| 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 _____ | R-C 03/11/2025 |

| 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 |
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| {M 000} | INITIAL COMMENTS<br><br>On 03/11/2025, Surveyor completed a verification visit, a complaint investigation, and 2 self-report reviews at Roots Residential Adult Family Homes LLC - Upper. As a result, 3 of the previous 7 deficiencies were corrected. Four of the previous deficiencies were re-cited, with 2 new deficiencies; therefore, 6 total deficiencies were identified. One complaint was substantiated. One of 2 self-report reviews resulted in deficiencies.<br><br>Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.<br><br>Census: 3 | {M 000} | | |
| {M 216} | 88.04(2)(a) RESPONSIBILITIES<br><br>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.<br><br>This Rule is not met as evidenced by:<br>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 a verification visit, a complaint investigation, and 2 self-report reviews. Six deficiencies were identified during the investigation. Four of the 6 were repeat deficiencies. One complaint was substantiated and 1 of 2 self-reports resulted in deficiencies.<br><br>This is a repeat violation. See Statement of Deficiency (SOD) SO2U11, dated 09/11/2024.<br><br>Findings include: | {M 216} | | |

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

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| {M 216} | Continued From page 1<br><br>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.<br><br>Surveyor conducted a verification visit, a complaint investigation, and 2 self-report investigations. The following 6 violations, which includes this violation, were identified:<br><br>88.04(2)(a) - Responsibilities - This is a repeat violation.<br>88.05(3)(a) - Home Environment - This is a repeat violation.<br>88.06(3)(d)1 - Description of Services - This is a repeat violation.<br>88.07(2)(a) - Services<br>88.09(1)(a) - Resident Records<br>88.10(3)(e) - Self-Direction - This is a repeat violation.<br><br>On 03/11/2025, at 11:00 AM, Surveyor interviewed Licensee A and Director of Human Resources (HR) B. Licensee A reported they are working on maintenance in the home and have future plans to make some changes which will alleviate the difficulty in getting materials and parts for home repairs. Licensee A and HR B reported individual service plans (ISPs) were updated to include a description of services and coping skills. Licensee A reported a new system was implemented to have resident records available in the home. Licensee A denied resident rights violations existed in the home. | {M 216} | | |

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| {M 276} | Continued From page 2 | {M 276} | | |
| {M 276} | 88.05(3)(a) HOME ENVIRONMENT<br><br>An adult family home shall be safe, clean and well-maintained and shall provide a homelike environment.<br><br>This Rule is not met as evidenced by:<br>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 3 residents in the home. The home required cleaning and/or repairs.<br><br>This is a repeat violation. See Statement of Deficiency (SOD) SO2U11, dated 09/11/2024.<br><br>Findings include:<br><br>On 02/05/2025, at 9:03 AM, Surveyor conducted an onsite tour of the home and observed the following:<br><br>Resident 5's Bedroom<br>- Trim pieces within the frame of the window were broken, hanging and laying inside of the window jam. This was the same observation noted in the previous Statement of Deficiency (SOD), SOD SO2U11, dated 09/11/2024. The on-site visit for SOD SO2U11 occurred on 06/11/2024.<br>- The window was nailed closed due to the locking mechanism broken and missing.<br>- The window was sealed with a clear plastic.<br><br>Kitchen | {M 276} | | |

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| {M 276} | Continued From page 3<br>- A standalone cabinet was missing 1 of 2 doors, which was laying on the top of the cabinet. The shelving inside was sitting loosely at the bottom of the cabinet.<br>- The flooring from the kitchen leading into the pantry was cracked and peeling up.<br>- Above the stove was a light and vent fan. The white cover for the light was covered in a yellowish and black greasy, sticky substance, consistent with food grease and splatter. It was also covered in multiple small dead insects.<br><br>On 02/05/2025, at 12:34 PM, Director of Human Resources (HR) B toured the home with Surveyor and inquired what repairs were needed. Surveyor pointed out the above noted information. HR B acknowledged the broken, non-functioning window in Resident 5's room, the flooring in the kitchen, and the light above the stove. At 1:20 PM, maintenance was at the home looking at the repairs and removed Resident 5's window for replacement.<br><br>On 03/11/2025, at 11:00 AM, Surveyor interviewed Licensee A and HR B. HR B reported staff were responsible for cleaning the home and reporting maintenance concerns. Licensee A reported maintenance position was made a full-time position and the maintenance staff made rounds to all of the Roots facilities. Licensee A reported some of the windows in the home were not a standard size and were difficult to replace or find parts for. S/He had plans to replace some windows in summer with standard sizes so materials would be readily available for any future repairs required and will continue to make the necessary repairs. | {M 276} | | |

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| {M 412} | Continued From page 4 | {M 412} | | |
| {M 412} | 88.06(3)(d)1 DESCRIPTION OF SERVICES<br><br>A description of services the licensee will provide to meet the assessed need.<br><br>This Rule is not met as evidenced by:<br>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 3). Resident 3's ISP did not include information regarding how staff were to manage Resident 3's behaviors. Resident 3 was assigned a 1:1 caregiver, but the ISP did not identify how the service of designated staff would assist Resident 3 with behavior management and mental/emotional health. Resident 3's behaviors escalated and s/he required hospitalization due to self-harm.<br><br>This is a repeat violation. See Statement of Deficiency (SOD) SO2U11, dated 09/11/2024.<br><br>Findings include:<br><br>On 02/05/2025, Surveyor reviewed Resident 3's record. The following was identified:<br><br>- Resident 3 was admitted to the facility on 02/08/2024, with diagnoses of severe recurrent depression, anxiety, suicidal ideation, type 1 diabetes, and diabetic neuropathy. | {M 412} | | |

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| {M 412} | Continued From page 5<br>- Resident 3's ISP, dated 10/10/2024, identified Resident 3 required 24-hour supervision and was assigned a one-on-one staff member. Resident 3's ISP identified Resident 3 exhibited behaviors and stated, " . . . Behavior Patterns: Wandering: Current Status: High risk for elopement as member has attempted to elope many times. Frequency of Service and Service Provided: 24-hour awake staff to redirect. Goal/Outcome: Follow resident if elopement occurs and notify non-emergency . . . Self-Abusive Behavior: Current Status: Risk of self-abuse. As member will inject [her/himself] with insulin that is not needed to lower [her/his] blood sugar levels so [s/he] could get admitted. Frequency of Service and Service Provided: Staff will monitor all behaviors and redirect as needed. Goal/Outcome: To remain free from self-harm . . . Suicidal Tendencies: Current Status: Member has suicidal tendencies related to wanting to use drugs. Frequency of Service and Service Provided: Staff will assist and redirect as needed. Goal/Outcome: To keep encourage (sic) member to use coping skills and express to staff when feelings arrive . . . Mental and Emotional Health: Self-Concepts: Current Status: Shows mostly positive concepts. Frequency of Service and Service Provided: Staff will encourage and point out all of member's positive concepts and calmly redirect negative. Goal/Outcome: To maintain positive concepts . . . Attitude: Current Status: Member mood is based off of if [s/he] has nicotine as [s/he] shows a positive attitude until [s/he] does not have nicotine or is in search of additional drugs. Frequency of Service and Service Provided: Staff will continue to encourage positive attitude. Goal/Outcome: To keep attitude positive at all times . . . Leisure Time Activities: Current Status: Vaping, television, social media. Frequency of Service and Service Provided: Staff | {M 412} | | |

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| {M 412} | Continued From page 6 | {M 412} | | |

will encourage these as coping skills and to fill idle time. Goal/Outcome: Staff encourage participation in leisure activities . . . Other: Member utilizes [her/his] personal phone for 1/hr a day as [s/he] utilizes it to attempt to get funds for drugs. Frequency of Service and Service Provided: Member can cannot smoke after 9pm as member would attempt to elope looking for drugs. Goal/Outcome: Member can only smoke/vape every hour starting from 8am-8pm as member would attempt to elope or attack staff if [s/he] is out of nicotine . . . Making the Environment Safe: Staff will work with member on identifying triggers prior to attempting to elope, staff will ensure that member is properly injecting himself with insulin, staff will perform searches of property and pockets once member returns from visits as [s/he] has been caught with marijuana after visits, staff will monitor purchases as member would try to buy illegal drugs, staff also ensures that member game console cord is locked up as member would not sleep if [s/he] had 24/hr access to it (sic)."

- Resident 3's record did not include strategies for teaching appropriate coping skills.

- Resident 3's record did not describe how Resident 3's one-on-one staff assigned to her/him would monitor her/his behavior.

- Resident 3's record did not identify ways for Resident 3's staff to redirect Resident 3 when having various behaviors identified.

- Resident 3's record did not identify how staff were to assist with keeping Resident 3's "attitude positive at all times."

- Resident 3's record identified vaping, television,

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| {M 412} | Continued From page 7 | {M 412} | | |

and social media as coping skills. Contradictory to those listed coping skills, staff were to lock up Resident 3's game console cord, limit her/his personal phone use to 1 hour per day, and limit smoking/vaping to every hour between 8:00 AM and 8:00 PM.

On 02/05/2025, at approximately 10:00 AM, Surveyor requested from Director of Human Resources (HR) B documentation of the incident which occurred with Resident 3 on 08/17/2024. Surveyor received an incident report which documented the following:

On 08/17/2024, at 7:00 PM, "[Resident 3] struck staff outside in the arm as staff refused to provide [Resident 3] a vape. Staff redirected member and educated [her/him] on how hitting staff was not appropriate. Staff attempted to work with [Resident 3] on [her/his] coping skills and explained to [her/him] that staff could not provide [her/him] with a vape. Once in [her/his] room [Resident 3] was cursing at staff and stated no one cares for [her/him] as they would not buy [her/him] a vape. Once dinner was offered to [Resident 3], [s/he] declined it and stated that [s/he] was not eating unless [s/he] had a vape. Upon doing a room check on member at 2am staff noticed that member was nonresponsive. Staff began contacting 911 and the ambulance transferred [her/him] to the hospital as staff followed behind them. Upon arriving at the hospital staff confirmed that [Resident 3] had injected [her/himself] with 20 units of insulin (sic)."

The incident documented the interventions attempted were "member coping skills" and "talk to member." Resident 3's coping skills listed in her/his ISP were vaping, television, and social media. On 08/17/2025, staff had refused to

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| {M 412} | Continued From page 8<br>provide Resident 3 with a vape and Resident 3's ISP put restrictions on when s/he was able to use her/his phone and gaming system. It was not reported what coping skills staff attempted.<br><br>On 02/05/2025, at 10:32 AM, Surveyor interviewed HR B. HR B stated, "anytime [Resident 3] goes to the hospital is because of [her/his] diabetes (sic)."<br><br>On 02/05/2025, at approximately 4:00 PM, Surveyors interviewed HR B. HR B confirmed Resident 3's ISP did not describe how Resident 3's 1:1 staff assigned to her/him should respond when target behaviors occur. HR B stated, "It sounds like you want me to create a care plan."<br><br>On 03/11/2025, at 11:00 AM, Surveyor interviewed Licensee A and HR B. HR B reported Resident 3's coping skills include deep breathing, walking, basketball, AODA counseling, and talking with her/his parent. Surveyor inquired where that information was located in Resident 3's file and HR B reported it was in her/his newest ISP. The ISP and behavior support plan (BSP) provided to Surveyor did not include those coping skills. Licensee A stated, "how is that not in the ISP?" | {M 412} | | |
| M 436 | 88.07(2)(a) SERVICES<br><br>The licensee shall provide or arrange for the provision of individualized services specified in a resident's individual service plan that are the licensee's responsibility. | M 436 | | |

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| M 436 | Continued From page 9 | M 436 | | |

This Rule is not met as evidenced by:
Based on record review, observation, and interview the provider did not ensure 1 of 1 resident (Resident 4) received the required supervision. Resident 4 required one-on-one (1:1) staffing 24 hours per day.

Findings include:

On 02/05/2025, at approximately 10:30 AM, Surveyor reviewed Resident 4's records. The following was identified:

- Resident 4 was admitted to the facility on 05/16/2023, with diagnoses of schizoaffective disorder, personality disorder, and abuse of non-psychoactive substances.

- Resident 4 required 1:1 staffing 24 hours per day.

- Resident 4 was a high elopement risk.

- Resident 4's individual service plan (ISP) and behavior support plan (BSP), dated 10/10/2024, documented the following: "Making the Environment Safe: Keeping cigarettes, lighters, card, money as member will elope, pass out all of [her/his] funds, or smoke in the home. Staff will do hour room checks on member as [s/he] is a high elopement risk. Door chimes will remain on all doors in the home (sic)."

On 09/03/2024, Director of Human Resources (HR) B submitted a self-report to the Department. The report documented the following:

On 08/31/2024, at 9:10 AM, "[Resident 4] eloped

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| M 436 | Continued From page 10 | M 436 | | |

from residence as [s/he] pretended to go to the bathroom but walked out of the back door. Staff attempted to chase behind him, but he had already made it out of the home. An alert was placed and additional staff attempted to locate [Resident4] but was not successful. Non-emergency was contacted and were notified to locate him as well. [Resident 4] was found by staff at 12:10am. Member came into the home and slept on the couch. Non emergency was notified and they removed their alert. The following morning [Resident 4] informed staff [s/he] had drank 3 mikes hard lemonades, Robitussin cough syrup, and an alcoholic beverage called Mr. Beast (sic)."

Resident 4 was gone for 15 hours during the elopement on 08/31/2024. When surveyor inquired how this happened with 1:1 staffing, HR B did not provide an answer.

On 02/05/2025, at 9:37 AM, Surveyor interviewed Resident 4. Resident 4 reported s/he had eloped 3 times in the last year. S/He did this because s/he wanted to "go buy juice." Resident 4 began describing an incident where s/he tried to elope and kicked staff, and then did not want to discuss it any further.

On 02/05/2025, Surveyor was conducting an onsite survey at Roots Residential AFH LLC - Upper. At approximately 4:00 PM, Surveyor exited the home and entered the lower duplex. Prior to Surveyor exiting the home, Resident 4's 1:1 staff was with her/him, and the incoming 1:1 staff for the next shift were arriving. Surveyor was interviewing HR B in a separate licensed adult family home (AFH) located on the first level of a duplex. Surveyor observed Resident 4 enter the separately licensed AFH, and Resident 4 stated,

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| M 436 | Continued From page 11<br><br>"I snuck out." Resident 4 then asked HR B if s/he could take her/him to get cigarettes. Surveyor inquired where Resident 4's 1:1 staff was and how s/he was able to elope from her/his residence. HR B stated, "that is a good question!" HR B showed Surveyor a group message s/he sent on her/his phone requesting an immediate replacement for Resident 4's 1:1 staff. HR B reported elopements were not tolerated when there is 1:1 staffing, and Resident 4's 1:1 staff would be immediately replaced. Resident 4 eloped and was gone for approximately 1-2 minutes before staff came to the lower duplex and convinced Resident 4 to return home. The group message from HR B was what prompted staff to know Resident 4 had eloped.<br><br>On 03/11/2025, Surveyor interviewed Licensee A and HR B. HR B confirmed Resident 4 required 1:1 staffing. HR B reported Resident 4 has eloped from the AFH 2 or 3 times since residing there. HR B reported the bathroom in the AFH is located between the back exit door and the stairwell, which presented the opportunity for Resident 4 to elope when going to/from the bathroom. Licensee A reported de-escalation and verbal redirection were used to prevent Resident 4 from eloping. Licensee A reported staff were to follow behind Resident 4 if s/he eloped, and to call the police. Staff were to stand between the doors monitoring Resident 4 when s/he went into the bathroom. The door chimes were to be kept active to monitor Resident 4 exiting the home. | M 436 | | |
| M 482 | 88.09(1)(a) RESIDENT RECORDS<br><br>The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure | M 482 | | |

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|---|---|---|---|
| | 0016034 | A. BUILDING: _____ B. WING _____ | R-C 03/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| M 482 | Continued From page 12<br>location within the home to prevent unauthorized access.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the provider did not maintain the records for 1 of 1 resident (Resident 3) reviewed in a secure location within the home.<br><br>Resident 3's medical records were not accessible to Surveyor.<br><br>Findings include:<br><br>On 02/05/2025, Surveyor reviewed Resident 3's record and identified the following:<br><br>-Resident 3 was admitted to the provider's home on 02/08/2024.<br><br>-Resident 3's record in the home did not contain his/her medical records.<br><br>On 02/05/2025, at approximately 10:00 AM, Surveyor requested Resident 3's medical records from Director of Human Resources (HR) B. HR B stated Resident 3's medical records were not onsite in the home and were at the office (a different location). HR B stated s/he would have to go get Resident 3's medical records from the office.<br><br>On 02/05/2025, at approximately 2:30 PM, Surveyor received part of Resident 3's medical records from HR B. On 02/06/2025, at 1:37 PM, Surveyor requested copies of medical records related to Resident 3's incident on 08/17/2025. | M 482 | | |

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| M 482 | Continued From page 13<br>On 02/06/2025, at 4:40 PM, Surveyor received another part of Resident 3's medical records.<br><br>On 03/11/2025, at 11:00 AM, Surveyor interviewed Licensee A. Licensee A confirmed resident records were to be kept secure within the home. Licensee A reported not all records had been kept within the home due to resident behaviors and water damage. S/He reported the facility was working on using tubs to store documents and finding a secure location on site to store them. | M 482 | | |
| {M 556} | 88.10(3)(e) Self-Direction<br><br>Self-direction. To have opportunities 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.<br><br>This Rule is not met as evidenced by:<br>Based on interview, observation, and record review, the provider did not ensure 2 of 2 residents had opportunities to make decisions related to care, activities, and other aspects of life in the adult family home (AFH). Resident 3 and Resident 4 were required to be in their bedrooms nightly by approximately 8:30 PM and remain there until approximately 8:00 AM. Residents did | {M 556} | | |

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| {M 556} | Continued From page 14 | {M 556} | | |

not have access to the kitchen after 7:00 PM. Residents' personal cell phones and other personal property were taken and secured by staff on a nightly basis. Residents were required to leave the home for other residents' appointments.

This is a repeat violation. See Statement of Deficiency (SOD) SO2U11, dated 09/11/2024.

Findings include:

On 02/05/2025, at 9:14 AM, Surveyor interviewed Resident 3, and s/he reported the following:

S/He was required to turn in her/his personal cell phone nightly at 9:30 PM and received it back when s/he completed her/his morning routine. Her/His cell phone was kept locked in a file cabinet. Surveyor inquired if Resident 3 had remembered signing anything related to use of her/his cell phone, and s/he reported s/he did not remember signing or discussing anything. Residents were required to retreat to their bedrooms on a nightly basis between 8:30 and 9:00 PM. One of the staff announced to the home when it was time for residents to go to their rooms. Residents were allowed to exit their bedrooms to utilize the bathroom during this time but were otherwise expected to stay in their bedrooms until morning. Resident 3's snacks were kept locked up and s/he received a small bag of chips in the evening. Residents were not allowed to cook in the kitchen after 7:00 PM. Resident 3 reported s/he felt s/he had "no freedom," and the facility had "so many rules," which changed often and made living there "hectic."

On 02/05/2025, at 9:37 AM, Surveyor interviewed

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| {M 556} | Continued From page 15<br>Resident 4, and s/he reported the following:<br><br>Some caregivers require residents to be in their bedrooms nightly at 8:00 PM, and some require residents to be in their bedrooms nightly at 9:00 PM. Resident 4 stated, "The ones that say 8 PM let us stay in the living room until 8:30, and the ones that say 9 let us smoke until 8:30. They're very rule oriented here. I feel like I'm in jail." The rules are not the same with all of the staff. Resident 4 had a Roku remote programed on her/his tablet, which controled her/his bedroom television (tv). S/He was not allowed to have her/his tv remote without asking staff. Resident 4's tablet was locked in a file cabinet. Resident 4 kept oyster crackers under her/his bed for a snack. Surveyor inquired about cooking in the kitchen and Resident 4 stated, "the cut off is 7 PM in the kitchen."<br><br>On 02/05/2025, at approximately 10:00 AM, Surveyor observed Resident 3 had left the AFH with her/his one-on-one (1:1) staff, Caregiver H. Surveyor overheard a conversation between Director of Human Resources (HR) B and Caregiver J. HR B inquired why it was taking so long to leave for Person I's appointment. Caregiver J told HR B s/he was waiting for Caregiver H because s/he was the driver. Surveyor observed Resident 3, Person I, Caregiver J and Caregiver H leaving the AFH. When Resident 3 returned, Surveyor inquired if s/he had the choice to ride to the appointment for Person I, or if s/he was required to go. Resident 3 reported s/he had been required to go.<br><br>On 02/05/2025, at approximately 10:45 AM, Surveyor reviewed daily logs for Resident 3. The following was documented: | {M 556} | | |

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| {M 556} | Continued From page 16<br><br>02/01/2025 -<br>8:00 AM, "[Resident 3] received [her/his] phone and game cord."<br>9:00 PM, "[Resident 3] went out to smoke and turned in [her/his] phone game cord."<br>10:30 PM, "[Resident 3] called sister and turned phone in . . . "<br>"Notes: . . . [Resident 3] turned in phone and game cord . . . "<br><br>On 03/11/2025, at 11:00 AM, Surveyor interviewed Licensee A and HR B. Surveyor inquired when residents were required to be in their bedrooms. HR B stated, "there's no hours around anything in the home." HR B reported the only time residents were required to step into their rooms was during shift exchange so staff could discuss any Health Insurance Portability and Accountability Act (HIPPA) related information in private. Licensee A reported the AFH at one point removed tv remotes from the home and everyone had remotes on their phones. This was in response to a resident behavior. They reported Resident 4 did not have a restriction on her/his tablet. Licensee A reported a new system would be implemented where residents would have their own lock box for their personal possessions to prevent staff from withholding residents' personal belongings. | {M 556} | | |