STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016022	A. BUILDING: _____ B. WING _____	R-C 02/07/2025

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

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{M 000}	INITIAL COMMENTS On 02/05/2025, with information gathered through 02/07/2025, Surveyor conducted a standard survey and two verification visits at Roots Residential Adult Family Homes LLC - Lower Unit for Statement of Deficiency (SOD) T6PA11 and HI6T11. Eight deficiencies were identified. Six of the 8 are repeat violations. See Statement of Deficiency (SOD) T6PA11 dated, 07/22/2024, SOD HI6T11, dated 10/21/2024, SOD OGK414, dated 06/10/21, and SOD OGK413, dated 05/01/2019. Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed. Census: 1	{M 000}		
M 232	88.04(2)(g)1 HEALTH SCREENING FOR STAFF The licensee shall obtain documentation from a physician, a registered nurse or a physician's assistant indicating that the licensee and any service provider has been screened for illness detrimental to residents, including for tuberculosis. The documentation is to be completed within 90 days before the start of providing service. The documentation shall be kept confidential except that the licensing agency shall have access to the documentation for verification. This Rule is not met as evidenced by:	M 232		

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

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M 232	Continued From page 1 Based on record review and interview, the provider did not ensure 3 of 3 employees (Caregiver J, Caregiver K, and Caregiver L) employee records reviewed had evidence the employee had been screened for illness detrimental to residents within 90 days before the start of providing service. This is a repeat violation. See Statement of Deficiency (SOD) OGK413, dated 05/01/2019. Findings include: The home was licensed as an ambulatory adult family home caring for up to 3 residents in the client groups of developmentally disabled and emotionally disturbed/mental illness. On 02/05/2025, Surveyor reviewed staff records and identified the following: -Caregiver J was hired on 09/02/2024. There was no evidence Caregiver J had been screened for illness detrimental to residents within 90 days before the start of providing service. -Caregiver K was hired on 05/17/2024. There was no evidence Caregiver K had been screened for illness detrimental to residents within 90 days before the start of providing service. -Caregiver L was hired on 03/05/2024. There was no evidence Caregiver L had been screened for illness detrimental to residents within 90 days before the start of providing service. On 02/05/2025, at approximately 3:55 PM, Surveyor interviewed Executive Office Manager (EOM) I. EOM I stated s/he was responsible to ensure employees were tested for tuberculosis.	M 232		

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M 232	Continued From page 2 EOM I stated s/he was not aware of the requirement employees had to be screened for illness detrimental to residents within 90 days before the start of providing service as well.	M 232		
{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. This had the potential to affect 1 of 1 resident residing in the facility. This is a repeat violation. See statement of deficiency (SOD) T6PA11, dated 07/22/2024. Findings include: The home was licensed as an ambulatory adult family home caring for up to 3 residents in the client groups of developmentally disabled and emotionally disturbed/mental illness. On 02/05/2025, at approximately 10:32 AM, Surveyor conducted a tour of the facility and observed the following: -Bedroom 1 window was unable to be opened	{M 276}		

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{M 276}	Continued From page 3 and closed, which left a gap to the outside. Inside the windowsill was dust, debris, and paint chips. -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. On 02/05/2025, at approximately 11:27 AM, Surveyor interviewed Director of Human Resources (HR) B. HR B reported s/he put in a request to the maintenance person on 01/28/2025 to make home repairs.	{M 276}		
M 332	88.05(4)(a) FIRE SAFETY-FIRE EXTINGUISHERS Fire extinguishers. Every adult family home shall be equipped with one or more fire extinguishers on each floor. Each required fire extinguisher shall have a minimum 2A, 10-B-C rating. All required fire extinguishers shall be mounted. A fire extinguisher is required at the head of each stairway and in or near the kitchen except that a single fire extinguisher located in close proximity to the kitchen and the head of a stairway may be used to meet the requirement for an extinguisher at each location. Each required fire extinguisher shall be maintained in readily usable condition and shall be inspected annually by the authorized dealer or the local fire department and have an attached tag showing the date of the last dealer or fire department inspection.	M 332		

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M 332	Continued From page 4 This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure 1 of 2 fire extinguishers were mounted. The fire extinguisher located in the basement was not mounted. This is a repeat violation. See Statement of Deficiency (SOD) OGK414, dated 06/10/2021. Findings include: On 02/05/2025, at approximately 10:32 AM, Surveyor conducted a tour of the facility. The following was observed: -The fire extinguisher located in the basement was not mounted. On 02/05/2025, at approximately 11:27 AM, Surveyor interviewed Director of Human Resources (HR) B. HR B confirmed the fire extinguisher located in the basement was not mounted. HR B stated s/he would have the maintenance person mount the fire extinguisher in the basement.	M 332		
M 334	88.05(4)(b)1 FIRE SAFETY-SMOKE DETECTORS Every adult family home shall be equipped with one or more single station battery operated, electrically interconnected or radio signal emitting smoke detectors on each floor level. Required smoke detectors shall be located in each habitable room except the kitchen and bathroom and	M 334		

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M 334	Continued From page 5 specifically in the following locations: at the head of each open stairway, at the door leading to every enclosed stairway, on the ceiling of the living room or family room, on the ceiling of each sleeping room and in the basement. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure there was a smoke detector in 2 of 7 required locations. There was no smoke detector at the head of basement stairwell and in the basement. This is a repeat violation. See Statement of Deficiency (SOD) OGK414, dated 06/10/2021. Findings include: On 02/05/2025, at approximately 10:32 AM, Surveyor conducted a tour of the facility. The following was observed: -The head of basement stairwell did not contain a smoke detector. -The basement did not contain a smoke detector. On 02/05/2025, at approximately 11:27 AM, Surveyor interview Director of Human Resources (HR) B. HR B stated s/he would have the maintenance person install a smoke detector at the head of the basement stairwell in the basement.	M 334		

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M 346	Continued From page 6	M 346		
M 346	88.05(4)(d)2.b FIRE EVACUATION ANNUAL EVALUATION Each resident shall be evaluated annually for evacuation time, using the departments form. All service providers who work on the premises shall be made aware of each resident having an evacuation time of more than 2 minutes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 resident reviewed was evaluated annually for evacuation time, using the Department's form. Resident 2 had not been evaluated for evacuation for calendar years 2023 and 2024 using the Department's form. Findings include: The home was licensed as an ambulatory adult family home caring for up to 3 residents in the client groups of developmentally disabled and emotionally disturbed/mental illness. On 02/05/2025, Surveyor reviewed Resident 2's record. Resident 2's record indicated the following: -Resident 2 was admitted to the provider's home on 03/24/2022. Resident 2's record did not contain evidence of an evacuation assessment for calendar years 2023 and 2024 using the Department's form. On 02/05/2025 at approximately 12:05 PM, Surveyor interviewed Director of Human Resources (HR) B. HR B stated s/he did not have	M 346		

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M 346	Continued From page 7 an annual evacuation for Resident 2 for calendar year 2023 and 2024. HR B stated if it was not in Resident 2's record it was not completed.	M 346		
{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 Individual Service Plan (ISP) included a description of service staff were to implement to manage behaviors for 1 of 1 resident (Resident 2). Resident 2's ISP did not include information regarding how staff were to manage Resident 2's behaviors. Resident 2 was assigned 1:1 staffing on first shift and 2:1 staffing on second and third shift, but the ISP did not identify how the staff should respond when target behaviors occurred. This is a repeat violation. See Statement of Deficiency (SOD) T6PA11, dated 07/22/2024, and SOD HI6T11, dated 10/21/2024. Findings include: On 02/05/2025, Surveyor reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the provider's home on 03/24/2022, with diagnoses including	{M 412}		

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{M 412}	Continued From page 8 schizoaffective disorder, antisocial personality, major neurocognitive disorder-attention, concentration, mental shifting, alcohol use disorder, and cannabis use disorder. -Resident 2 had a legal guardian. -Resident 2's ISP, dated 10/23/2024, identified the following: -Resident 2 required 24-hour supervision and was assigned 1:1 staffing first shift and 2:1 staffing on second and third shift. -Resident 2 ISP identified Resident 2 "Target" Behaviors: "Making false complaints on staff and third parties, Suicidal Ideation, Harming Others, Property Damage, Elopement (going to get alcohol and marijuana), and calling city and state officials." "Staff will ensure that [Resident 2] is utilizing his/her oxygen tank, staff will ensure that [Resident2] is watching his/her sodium intake level by preparing meals within his/her requirements, staff will ensure that [Resident 2] is not taking things in the home that do not belong to him/her. Staff will continue to assist [Resident 2] with making calls. Staff will alert care team and also attempt to follow [Resident 2] within a safe range and encourage him/her not to purchase alcohol or marijuana." -Resident 2's ISP did not describe how Resident 2's 1:1 and 2:1 staff assigned to him/her should respond when target behaviors occur. -Resident 2's ISP did not identify Resident 2's elopement plans and procedure. On 02/05/2025, at approximately 4:00 PM,	{M 412}		

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{M 412}	Continued From page 9 Surveyor interviewed Director of Human Resources (HR) B. HR B confirmed Resident 2's ISP did not describe how Resident 2's 1:1 and 2:1 staff assigned to him/her should respond when target behaviors occur. HR B stated the following: "It sounds like you want me to create a care plan." Surveyor responded to HR B stating the following: "An ISP is the resident care plan."	{M 412}		
M 482	88.09(1)(a) RESIDENT RECORDS The licensee shall maintain a record for each resident. Resident records shall be maintained in a secure location within the home to prevent unauthorized access. This Rule is not met as evidenced by: Based on observation and interview, the provider did not maintain the records for 1 of 1 resident (Resident 2) reviewed in a secure location within the home. Resident 2's medical records were not accessible to Surveyor. Findings include: On 02/05/2025, Surveyor reviewed Resident 2's record and identified the following: -Resident 2 was admitted to the provider's home on 03/24/2022 and had a legal guardian. -Resident 2's record in the home did not contain his/her medical records.	M 482		

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M 482	Continued From page 10 On 02/05/2025, at approximately 9:30 AM, Surveyor requested Resident 2's medical records from Director of Human Resources (HR) B. HR B stated Resident 2'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 2's medical records from the office. On 02/05/2025, at approximately 2:30 PM, Surveyor received Resident 2's medical records from HR B.	M 482		
M 570	88.10(3)(l) Safe Physical Environment Individuals, except for correctional residents, have basic rights which they do not lose when they enter an adult family home. A resident shall have a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition or disability. This Rule is not met as evidenced by: Based on observation and interview, the provider did not safeguard residents who cannot fully guard themselves from environmental hazards. The provider did not ensure the dryer vent made of rigid venting was attached to the dryer. This is a repeat violation. See statement of	M 570		

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M 570	Continued From page 11 deficiency (SOD) OGK413, dated 05/01/2019. Findings include: On 02/05/2025, at approximately 10:32 AM, Surveyor conducted a tour of the facility and observed the following: -The dryer vent made of rigid venting was not attached to the dryer. On 02/05/2025, at approximately 11:03 AM, Surveyor interviewed Director of Human Resources (HR) B. HR B confirmed the rigid venting was not attached to the dryer. HR B stated s/he would have the maintenance person attach the rigid venting to the dryer.	M 570		