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	0016022	A. BUILDING: _____ B. WING _____	C 07/22/2024

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ROOTS RESIDENTIAL ADULT FAMILY HOMES	1715 LASALLE STREET LOWER RACINE, WI 53402

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M 000	INITIAL COMMENTS On 07/22/2024, Surveyor completed 4 complaint investigations at Roots Residential Adult Family Homes LLC-Lower. As a result, 8 deficiencies were identified. Four complaints were substantiated. Census: 3	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 4 complaint investigations, and 8 deficiencies were identified during the investigation. Four of 4 complaints were substantiated. Findings include: The home was licensed as an ambulatory adult family home caring for up to 3 residents in the client groups of emotionally disturbed/mental illness and developmentally disabled. Surveyor conducted 4 complaint investigations. The following 8 violations, which includes this violation, were identified: 88.04(2)(a) - Responsibilities 88.05(3)(a) - Home Environment	M 216		

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

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M 216	Continued From page 1 88.06(3)(d)1 - Description of Services 88.07(3)(a) - Prescription Medications 88.10(3)(a) - Fair Treatment 88.10(3)(e) - Self-Direction 88.10(3)(p) - Prompt and Adequate Treatment 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 home was safe, clean, well-maintained, and homelike. The home required cleaning and/or repairs, and cleaning compounds were left unsecured. Findings include: The home was licensed as an ambulatory adult family home caring for up to 3 residents in the	M 276		

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M 276	Continued From page 2	M 276		

client groups of emotionally disturbed/mental illness and developmentally disabled.

On 06/11/2024, at 9:00 AM, Surveyor conducted an onsite tour of the home and observed the following:

Resident 1's bedroom window was unable to be opened and closed, which left a gap to the outside and allowed bugs to get in. Inside the windowsill was dust, debris, and paint chips.

Resident 2's bedroom door was missing the strike plate. The ceiling light fixture in Resident 2's bedroom did not work.

The dining room contained a ceiling fan with 3 lights. One of 3 lights was missing a light bulb, and 1 of 3 lights was missing the glass lamp shade. Inside the dining room windowsill was dust, debris, and paint chips.

The resident bathroom had laminate flooring, which was peeled up near the toilet. There was approximately a 2-inch by 2-inch area of the flooring missing, exposing the subfloor. The following cleaning compounds were located unsecured in a cabinet in the bathroom, which did not contain a door: 2 bags of laundry pods, 1 can of Lysol spray, and 2 bottles of OdoBan disinfectant.

On 06/11/2024, at 9:03 AM, Surveyor interviewed Resident 1. Surveyor inquired how things were going at the home. Resident 1 stated, "I feel like a patient in the hospital sometimes. It's supposed to feel like home." Resident 1 reported the following. Her/His window did not function properly, and it took 2 days after admission for her/him to get the window open. Resident 1 liked

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M 276	Continued From page 3 to open her/his window for the fresh air and to keep the room cool. Bugs flew in through the opening in the window. S/He told staff the window was broken, but nothing had been done to fix it. On 06/11/2024, at 9:53 AM, Surveyor interviewed Resident 2. Resident 2 reported the following. The ceiling light fixture in her/his bedroom did not work. The door to her/his bedroom was unable to be latched closed, due to the strike plate missing. Resident 2 estimated these issues to have been this way for 4 months. On 06/11/2024, at approximately 12:36 PM, Surveyor interviewed Licensee A and Director of Human Resources (HR) B. They reported the home was recently painted and some repairs have been made.	M 276		
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 4's ISP did not include information regarding how staff were to manage Resident 4's behaviors. Resident 4's was assigned a 1:1 staff person, but the ISP did	M 412		

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not identify how the service of designated staff would assist Resident 4 with behavior management. Resident 4's behaviors escalated to requiring additional staff to calm Resident 4 down, police intervention, and hospitalization due to self-harm.

Findings include:

On 05/30/2024, Surveyor reviewed Resident 4's record. The following was identified:

- Resident 4 was admitted to the facility on 06/20/2023, with diagnoses including attention deficit hyperactivity disorder (ADHD), anxiety, autism spectrum disorder, bipolar disorder, intellectual disability, oppositional defiance disorder, vocal tic disorder, and borderline personality disorder.

-Resident 4 was her/his own person.

-Resident 4's ISP, dated 01/01/2024, identified Resident 4 required 24-hour supervision and was assigned a one-on-one staff member. Resident 4's ISP identified Resident 4 exhibited behaviors and stated, "...Behavior Patterns: Wandering: [Resident 4] has attempted to elope three times...Service Provided: 24 hour awake staff to redirect. Goal/Outcome: To encourage more outdoor activities to prevent elopement...Suicidal Tendencies: Has displayed this behavior previously...Service Provided: Staff will assist and redirect [Resident 4] as needed. Goal/Outcome: To keep [Resident 4] active and refrain from suicidal tendencies...Destructive of Property or Self, Physically, Mentally Abusive: [Resident 4] has property damage and self...Service Provided: Staff will monitor behavior and redirect in a calming tone...Goal/Outcome: To encourage

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M 412	Continued From page 5 [Resident 4] to refrain from destructive behavior...Mental and Emotional Health...Attitude: displays a positive attitude most of the time, [s/he] does struggle at times with [wo/men/opposite gender] and [his/her] conversation and approach with them...Service Provided: Staff will continue to encourage positive attitude and swiftly redirect and correct any aggressive behavior. Goal/Outcome: To keep attitude positive with men and women...Interactions with Others: [Resident 4] interactions with others are good except with staff at times...Service Provided: Staff continue to redirect and correct behaviors when in public and end of appointment if behavior becomes too erratic. Goal/Outcome: To continue to encourage [Resident 4] to remain polite towards peers, third parties, and anyone [s/he] encounters. Aggressive/Combative: [Resident 4] has a long history of aggressive behavior and has previously attacked staff. Service Provided: In the event, [Resident 4] show [sic] aggressive or hits a staff or housemate [s/he] will be directed to [his/her] room or outside if this occurs talk through what occurred as well as how to move forward. With 3 staff in place this is highly unlikely but we also have the option for [him/her] to take a ride or walk with staff. Goal/Outcome: To keep [Resident 4] happy and calm and refrain from aggressive behaviors..." -Resident 4's record did not include strategies for teaching appropriate coping skills or inform staff what coping skills should have been practiced when Resident 4 had behaviors. -Resident 4's record did not describe how Resident 4's 1 on 1 staff assigned to him/her would monitor his/her behavior. -Resident 4's ISP did not identify outdoor	M 412		

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activities Resident 4 liked to participate in to ensure staff assisted with discouraging elopement behavior.

-Resident 4's record did not identify ways for Resident 4's staff to redirect Resident 4 when having various behaviors identified.

-Resident 4's ISP did not identify how staff were to assist with keeping Resident 4 "happy and calm" to decrease behaviors.

-Resident 4's ISP did not identify Resident 4 had a crisis plan or note any interventions to assist Resident 4 with calming him/herself before his/her behavior becomes a crisis.

On 05/30/2024, Surveyor reviewed Resident 4's Service Coordination Crisis Plan (SCCP) (which was not referenced in Resident 4's ISP), dated 02/06/2024, developed by Crisis Worker H, Resident 4, and Director of Human Resources (HR) B and sent via email to Surveyor by Executive Office Manager I. The SCCP stated, "Strengths/Needs: [Resident 4] is triggered when [s/he] is not given enough attention, when [s/he] feels, [s/he] is going to get in trouble and if [s/he] is getting close to staff . . . [HR B], noticed that [Resident 4] will become more verbally aggressive towards [the opposite gender] to try to scare them . . . When [Resident 4] is symptomatic, [s/he] will become verbally aggressive and physically aggressive towards [her/himself]. [Resident 4] will punch [her/himself] and swallow screws . . . Early signs that [s/he] symptomatic [sic] [s/he] will become more anxious prior to and then lash out and say things towards staff...[Resident 4] is helpful, smart and likes to learn new things. [S/He] needs others to be firm, direct, consistent, and patient with

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[her/him]. [Resident 4] struggling [sic] to build rapport with others but does better with [the same gender]..." The SCCP listed additional interventions when Resident 4 was in crisis, which were not included in Resident 4's ISP.

On 05/29/2024, at approximately 2:00 PM, Surveyor requested documentation of incident reports involving Resident 4 from Human Resource Director (HR) B. Surveyor received documentation of incident reports dating back to 08/05/2023. The following was reported:

-08/05/2023, at 5:30 PM, stated: "[Resident 4] came out of [her/his] room and made a derogatory comment towards both [fe/male (opposite gender)] staff. [Resident 4] told staff that [s/he] wanted them to slam their private part down [her/his] throat. Staff redirected [her/him] and reminded [her/him] that this language was not appropriate. [Resident 4] continued and informed staff that [s/he] would forcefully [cause harm to] them. Staff redirected [Resident 4] to [her/his] room to cool off. [Resident 4] went to [her/his] room and then began to undress with the door open. Staff closed the door and educated [Resident 4] on how this was not appropriate. [Resident 4] continued to yell at staff for a few minutes until [s/he] returned to [her/his] room. Staff later approached [her/his] room and informed [her/him] that the behavior [s/he] had displayed could not continue. Describe what worked to calm the member down: Additional staff, constant cues and redirection Describe the outcome of the overall incident: [Resident 4] stayed in [her/his] room the remainder of the shift only coming out to eat and take medication [sic]."

-08/06/2023, at 7:00 PM, stated: "[Resident 4] came out of [her/his] room and walked up to one

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of [her/his] staff members and said that [s/he] would beat the living [expletive] out of them. Staff stood up and gave [Resident 4] space. Staff redirected [Resident 4] and encouraged [her/him] to work on [her/his] coping skills as this behavior was not appropriate. [Resident 4] then stated that [s/he] was leaving and attempted to leave the home. Staff followed behind [her/him] and informed [her/him] that [s/he] could not walk off without staff. Staff was able to redirect [Resident 4] to the home but then [s/he] punched a hole in [her/his] door. Staff was able to talk to [Resident 4] and inquire about if [s/he] felt like [s/he] needed a prn (as needed medication). [Resident 4] was able to take [her/his] prn for agitation and sleep. [Resident 4] stayed in [her/his] room the remainder of the night."

-10/03/2023, at 1:00 PM, stated: " [Resident 4] was in the movie theater watching a movie when [s/he] informed staff that [s/he] had to use the bathroom. Staff walked [her/him] to the bathroom, but [s/he] began to run around the movie theater stating that [s/he] was controlled by [her/his] [girl/boyfriend] [name]. Staff and the movie theatre staff tried to redirect [her/him], but [s/he] continued to pace the hospital [sic]. Staff attempted to leave movies and return [Resident 4] to the facility. The movies asked [her/him] to leave, and [s/he] refused which resulted in them calling the police. [Resident 4] began to punch [her/himself] in the face. Leadership arrived and [s/he] stated that [s/he] needed to be chaptered again as [s/he] cannot control [her/his] thoughts. Police arrived and took [her/him] to be cleared by the mental health unit at the hospital. Describe what worked to calm the member down: Additional staff, police intervention Describe the outcome of the overall incident: [Resident 4] remains at the hospital to be evaluated. Police

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M 412	Continued From page 9 report number: 23-7474 [sic]." -10/17/2023 at 2:00 PM, stated: " [Resident 4] came out of [her/his] room from watching the news and began to punch [her/himself] in the face causing [her/his] nose to bleed. [S/He] then told everyone ion [sic] the house that they were going to get killed by Putin. [Resident 4] ran out of the home with staff following [her/him]. [Resident 4] refused to get in the vehicle with staff. Additional staff arrived and were able to get [her/him] in the vehicle. [Resident 4] continued saying that Putin was going to kill everyone prior to taking a prn and laying down. Describe what worked to calm the member down: additional staff, constant cues, redirection, leadership call Describe the outcome of the overall incident: [Resident 4] remained in [her/his] room the remainder of the night, only coming out for medication and dinner [sic]." -12/08/2023, at 4:30 PM, stated: "staff entered [Resident 4] room after they heard [her/him] slamming items in [her/his] room. Upon arriving in the room [Resident 4] had broken [her/his] dresser, television, pictures, and bank in [her/his] room. Staff inquired about what was going on and [Resident 4] stated that [s/he] was fighting demons and [s/he] wanted staff to punish and hit [her/him]. Staff gave space and tried to redirect [Resident 4] out of [her/his] room. [Resident 4] slammed the door and attempted to barricade [her/himself] in the room. Staff were able to talk [her/him] into opening the door. [Resident 4] came into the living [sic] punched a hole in the wall and continued to pace the home. Additional staff arrived and attempted to calm [Resident 4] down. [Resident 4] was offered a prn but refused it for agitation. Leadership arrived and attempted to understand what had been bothering [Resident 4] and [s/he] stated that it was a demon. Staff	M 412		

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asked [her/him] to come out of the room and sit on the couch to talk but [s/he] began to kick leadership. Leadership gave space and [Resident 4] was able to be redirected out of the room by multiple staff. [Resident 4] then walked off. Staff gave space and followed but [s/he] continued to walk. Staff alerted non-emergency prior to [Resident 4] walking back to the vehicle apologizing for [her/his] actions. Staff cancelled non-emergency call and [Resident 4] was able to ride back with staff to location. Once back on location [Resident 4] again became combative stating that [s/he] needed to go to the hospital as [s/he] swallowed a nail. Non-emergency was again called. [Resident 4] told them [s/he] needs to be placed on a chapter 51 as [s/he] needs help and should not have been taken off of [her/his] order. Describe what worked to calm the member down: multiple staff intervention, police intervention, non-emergency medical. Describe the outcome of the overall incident: [Resident 4] was admitted to the hospital [sic]."

-01/25/2024, at 7:00 PM, stated: "[Resident 4] came out of [her/his] room stating that [s/he] had a flashback from the past and started to attack staff. Staff attempted to redirect [Resident 4] but [s/he] started to punch [her/himself] in the face. Additional staff arrived and were able to redirect [Resident 4]. Staff aided [her/him] in cleaning up [her/his] face. [Resident 4] was able to take a prn and relax in [her/his] room. Describe what worked to calm the member down: additional staff, redirection Describe the outcome of the overall incident: staff removed all objects from room that member could self-harm [her/himself] with [sic]."

- 02/26/2024, at 2:15 PM, stated: "[Resident 4] had just ended a call with [her/his] case manager, and [s/he] began to yell that [s/he] likes being

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M 412	Continued From page 11 destructive. Staff inquired about why [s/he] was stating that and then [s/he] just punched [her/himself] in the nose. Staff went to aid [her/him] with cleaning the wound and [s/he] took off running outside. Staff followed at a close distance. Staff was able to talk [her/him] into returning to the location. Upon walking back to the location, [s/he] kicked one of [her/his] staff and hit staff in the face with a lid from a container. Upon return to the location staff aided [Resident 4] with cleaning [her/his] face and provided [her/him] with a prn. Describe what worked to calm the member down: Additional staff redirection Describe the outcome of the overall incident: Member will remain in [her/his] room outside of meals and medication [sic]." The report was reviewed by HR B and managerial comments stated, "[Resident 4] has a behavior every day after [s/he] has a call with [her/his] case manager." -04/05/2024, at 9:00 AM, stated: "[Resident 4] stated that if [s/he] was alone with [her/his] [fe/male/opposite gender] staff, [s/he] would severely harm [her/him] as [s/he] needed to understand that [s/he] was god [sic]. Staff attempted to redirect [Resident 4] and educate [her/him] on how this behavior was not appropriate. [Resident 4] continued to repeat the same verbiage despite redirection from staff. [Resident 4] staff had to be swapped out as [s/he] continued to go back and forth with staff. Describe what worked to calm the member down: Additional staff redirection. Describe the outcome of the overall incident: Member will remain in [her/his] room outside of meals and medication[sic]." The report was reviewed by HR B and managerial comments stated, "[Resident 4] has been in behavior since [s/he] intentionally lost [her/his] job."	M 412		

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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 412	Continued From page 12 04/09/2024, at 8:00 AM, stated: " [Resident 4] was making threats to harm [fe/male] staff. Staff spoke with [Resident 4] and reminded [her/him] that [her/his] behavior was not appropriate. [Resident 4] began to continue to make comments to staff. [Resident 4] was asked to step into [her/his] room but declined. Additional staff was able to redirect [Resident 4] back into [her/his] room. Describe what worked to calm the member down: additional staff redirection Describe the outcome of the overall incident: [Resident 4] will remain in [her/his] room outside of meal and medication times [sic]." The report was reviewed by HR B and managerial comments stated, "Staff have removed all [fe/male/opposite gender] staff from working with [Resident 4]." 04/26/2024, at 1:00 PM, stated: "[Resident 4] started to verbally abuse [her/his] caregiver at Dollar General. [Resident 4] began to call [her/his] caregiver a [expletive] Staff assisted [her/him] with checking out and then [s/he] began to yell in the parking lot and attempted to attack [her/his] staff. Security from the store came out and [Resident 4] continued the behavior and laid in the parking [sic] and refused to get up. Additional staff arrived and was able to redirect [Resident 4] to get in the van and return to location. Describe what worked to calm the member down: additional staff redirection, store security. Describe the outcome of the overall incident: [Resident 4] will remain in [her/his] room outside of meal and medication times." Report was reviewed by HR B and managerial comments stated, "[Resident 4] is struggling with [her/his] behaviors and has had a behavior every time [s/he] has been taken out int [sic] the community."	M 412		

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M 412	Continued From page 13 -05/09/2024, at 7:00 PM, stated: "[Resident 4] came out of [her/his] room and stated that [s/he] removed a battery from the door chimes in [her/his] room. Staff prompted [Resident 4] to sit down. Staff contacted 911 to have [Resident 4] transported to the hospital. While awaiting on 911 staff inquired why [Resident 4] swallowed the battery and [s/he] stated that [s/he] was anxious and looking for attention. [Resident 4] was transported to the hospital. Describe what worked to calm the member down: Education and Paramedics. Describe the outcome of the overall incident: [Resident 4] remains in the hospital as they stated the battery has to fully run through [her/him]." The report was reviewed by HR B and managerial comments stated, "Door chimes have been removed from [her/his] door." -05/15/2024, at 5:00 PM, stated: "[Resident 4] came out of [her/his] room stating that [s/he] was going to have a behavior. Staff spoke with member and inquired what was bothering [her/him]. [Resident 4] began to state that [s/he] was anxious, and [s/he] was about to clown on staff. Staff attempted to work on [her/him] with [her/his] coping skills and [s/he] began to punch [her/himself] in the nose. Staff attempted to redirect [her/him], and [s/he] then stated that [s/he] was going to call [her/his] caseworker and lie to [her/him] and state that [s/he] was abused as [s/he] saw [her/his] former roommate do this and get a reaction from aps (adult protective services). Staff educated [Resident 4] on how lying is not appropriate. Describe what worked to calm the member down: redirection and additional staff. Describe the outcome of the overall incident: [Resident 4] will remain in [her/his] room outside of medication and meals [sic]."	M 412		

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M 412	Continued From page 14 -05/17/2024, at 5:10 PM, stated: "[Resident 4] was changing [her/his] channel in the presence of staff and took the batteries out and swallowed them. Staff attempted to redirect [her/him] from doing it, but [s/he] stated that [her/his] impulses got the best of [her/him]. Staff informed [Resident 4] that [s/he] would need to be taken into the hospital immediately, but [s/he] stated that [s/he] was not going. Staff reminded [her/him] that [s/he] would need to be seen as this was a serious medical need and [s/he] agreed to allow staff to take [her/him] into the hospital. Describe what worked to calm the member down: N/A (not applicable). Describe the outcome of the overall incident: [Resident 4] has been taken into the hospital [sic]." The report was reviewed by HR B and managerial comments stated, "[Resident 4] has been in behavior since [s/he] copied the behavior of another resident 5/9/2024 [sic]. Staff has been in communication with [her/his] care team the past week about the continued behaviors." On 06/11/2024, at 12:36 PM, Surveyor interviewed Licensee A and HR B. License A and HR B reported the following. Resident 4 had behaviors and walked away from the facility on many occasions and has had police interventions. When Resident 4 returned from the hospital, following the incident on 05/17/2024, s/he was discharged from the home and admitted to a different facility within their company. The police told them on 06/05/2024, they would not be responding to calls involving Resident 4. In summary, Surveyor was provided with 13 documented behavioral incident reports for Resident 4, between the dates of 08/05/2023 and 05/17/2024. The behavioral incident report form	M 412		

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M 412	Continued From page 15 the facility used allowed for the reporting person(s) to identify any interventions attempted. The following are options of interventions the form provides: 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 4. For 13 of 13 incidents, staff did not attempt to suggest an activity, go for a walk, or go for a van ride as indicated in Resident 4's Crisis Plan. Seven of 13 incidents required additional staff redirection as an intervention. For 9 of 13 incidents, Resident 4 was redirected to her/his bedroom and remained there outside of medication passes and meals. Four of 13 incidents resulted in hospitalization for Resident 4. Two of 13 incidents resulted in police intervention. All 13 incident reports were reviewed by HR B, and in 6 of 13 reports the managerial notes reported staff had managed the behavior appropriately. Managerial notes on Resident 4's behavioral incident reports also documented the following: behaviors had occurred everyday after Resident 4 spoke with her/his case manager; behaviors occurred after Resident 4 intentionally lost her/his job; opposite gender staff were removed from working with Resident 4; Resident 4 had a behavior every time s/he went into the community; and door chimes were removed from Resident 4's door. On 05/17/2024, a staff member was present and observed Resident 4 remove batteries from a remote and swallow them. Managerial comments for the incident on 05/17/2024, reported Resident 4 had been copying behavior of another resident since 05/09/2024. None of the 13 reports documented why the behaviors occurred, what interventions were effective or not effective for Resident 4, and what had been done to manage Resident 4's behaviors and prevent them from recurring.	M 412		

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M 412	Continued From page 16 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 and interview, the provider did not ensure 2 of 2 residents' (Resident 1 and Resident 2) prescription medications were securely stored. Resident 1's and Resident 2's medications were not securely stored in the file cabinets located in the dining room. Findings include: The home was licensed as an ambulatory adult family home caring for up to 3 residents in the client groups of emotionally disturbed/mental illness and developmentally disabled. On 06/11/2024, at 10:40 AM, Surveyor was checking file cabinets for items Resident 1 reported were locked up. Each resident had a 2-drawer file cabinet assigned to them, which were in the dining room. Resident 1's file cabinet	M 458		

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M 458	Continued From page 17 had 1 unlocked drawer, which contained 6 bubble packs of prescription medications. Resident 2's file cabinet had 1 unlocked drawer, which contained 7 bubble packs of prescription medications. Surveyor observed residents moving freely around the facility throughout the survey. On 06/11/2024 , at 10:43 AM, Surveyor interviewed Caregiver C. Surveyor inquired about the unsecured medications. Caregiver C confirmed the requirement prescription medications shall be securely stored. Caregiver C reported both drawers on the file cabinets should have been locked. Caregiver C didn't know why the drawers containing medications were unsecured. On 06/11/2024, at approximately 12:36 PM, Surveyor interviewed Licensee A and Director of Human Resources (HR) B. They confirmed prescription medications should be secured at all times.	M 458		
M 548	88.10(3)(a) Fair Treatment Fair treatment. To be treated with courtesy, respect and full recognition of the resident's dignity and individuality. This Rule is not met as evidenced by: Based on interview and observation, the provider did not ensure 1 of 1 resident (Resident 1) was treated with courtesy, respect and full recognition of their dignity and individuality.	M 548		

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M 548	Continued From page 18 Findings include: The home was licensed as an ambulatory adult family home caring for up to 3 residents in the client groups of emotionally disturbed/mental illness and developmentally disabled. On 06/21/2024 and 07/05/2024, the department received two complaints alleging the staff spoke to the residents in an abusive and inappropriate manner. On 06/11/2024, at 9:03 AM, Surveyor interviewed Resident 1. Resident 1 reported the following: - Director of Human Resources (HR) B rushed through initial paperwork with Resident 1 and s/he was not given an opportunity to read through what s/he was signing. Resident 1 stated, "[HR B] told me, we want you out of here." - Upon moving into the home, Caregiver C was assigned as Resident 1's one-on-one staff during dayshift hours. On or around 05/23/2024, Caregiver C yelled at Resident 1 due to medications being incorrect. Resident 1 stated, "I felt brain dead. I was crying and scared." Caregiver C sent Resident 1 to her/his room, after Resident 1 reported symptoms s/he was experiencing. - On 06/10/2024, Caregiver C had planned to go grocery shopping with Resident 1. Resident 1 was asked in advance to create a grocery list so Caregiver C could take her/him shopping. Caregiver C did not take Resident 1 to get groceries. Caregiver C forced Resident 1 to go on a 3-hour car ride to pick up another facility's resident and caregiver who were experiencing vehicle trouble. Resident 1 did not want to go on	M 548		

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the car ride and was uncomfortable with the situation. S/He was scared to express her/his concerns to Caregiver C out of fear of being reprimanded.

- On 06/11/2024, Resident 1 was cooking breakfast prior to completing her/his morning hygiene routine, and Caregiver C yelled at Resident 1 about being in the kitchen before getting cleaned up. Another resident was using the bathroom at the time Resident 1 planned to take a shower, so s/he chose to cook and eat breakfast while s/he waited. Resident 1 stated, "[Caregiver C] told me, now you're breathing in the fridge [sic]; you're all dirty and grimy." Caregiver C had Resident 1's cell phone locked up from the previous evening and did not allow Resident 1 access to her/his cell phone until s/he completed all cares and chores.

On 06/11/2024, at 10:36 AM, Surveyor interviewed Caregiver C. Surveyor inquired about the incident which took place earlier in the morning with Resident 1. Caregiver C reported, in a loud agitated voice, s/he wanted Resident 1 to handle cares before going into the kitchen to cook and eat breakfast. Surveyor inquired why Resident 1 was not allowed to cook and eat before completing cares. Caregiver C stated, "you haven't washed your face or brushed your teeth before you be in the kitchen and refrigerator [sic]."

On 06/11/2024, at 11:06 AM, Resident 1 requested her/his cell phone from Caregiver C. Surveyor observed Caregiver C unlock the file cabinet and retrieve Resident 1's cell phone. Caregiver C took the phone and tossed it on top of the file cabinet.

On 07/15/2024, Surveyor interviewed Social

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M 548	Continued From page 20 Worker D. Social Worker D reported s/he works with Resident 1 and occasionally speaks with Resident 1 by phone. During phone conversations with Resident 1, Social Worker D has heard the following statement from Caregiver C to Resident 1. "[S/He] got the wrong [expletive], who the [expletive] do [s/he] think [s/he] is." Social Worker D also reported overhearing the following statements from an unknown caregiver, after filing a complaint with the Department, on Resident 1's behalf. "What? That's [expletive]. Now our ratings are dropping. If [s/he] say something, [s/he] dead. [S/He] dead [expletive] about . . . Shut up [Resident 1]. You sound like Pac Man or some [expletive]. Wawa. Get the [expletive] out of here; go to your room." In summary, Resident 1 was rushed through paperwork, told s/he wasn't wanted at the home, sent to her/his room after expressing s/he was experiencing symptoms with medications, forced to go on a 3-hour car ride, spoken to by caregivers using explicit language and loud voices, and withheld of her/his personal property. On 06/11/2024, at approximately 12:36 PM, Surveyor interviewed Licensee A and Director of Human Resources (HR) B. They reported their staff are trained and denied any unfair treatment in the home.	M 548		
M 556	88.10(3)(e) Self-Direction 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	M 556		

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M 556	Continued From page 21 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 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 1, Resident 2, Resident 3, and Resident 4 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 9:03 AM, Surveyor interviewed Resident 1. Resident 1 reported the following: There was an unwritten house rule enforced by the caregivers, which required residents in the AFH to remain in their bedrooms from 8:00 PM until 8:00 AM. 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. Resident 1 has requested to bring a glass of water into her/his room and was told by Caregiver C s/he could not. The kitchen was closed to residents at 8:00 PM. Resident 1's personal cell phone was taken from her/him nightly, at 8:00 PM, secured in a file cabinet, and not returned to her/him until all chores and cares were done for	M 556		

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the following day. Resident 1 reported s/he did not like the curfew or having to ask for permission from staff for things. S/He did not give permission for her/his cell phone to be taken away.

On 06/11/2024, at 9:57 AM, Surveyor interviewed Resident 3. Resident 3 reported the following: S/He needed to follow the curfew and be in her/his bedroom by 9:30 PM. The kitchen was closed to residents at 8:00 PM. Residents were required to ask their one-on-one staff permission to exit their bedrooms during the curfew hours. Resident 3 was unclear of the curfew time in place for the morning but thought s/he was not allowed to exit her/his room before 7:00 AM. Resident 3's personal cell phone was taken from her/him nightly, at 8:30 PM, secured in a file cabinet, and returned to her/him at 8:00 AM.

On 06/11/2024, at 10:27 AM, Surveyor interviewed Caregiver C and Caregiver E. Caregiver C and Caregiver E reported the 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 inquired if the house rules were posted in the AFH. Caregiver E looked for the posting and stated, "we just had this room painted and I'm not sure why the maintenance [person] did not put it back up." Surveyor observed many other postings on the walls required by the Department but did not locate posted house rules. Caregiver C and Caregiver E reported they learned of the house rules from Director of Human Resources (HR) B. Caregiver E reported the kitchen was closed after 7:00 PM. Surveyor inquired what was done if a resident wanted food after 7:00 PM. Caregiver E stated, "there's no need to be in the kitchen in the

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M 556	Continued From page 23 middle of the night. The kitchen is closed." On 06/11/2024, at 11:43 AM, Surveyor interviewed Resident 4, who was a resident of this facility until 05/29/2024 and moved to the adult family home in the upper level of the duplex (owned by the same licensee). Resident 4 reported the following: 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 12:36 PM, Surveyor interviewed Licensee A and HR B. Licensee A and HR B reported the following: 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. On 07/17/2024, Surveyor reviewed the program statement for the home, dated 04/13/2016. 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 1, Resident 2, Resident 3, and Resident 4, and identified the following: Resident 1 was admitted to the home on 05/22/2024. Resident 1 was her/his own person. Resident 1 was under the care of 24/7 one-on-one staff. Resident 1's ISP was dated 05/28/2024 and 06/25/2024. Resident 1's ISP stated, "Member has a personal cell phone that	M 556		

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[s/he] has access to from 8am-8pm if [s/he] completes [her/his] daily cares and works on [her/his] goals from CCS (comprehensive community services). Member also makes excessive calls which prevents [her/him] from having it on [her/his] person all day. Member has a computer that [s/he] keeps daily with [her/him] 24/7."

Resident 2 was admitted to the home on 03/24/2022. Resident 2 had a guardian who made decisions on her/his behalf. Resident 2 was under the care of 24/7 one-on-one staff. Resident 2's ISP was dated 07/01/2024. Resident 2's ISP stated, "Member cannot freely use phones as [s/he] will make inappropriate calls to officials, and strain county resources. Member cannot freely go into the kitchen as [s/he] will eat other residents [sic] food."

Resident 3 was admitted to the home on 10/11/2023. 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 07/12/2024. 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 also stated, "Other: Cellphone is used from 8am-8pm as member would not sleep if [s/he] had it all night." 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 06/20/2023. Resident 4 was her/his own person.

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ROOTS RESIDENTIAL ADULT FAMILY HOMES	1715 LASALLE STREET LOWER 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 556	Continued From page 25 Resident 4 was under the care of 24/7 one-on-one staff. Resident 4's ISP was dated 07/15/2024. Resident 4'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." 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		
M 580	88.10(3)(p) Prompt and Adequate Treatment Prompt and adequate treatment. To receive prompt and adequate treatment and services appropriate to the resident's needs. This Rule is not met as evidenced by: Based on interview, observation, and record review, the provider did not ensure 1 of 1 resident (Resident 1) received prompt and adequate treatment. Resident 1 developed raised red sores	M 580		

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M 580	Continued From page 26	M 580		

on her/his arms, requested to be seen by a doctor, and was not treated by a medical professional within an adequate timeframe.

Findings include:

On 06/11/2024, at 9:03 AM, Surveyor interviewed Resident 1. Resident 1 reported s/he was admitted on 05/22/2024, which was the first night s/he stayed in her/his bedroom, and s/he developed bug bites on her/his arms. Surveyor observed Resident 1 had multiple raised red sores on both arms; some appeared to be new, and some appeared to be scabbed over and older. Resident 1 reported s/he had requested to go to a doctor's office to have the sores checked out, and the adult family home (AFH) staff provided an antiseptic cream and denied Resident 1's request to visit a doctor. Resident 1 reported the bug bites were painful and caused her/him to have welts the size of a dollar bill. Resident 1 had experienced the bug bites everyday s/he was in her/his bed. As the bites increased, swelled up, and became itchy and painful, Resident 1 again requested to go to a doctor, and was denied medical treatment by AFH staff. Resident 1 was unaware of any future appointments made for her/him to seek medical treatment for the bugs bites.

On 06/11/2024, at 12:36 PM, Surveyor interviewed Director of Human Resources (HR) B. HR B reported the following. Resident 1's possessions were in a storage facility prior to moving into the AFH. The bedroom Resident 1 resided was treated for bedbugs prior to Resident 1 moving in. Resident 1 was seen by a doctor for the bug bites on her/his arms. HR B did not comment on her/his observation of bug bites on Resident 1. HR B denied any ongoing problem

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with bed bugs and did not comment on future treatments for bed bugs. Surveyor requested HR B produce the paperwork from the doctor's visit.

On 06/11/2024, at 4:24 PM, HR B emailed a copy of an after visit summary report for Resident 1, for an appointment which occurred following Surveyor's on-site survey. Records provided confirmed Resident 1 had not been previously taken to the doctor for treatment of the bug bites, as stated by HR B.

Surveyor reviewed the after-visit summary from Resident 1's medical appointment and the document reported the following:

- Resident 1 was taken to an Aurora Health Care facility on 06/11/2024, at 2:20 PM, for an appointment with a medical doctor.
- Bug bites were the issue addressed during the visit.
- Sulfamethoxazole-trimethoprim 800-160 milligrams tablets (an antibiotic used to treat or prevent and infection) were prescribed. The after-visit summary stated, "take 1 tablet by mouth in the morning and 1 tablet in the evening. Do all this for 7 days."
- Attachments were included for information on insect bites and discharge instructions for cellulitis.
- A follow-up visit was scheduled for 06/24/2024.

On 07/17/2024, Surveyor reviewed Resident 1's record and identified the following:

Resident 1 was admitted to the AFH on 05/22/2024.

Resident 1's individual service plan (ISP), dated 05/28/2024, documented:

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M 580	Continued From page 28 "General Health - Current Status: Overall health is good; Frequency of Service and Service Provided: Staff to ensure maintains consistency with all doctor's appointments; . . . Service provider responsible: RRAFH, LLC . . . Staff to make and keep all doctor's appointments . . . [Resident 1] to attend all appointments and follow all orders." In summary, Resident 1 began experiencing bug bites on 05/22/2023. S/He requested to be treated by a medical professional on more than one occasion and was denied by staff. Medical treatment for Resident 1 was not sought prior to Surveyor's inquiry on 06/11/2024. Resident 1 remained untreated for bug bites for 20 days, which caused pain, itchiness, and infection.	M 580		
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.	Z 010		

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Z 010	Continued From page 29 If information obtained under par. (am) or (b), a 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 determine the final disposition of a charge of a serious crime, related to s. 948.03(2)(a), for 1 of 1 caregiver (Caregiver E). Findings include: On 05/29/2024, at 1:28 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 E and Caregiver F. 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 requested information was missing. Surveyor requested HR B send the missing documentation by 5:00 PM, on 05/31/2024.	Z 010		

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Z 010	Continued From page 30 On 05/31/2024, Surveyor reviewed the additional documents HR B had sent. Those documents included a background information disclosure form (BID), a State of Wisconsin Department of Justice (DOJ) background check, and caregiver background check (IBIS), for Caregiver E. The following are the findings from the above documents. Caregiver E was hired as a caregiver on 03/19/2019. BID - The BID was completed and signed on 03/19/2019, by Caregiver E. - Caregiver E disclosed s/he was convicted of a crime in "Racine, WI March 2016 [sic]." - Caregiver E disclosed s/he had been found by a government or regulatory agency to have committed child abuse or neglect. The disclosure stated, "with my teenage [daughter/son] March 2014 [sic]." DOJ - The DOJ record was requested and reported on 03/19/2019. - "Date of offense: 05/20/2013 . . . 948.03(2)(A) - Child Abuse - Intentional Cause Great Harm . . . Charge: 948.03(2)(A) - Child Abuse - Intentional Cause Great Harm . . . Disposition date: 08/16/2013 Disposition: Disposition not reported." - "Arrest Data . . . Date: 03/24/2014 . . . Court date: 08/12/2014 . . . Comments: CCAP disposition . . . Charge . . . Sequence number: 05 Statute number: 948.03(2)(A) - Child Abuse - Intentional Cause Great Harm . . . Comments: Information filed . . . Disposition date: 01/05/2016	Z 010		

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Z 010	Continued From page 31 Disposition: Information filed . . . Charge . . . Statute number: 948.03(3)(A) - Child Abuse - Recklessly Cause Great Harm . . . Disposition date: 01/05/2016 Disposition: Convicted." - "Date of offense: 03/25/2015 . . . 948.03(2)(A) - Child Abuse - Intentional Cause Great Harm . . . " - "Date of offense: 01/11/2016 . . . 948.03(3)(A) - Child Abuse - Recklessly Cause Great Harm . . . Disposition date: 01/11/2016 . . . Confined custody sentence: Prison; Sentence Date: 01/11/2016; Length: 4 years, 4 days." IBIS - The IBIS record was requested and reported on 03/19/2019. - 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 reported s/he completed Caregiver E's background check and was aware of her/his record. Licensee A and HR B reported they were unaware Caregiver E's record indicated a charge of a serious crime, which may have affected her/his caregiver eligibility. 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 E's background check.	Z 010		