, and provided a homelike environment for 3 of 4 residents in the home. The home required cleaning and/or repairs.	M 276		

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M 276	Continued From page 2 Findings include: On 06/11/2024, at 11:12 AM, Surveyors conducted an onsite tour of the home and observed the following: Resident 5's bedroom contained an oscillating pedestal fan, which was missing the front cover, exposing the blades of the fan, and was covered in approximately ¼ inch of a grayish substance, consistent with dust. The door to Resident 5's bedroom was not the same size as the frame, causing approximately a 2-inch gap at the top. The door was not openable more than 17 inches and could not be latched closed. Clothing was hung up in front of the window to block the outside light and was absent of window treatments for the upper portion of the window. Trim pieces within the inside frame of the window were broken, hanging, and did not allow for the window to close. In Resident 2's and Resident 3's shared bedroom, the flooring at the door entry to the room was missing, exposing the subfloor. The area of the missing flooring was approximately 28 inches in length and 6 inches in width. On 06/11/2024, at 12:36 PM, Surveyor interviewed Licensee A and Director of Human Resources (HR) B. They reported the home was recently painted and some repairs had been made.	M 276		
M 410	88.06(3)(d) INDIVIDUAL SERVICE PLAN The individual service plan shall contain at least the following:	M 410		

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M 410	Continued From page 3	M 410		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 2 of 2 residents' (Resident 1 and Resident 3) Individual Service Plans (ISPs) included information that was specific to the individual, and accurately identified current needs and abilities.

Findings include:

The home was licensed as an ambulatory adult family home (AFH) caring for up to 4 residents in the client groups of traumatic brain injury, correctional clients, developmentally disabled, alcohol/drug dependent, irreversible dementia/Alzheimer's, physically disabled, advanced age, terminally ill, and emotionally disturbed/mental illness.

On 05/31/2024, Surveyor reviewed Resident 1's ISP, dated 12/22/2023, and the following was reported:

Resident 1 was admitted to the facility on 12/21/2023, had a guardian, and required 24-hour supervision with a one-on-one staff. Resident 1's ISP documented the following:

"Interaction with others: Current Status: Has struggled with staff and peer interactions; Frequency of Service and Service Provided: staff is to monitor all member's behaviors and redirect with verbal cues as needed; Goal/Outcome: to continue to encourage [Name - someone other than Resident 1] to remain polite towards peers;

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Service Provider Responsible: RRAFH, LLC. Aggressive/Combative: Current Status: Has history of aggression; Frequency of Service and Service Provided: In the event, staff will redirect with verbal cues, additional staff, provide space; Goal/Outcome: To keep [Name - someone other than Resident 1] happy and calm and refrain from aggressive behaviors; Service Provider Responsible: RRAFH, LLC [sic]."

On 2 occasions, the ISP referenced another person, other than Resident 1, within the goal/outcome section of Resident 1's ISP.

Resident 3 was admitted to the facility on 02/08/2024, was her/his own person, and required 24-hour supervision with a one-on-one staff. Resident 3's ISP documented the following:

"Maturation: Current Status: is at the appropriate maturity level; Frequency of Service and Service Provided: Staff will encourage [Name - someone other than Resident 3 crossed out] [Resident 1] to live independently . . . Interaction with Others: Current Status: Has struggled with staff and peer interactions; Frequency of Service and Service Provided: Staff is to monitor all member's behaviors and redirect with verbal cues as needed; Goal/Outcome: To continue to encourage [Name - someone other than Resident 3] to remain polite towards peers; Service Provider Responsible: RRAFH, LLC. Aggressive/Combative: Current Status: none listed; Frequency of Service and Service Provided: In the event, staff will redirect with verbal cues, additional staff, provide space; Goal/Outcome: To keep [Name - someone other than Resident 3] happy and calm and refrain from aggressive behaviors; Service Provider Responsible: RRAFH, LLC [sic]."

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M 410	Continued From page 5 On 3 occasions, the ISP referenced another person, other than Resident 3, within the frequency of service and service provided and goal/outcome sections of Resident 3's ISP. Between 09/10/2024 and 09/11/2024, Surveyor interviewed Director of Human Resources (HR) B. HR B reported everyone was included in writing ISPs for the residents. S/He reported everyone viewed and went through the ISPs as well. Surveyor inquired who HR B was referring to when s/he reported, "everyone." HR B reported s/he was responsible for writing ISPs and wrote them in the presence of the resident and other AFH staff. Following the creation of an ISP, the draft was sent to a guardian, if one existed for the resident, and the resident's care team. The guardian/resident's care team sent back any corrections to the ISP, and the ISP was implemented.	M 410		
M 412	88.06(3)(d)1 DESCRIPTION OF SERVICES A description of services the licensee will provide to meet the assessed need. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure each resident's Individual Service Plan (ISP) included a description of services staff were to implement to manage behaviors for 1 of 1 resident. Resident 1's ISP did	M 412		

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M 412	Continued From page 6	M 412		

not include information regarding how staff were to manage Resident 1's behaviors. Resident 1 was assigned a 1:1 staff person, but the ISP did not identify how the service of designated staff would assist Resident 1 with behavior management. Resident 1's behaviors escalated to requiring additional staff to calm Resident 1 down and hospitalization due to self-harm.

Findings include:

On 05/31/2024, Surveyor reviewed Resident 1's record. The following was identified:

- Resident 1 was admitted to the facility on 12/21/2023, with diagnoses including intellectual developmental disorder, traumatic brain injury (TBI), anxiety, major depressive disorder, substance use disorder, reactive attachment disorder, attention deficit hyperactivity disorder (ADHD), and borderline personality disorder traits.

- Resident 1 had a guardian.

- Resident 1's ISP, dated 12/22/2023, identified Resident 1 required 24-hour supervision and was assigned a one-on-one staff member. Resident 1's ISP identified Resident 1 exhibited behaviors and stated, " . . . Behavior Patterns: Self-Abusive Behavior: Risk of self-abuse. Service Provided: Staff will monitor all behaviors and redirect as needed. Goal/Outcome: To remain free from self-harm. Suicidal Tendencies: Previous suicidal tendencies at previous placement . . . Service Provided: Staff will assist and redirect as needed. Goal/Outcome: To keep encourage member to use coping skills and express to staff when feelings arrive . . . Mental and Emotional Health . . . Attitude: displays a positive attitude most of the

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M 412	Continued From page 7	M 412		

time . . . Service Provided: Staff will continue to encourage positive attitude. Goal/Outcome: To keep attitude positive at all times . . . Interaction with Others: Has struggled with staff and peer interactions . . . Service Provided: Staff is to monitor all member's behaviors and redirect with verbal cues as needed. Goal/Outcome: To continue to encourage [Name - someone other than Resident 1] to remain polite towards peers . . . Aggressive/Combative: Has history of aggression . . . Service Provided: In the event, staff will redirect with verbal cues, additional staff, provide space. Goal/Outcome: To keep [Name - someone other than Resident 1] happy and calm and refrain from aggressive behaviors."

- Resident 1's record did not include strategies for teaching appropriate coping skills or inform staff what coping skills should have been practiced when Resident 1 had behaviors.

- Resident 1's record did not describe how Resident 1's 1:1 staff assigned to him/her would monitor his/her behavior.

- Resident 1's record did not identify ways for Resident 1's staff to redirect Resident 1 when having various behaviors identified.

- Resident 1's ISP did not identify how staff were to assist with keeping Resident 1 "positive at all times" and "happy and calm" to decrease behaviors.

- Resident 1's ISP did not identify any interventions to assist Resident 1 with calming him/herself before his/her behavior becomes a crisis.

On 05/29/2024, at approximately 2:00 PM,

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M 412	Continued From page 8 Surveyor requested from Human Resource Director (HR) B documentation of incident reports with Resident 1. Surveyor received documentation of incident reports dating back to 01/18/2024. The following was reported: - 01/18/2024, at 5:00 PM, stated: "[Resident 1] got off a call with [her/his] [parent] and started threatening staff. [Resident 1] demanded that staff provide [her/him] with cigarettes and that [s/he] can come and go as [s/he] pleased. Staff attempted to redirect [her/him], but [s/he] continued to threaten staff and walk towards them aggressively. Staff gave space and additional staff arrived. [Resident 1] continued to make threats to harm staff but was able to be redirected by staff. Describe what worked to calm the member down. Additional staff redirection. Describe the outcome of the overall incident: [Resident 1] was in [her/his] room the remainder of the shift outside of medication pass and dinner." - 02/06/2024, at 7:00 PM, stated: "member was on the phone with [her/his] [parent]. Once off the phone member began to swear at staff telling them that [her/his] [parent] was going to jail again. Staff attempted to redirect [her/him], but [s/he] began to curse at staff. Member went into [her/his] bedroom and swallowed [her/his] battery out of [her/his] remote. Staff transported [her/him] to the hospital where they were not able to remove it and informed [her/him] that [s/he] would have to naturally allow for it to come out. Member was transported back home. Describe what worked to calm the member down: hospital visit. Describe the outcome of the overall incident: member returned home from hospital and went to sleep [sic]."	M 412		

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M 412	Continued From page 9 - 02/26/2024, at 2:00 PM, stated: "[Resident 1] ended a call with [her/his] [parent] and came into the living room and snatched a remote from another resident. Staff prompted [her/him] to give the remote back as [s/he] cannot take the remote from another member. [Resident 1] began to yell and curse at staff. Staff redirected [her/him] but [s/he] continued and made verbal threats to staff. An additional staff member assisted with redirecting [Resident 1] to [her/his] room to cool off. [Resident 1] later took a prn (as needed medication) and apologized for [her/his] behavior. Describe what worked to calm the member down: additional staff redirection Describe the outcome of the overall incident: member will remain in his room outside of meals and medication [sic]." The report was reviewed by HR B and managerial comments stated, "[Resident 1] has a behavior everyday after [s/he] has a call with [parent] as [s/he] encourages the behavior [sic]." - 02/28/2024, at 1:00 PM, stated: "[Resident 1] had been yelling at [her/his] roommate. One staff approached to redirect [her/him], [s/he] began to call both staff members [expletive] repeatedly. Staff encouraged [her/him] to communicate positively but [s/he] continued to call staff names and then began slamming [her/his] door. Additional staff were able to assist and redirect [her/him]. [Resident 1] later apologized for his behavior. Describe what worked to calm the member down: redirection from staff, education from staff. Describe the outcome of the overall incident: [Resident 1] will remain in [her/his] room outside of medication and meals [sic]." The report was reviewed by HR B and managerial comments stated, "[Resident 1] continues to display outburst after any phone call with [her/his] family [sic]."	M 412		

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M 412	Continued From page 10 - 05/09/2024, at 10:00 AM, stated: "[Resident 1] had fallen asleep in the living room and was asked to go into [her/his] room and sleep. [Resident 1] began to curse and make threats to harm staff. Additional staff intervened and attempted to redirect [Resident 1] as [s/he] continued to approach staff and make threats towards staff. Staff educated [Resident 1] on the consequences of harming staff, and [s/he] was able to be redirected back to [her/his] room. Describe what worked to calm the member down. Additional staff redirection. Describe the outcome of the overall incident: [Resident 1] was in [her/his] room the remainder of the shift outside of medication pass and meals [sic]." - 05/09/2024, at 6:00 PM, stated: "[Resident 1] had been caught by staff requesting money from [her/his] [parent] to send to an online scam. [Resident 1] [parent] had called staff asking where to send funds to for [her/him] to send to [her/his] [girl/boyfriend]. Upon [Resident 1] showing staff it was an online scam and they advised [Resident 1] and [her/his] [parent] that it was not a scam. Once [parent] was notified and did not send the funds, [s/he] began to curse staff out and make threats to harm staff. Staff were able to redirect [Resident 1] and educate [her/him] on scams and [s/he] appeared to calm down as [s/he] went into [her/his] room to lay down. [Resident 1] came out of [her/his] room shortly after and stated that [s/he] swallowed one of the small batteries from the window chime. Staff transported [her/him] to the hospital immediately. Describe what worked to calm the member down. Additional staff redirection. Describe the outcome of the overall incident: [Resident 1] remains in the hospital as the battery will need to be removed today [sic]."	M 412		

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M 412	Continued From page 11 On 06/11/2024, at 12:36 PM, Surveyor interviewed Licensee A and HR B. They reported Resident 1's behavioral incident on 05/09/2024, was the result of Resident 1 avoiding her/his court appearance. Licensee A and HR B did not comment on any of the other behavioral incident reports. In summary, Surveyor was provided with 6 documented behavioral incident reports for Resident 1, between the dates of 01/18/2024 and 05/09/2024. The behavioral incident report form the provider used allowed for the reporting person(s) to identify any interventions attempted. The following were options of interventions the form provided: give space; member coping skills; suggest an activity; go for a walk; go for a van ride; talk to member; and other, which were not individualized for Resident 1. Six of 6 incidents, staff did not attempt to suggest an activity, go for a walk, or go for a van ride. Five of the 6 behavioral incident reports documented Resident 1 had behaviors after speaking with a family member on the phone. Five of the 6 incidents required additional staff redirection as an intervention. Four of 6 incidents reported Resident 1 was redirected to her/his bedroom and remained there outside of medication passes and meals. Two of 6 incidents resulted in hospitalization for Resident 1. All 6 incidents were reviewed by HR B, and in 4 of 6 reports the managerial notes reported staff had managed the behavior appropriately. Managerial notes on Resident 1's behavioral incident reports also documented the following: behaviors occurred every day after Resident 1 spoke with her/his parent, and Resident 1 continued to display outbursts after phone calls with her/his family. None of the 6 reports documented why the behaviors occurred, what interventions were	M 412		

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M 412	Continued From page 12 effective or not effective for Resident 1, and what had been done to manage Resident 1's behaviors and prevent them from recurring. Cross reference: DHS 88.10(3)(e) Self-Direction.	M 412		
M 458	88.07(3)(a) PRESCRIPTION MEDICATIONS Every prescription medication shall be securely stored, shall remain in its original container as received from the pharmacy and be stored as specified by the pharmacist. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure 3 of 3 medications that required refrigeration were securely stored. Resident 3's insulin was stored in the common refrigerator, which was unlocked, and accessible to all 4 residents in the home. Findings include: The home was licensed as an ambulatory adult family home caring for up to 4 residents in the client groups of traumatic brain injury, correctional clients, developmentally disabled, alcohol/drug dependent, irreversible dementia/Alzheimer's, physically disabled, advanced age, terminally ill,	M 458		

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(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 458	Continued From page 13 and emotionally disturbed/mental illness. On 06/11/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the facility on 02/08/2024, with a diagnosis of diabetes. On 06/11/2024, at 11:18 AM, Surveyor observed Resident 3's insulin (4 Lantus SoloStar pens, 1 LyumJev KwikPen, and 2 Insulin Lispro 100 units 20 milliliters (ml)) in the side of the refrigerator door, unsecured. Residents were observed to be ambulatory and able to move around freely in the facility. On 06/11/2024 at 11:20 AM, Surveyor reviewed Resident 3's prescription labels on the medication boxes. Resident 3's prescription label as of 04/24/2024 stated the following: -Lantus: Inject 18 units subcutaneously every morning and 20 units every night at bedtime, maximum 40 units/day Resident 3's prescription label as of 05/14/2024 stated the following: -Insulin Lispro use up to 68 units per day with pump (1 of 2 bottle) -Insulin Lispro use up to 68 units per day with pump (2 of 2 bottle) On 06/11/2024, at 11:30 AM, Surveyors interviewed Caregiver D regarding the medication in the refrigerator. Caregiver D stated s/he did not know where the lockbox was.	M 458		
M 556	88.10(3)(e) Self-Direction Self-direction. To have opportunities	M 556		

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M 556	Continued From page 14	M 556		

to make decisions relating to care, activities and other aspects of life in the adult family home. No curfew, rule or other restrictions on a resident's freedom of choice shall be imposed unless specifically identified in the home's program statement or the resident's individual service plan. An adult family home shall help any resident who expresses a preference for more independent living to contact any agency needed to arrange it.

This Rule is not met as evidenced by:
Based on observation, interview, and record review, the provider did not ensure 4 of 4 residents had opportunities to make decisions related to care, activities, and other aspects of life in the adult family home (AFH). Resident 2, Resident 3, Resident 4, and Resident 5 were required to be in their bedrooms by 8:00 PM and remain there until 8:00 AM. Residents did not have access to the kitchen after 7:00 PM. Residents' personal cell phones were taken and secured by staff on a nightly basis.

Findings include:

On 06/11/2024, at 11:09 AM, Surveyors conducted an onsite tour of the home and observed the following:

A handwritten sign was posted in the common dining space. The following is what the sign documented, "Please follow!! 8:00 AM - 9:30 AM = Breakfast snack: 10:30 AM - 11:00 AM 12:00 PM - 1:30 PM = Lunch snack: 2:30 PM - 3:00 PM 4:00 PM - 6:00 PM = Dinner snack: 7:30 PM - 8:00 PM NO resident in kitchen alone!!! Kitchen

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M 556	Continued From page 15 close at 7:00 PM!!! [sic]." On 06/11/2024, at 11:43 AM, Surveyor interviewed Resident 2. Resident 2 reported staff kept her/his personal cell phone locked up. S/He was allowed 1 hour per day on her/his phone, while sitting next to staff. A curfew was enforced at 8:30 PM, requiring residents to be in their bedrooms until the morning. Food was not allowed after 7:00 PM. On 06/11/2024, at 12:07 PM, Surveyor interviewed Resident 4. Resident 4 reported a curfew was enforced from 8:00 PM - 7:00 AM, which required residents to be in their bedrooms. Residents were required to ask their one-on-one staff permission to exit their bedrooms during these hours if they needed to use the bathroom or get a drink of water. On 06/11/2024, at 12:23 PM, Surveyor interviewed Resident 3. Resident 3 reported a curfew was enforced at 8:30 PM, requiring residents to be in their bedrooms until the morning. Food was not allowed after 7:00 PM. Resident 3 was a diabetic and had her/his own snacks which were locked up. When Resident 3 needed to access her/his snacks to maintain blood sugars, s/he was required to ask staff to unlock her/his snack cabinet. Resident 3 did not have key access to her/his snacks. Resident 3 did not have her/his own cell phone but was aware of the house rule which required residents to turn in their personal phones at 8:30 PM, which were kept locked up until all chores and cares were completed in the morning. On 06/11/2024, at 10:27 AM, Surveyor interviewed Caregiver D and Caregiver F. Caregiver D and Caregiver F reported the	M 556		

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M 556	Continued From page 16	M 556		

following. The house rules included curfew hours, in which residents must remain in their bedrooms from 8:00 PM until 8:00 AM. If residents needed to use the bathroom or get a drink, they were required to ask their one-on-one staff. Surveyor did not locate posted house rules. Caregiver D and Caregiver F reported they learned of the house rules from Director of Human Resources (HR) B. Caregiver D reported the kitchen was closed after 7:00 PM. Surveyor inquired what was done if a resident wanted food after 7:00 PM. Caregiver D stated, "there's no need to be in the kitchen in the middle of the night. The kitchen is closed."

On 06/11/2024, at 12:36 PM, Surveyor interviewed Licensee A and HR B. Licensee A and HR B reported the facility did not have curfew hours in which residents were to stay in their bedrooms. Residents were allowed to leave their bedrooms whenever they needed. The kitchen was not closed to residents during specific times. Most residents have typically eaten meals and snacks during the times they were offered. They were unaware of a posted sign.

On 06/13/2024, at 4:47 PM, Licensee A sent an email which stated, "[Surveyor] I have followed up on a few items and there is no sign at the house that says 'kitchen closes at 7' and all the room doors work and lock so I'm confused why this was stated."

On 07/17/2024, Surveyor reviewed the program statement for the home, dated 07/20/2016. Surveyor did not observe a curfew, rule, or other restriction on the residents' freedom of choice within the program statement. Surveyor also reviewed individual service plans (ISPs) for Resident 2, Resident 3, and Resident 4, and

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M 556	Continued From page 17 identified the following: Resident 2 was admitted to the home on 06/20/2023. Resident 2 was her/his own person. Resident 2 was under the care of 24/7 one-on-one staff. Resident 2's ISP was dated 07/15/2024. Resident 2's ISP stated, "Member has a 1-hour cell phone restriction as [s/he] abuses the phone with calling local authorities, schools, and any number [s/he] wants to call to demand funds for [her/his] company. Member cannot use a computer without staff present as [s/he] will email and message anyone [s/he] can contact. Member cannot freely go into the refrigerator as [s/he] would eat other residents [sic] food and snacks." Resident 3 was admitted to the home on 02/08/2024. Resident 3 was her/his own person. Resident 3 was under the care of 24/7 one-on-one staff. Resident 3's ISP was dated 02/20/2024. Resident 3's ISP stated, "Destructive of Property or Self, Physically, Mentally Abusive - Current Status: No risk; Frequency of Service and Service Provided: Staff will monitor lock up all lighters and other sharps [sic]; Goal/Outcome: To remove and lock up all items that can lead to destructive behavior." Resident 3's ISP identified s/he was at no risk for destructive behavior, but the ISP further identified lighters and sharps were locked up due to destructive behavior. Resident 4 was admitted to the home on 05/16/2023. Resident 4 was her/his own person. Resident 4 was under the care of 24/7 one-on-one staff. Resident 4's ISP was dated 06/11/2024. Resident 4's ISP stated, "[Resident 4] calls have to be monitored and dialed by staff as [s/he] would call and abuse the phone if not managed by staff. All of [Resident 4] calls will	M 556		

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M 556	Continued From page 18 occur between 7am-3pm unless there is an emergency [sic]." In summary, residents were required to follow a curfew requiring them to remain in their rooms from approximately 8:00 PM until 8:00 AM. Residents could not exit their rooms during curfew unless permission was given by staff for use of the bathroom or a drink of water. Residents were not allowed access to the kitchen after 7:00 PM. Residents' personal cell phones were being confiscated by staff and securely stored during curfew. Cross reference: DHS 88.06(3)(d)1 - Description of Services	M 556		
Z 010	50.065(2)(bb) DETERMINE FINAL DISPOSITION OF CHARGE If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the disposition of the charge or the conviction, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge. If a background information form under sub. (6) (a) or (am) indicates a charge or a conviction of a serious crime, but information obtained under 011 par. (am) or (b) does not indicate such a charge, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and the final disposition of the complaint. If information obtained under par. (am) or (b), a	Z 010		

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Z 010	Continued From page 19 background information form under sub, (6) (a) or (am) or any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 941.30, 942.08, 947.01, or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or the entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction relating to that violation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure every reasonable effort was made to contact the clerk of courts to obtain a copy of the criminal complaint and judgement of conviction related to a conviction of s. 940.19(1), for 1 of 1 caregiver (Caregiver C). Findings include: On 05/29/2024, at 1:52 PM, Surveyor conducted a complaint survey at the facility. During the survey, Surveyor spoke with Director of Human Resources (HR) B and requested staff files for Caregiver C. At approximately 4:00 PM, HR B provided Surveyor with multiple documents. On 05/30/2024, Surveyor reviewed the documents HR B provided, and observed some requested information was missing. Surveyor requested HR B send Caregiver C's background information disclosure form (BID) and her/his caregiver background check (IBIS), by 5:00 PM, on 05/31/2024.	Z 010		

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Z 010	Continued From page 20 On 05/31/2024, Surveyor reviewed the additional documents HR B had sent. Those documents included a BID, a State of Wisconsin Department of Justice (DOJ) background check, and IBIS, for Caregiver C. The following are the findings from the above documents: Caregiver C was hired as a caregiver on 02/17/2022. BID - The BID was completed and signed on 02/17/2022, by Caregiver C. - Caregiver C disclosed s/he was convicted of a crime in "Racine, WI 2021 [sic]." DOJ - The DOJ record was requested and reported on 02/17/2022. - "Date of offense: 11/08/2019 . . . 940.19(1) - Battery . . . Disposition date: 07/06/2020 . . . Disposition: Convicted . . . Sentence: Jail Time served: 241 days Length: 9 months Comments: imposed & stayed CFTS if revoked . . . Sentence: probation Begin date: July 06, 2020 . . . Length: 18 months." IBIS - The IBIS record was requested and reported on 02/17/2022. - No findings - No denials - No exclusions - No rehabilitation review findings - No professional credential, license or certificate found On 06/11/2024, at approximately 12:36 PM, Surveyor interviewed Licensee A and HR B. HR B	Z 010		

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Z 010	Continued From page 21 reported s/he completed Caregiver C's background check and was aware of the conviction on her/his record. Licensee A and HR B reported Caregiver C had an incident with an ex-[girl/boy friend], which resulted in the conviction of Battery. Licensee A and HR B reported they were unaware a conviction of this offense required them to obtain the criminal complaint and judgement of conviction. Licensee A and HR B reported they did not retrieve any further information from the clerk of courts or any other entity to determine the final disposition of the charge indicated on Caregiver C's background check.	Z 010		