STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018606	A. BUILDING: _____ B. WING _____	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOTS RESIDENTIAL AFH LLC - 2713 GILLEN	2713 GILLEN STREET RACINE, WI 53403

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M 000	INITIAL COMMENTS On 06/26/2026, Surveyor completed a standard survey and self-report investigation at Roots Residential Adult Family Home LLC. As a result, 6 deficiencies were identified. Two of the 6 deficiencies were repeat violations (see Statement of Deficiency 5M8311, dated 01/25/2023). One of 1 self-report review did not result in a citation. Census: 1	M 000		
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		

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

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M 332	Continued From page 1 This Rule is not met as evidenced by: Based on observation and interview the provider did not ensure 2 of 2 fire extinguishers were inspected annually. The fire extinguisher in the kitchen and the fire extinguisher in the basement was last inspected April 2025. This is a repeat deficiency. See Statement of Deficiency 5M8311, dated 01/25/2023. Findings include: On 06/25/2026 at approximately 10:36 AM, Surveyors toured the facility. The fire extinguisher located in the kitchen had an inspection tag which indicated it was last serviced Aril 2025. The fire extinguisher located in the basement had an inspection tag which indicated it was last serviced April 2025. On 06/25/2026 at approximately 11:00 AM, Surveyor interviewed Director of Human Resources (HR) A. Director of HR stated the house lead was responsible for completing monthly fire extinguisher checks. While Surveyors were onsite, Director of HR contacted the main office of the adult family home to have two fire extinguishers brought to the home. One of the 2 fire extinguishers that were brought to the home was not the correct size. Director of HR stated he/she would ensure the correct fire extinguisher was brought home. Director of HR also had a conversation with House Lead B about the importance of inspecting the fire extinguisher monthly.	M 332		

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M 334	Continued From page 2	M 334		
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 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 smoke detectors were in 3 of 4 required locations. The living room smoke detector was located on the wall. Two of 2 resident bedrooms' smoke detectors were located on the walls. This is a repeat deficiency. See Statement of Deficiency 5M8311, dated 01/25/2023. Findings include: On 06/25/2026 between approximately 10:36 AM and 12:00 PM, Surveyors toured the adult family home. The following was observed: The smoke detector located in Resident 1's bedroom was located above the door on the wall.	M 334		

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M 334	Continued From page 3 The smoke detector located in the vacant resident bedroom was located on the wall above the door. The smoke detector located in the living room was located on the wall near the kitchen. On 06/26/2026 at approximately 1:28 PM, Surveyor interviewed Director of Human Resources A. Director of Human Resources A acknowledged the smoke detectors were on the wall and not the ceiling. Director of Human Resources A stated he/she would have the smoke detectors moved to the ceilings.	M 334		
M 336	88.05(4)(b)2 SMOKE DETECTORS-TESTING AND MAINTENANCE The licensee shall maintain each required smoke detector in working condition and test each smoke detector monthly to make sure that it is operating. If a unit is found to be not operating, the licensee shall immediately replace the battery or have the unit repaired or replaced. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the facility's smoke detectors were tested monthly for 2 (2024 and 2025) of 2 years. Findings include: On 06/25/2026 at approximately 11:00 AM, Surveyor reviewed the facility safety files. The smoke detectors were tested on the following	M 336		

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M 336	Continued From page 4 dates: 2024: 01/01/2024, 02/01/2024, 03/01/2024, 04/01/2024, 05/01/2024, 06/01/2024, 07/01/2024, 08/01/2024, 09/01/2024, 10/01/2024, 12/01/2024. 2025: 05/01/2025, 06/01/2025, 07/01/2025, 08/01/2025, 09/01/2025 Surveyor was unable to locate evidence that the smoke detectors were tested in 11/2024, 01/2025, 02/2025, 03/2025, 04/2025, 10/2025, 11/2025, and 12/2025. On 06/25/2026 at approximately 11:00 AM, Surveyor interviewed Director of Human Resources A and House Lead B. Director of Human Resources A and House Lead B could not locate evidence that the smoke detectors were tested on the above dates. Director of Human Resources A stated the house lead should have tested the smoke detectors each month.	M 336		
M 424	88.06(3)(f) REVIEW OF ISP The individual service plan shall be reviewed at least once every 6 months by the licensee, the resident or the resident's guardian, the service coordinator, if any, the designated representative, if any, the placing agency with the resident participating in a manner appropriate for the resident's level of understanding and method of communication. This review is to determine continued appropriateness of the plan and to update the plan as necessary. A plan shall be updated, in writing, whenever	M 424		

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M 424	Continued From page 5 the resident's needs or preferences change substantially or when requested by the resident or the resident's guardian. This Rule is not met as evidenced by: Based on record review and interview, the provider did not review the individual service plan (ISP) every 6 months from 2024 to April 2026 for 1 (Resident 1) of 2 residents reviewed. Findings include: On 06/25/2026 at approximately 2:00 PM, Surveyor reviewed Resident 1's record. Resident 1 was admitted into the adult family home on 02/23/2022. Resident 1's record contained a total of 4 ISPs between 2024 to current. One ISP had a review date of 09/11/2024. The 2nd ISP had a review date of 12/04/2024. The 3rd ISP had a review date of 03/11/2025. The 4th ISP had a review date of 10/28/2025. Surveyor observed no evidence Resident 1's ISP was reviewed and/or updated on or before 03/11/2024 and 04/28/2026. On 06/26/2026 at approximately 1:28 PM, Surveyor interviewed Director of Human Resources A. Director of Human Resources A acknowledged Resident 1's file did not contain an ISP that indicated Resident 1's ISP was reviewed and/or updated on or before 03/11/2024. Director of Human Resources A stated he/she was not responsible for completing ISPs prior to 2025 and could not state why Resident 1's ISP may not have been reviewed and/or updated on or before 03/11/2024. Director of Human Resources A	M 424		

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M 424	Continued From page 6 stated he/she met with Resident 1, Resident 1's legal guardian, and Resident 1's care team on 06/26/2026 to review and update Resident 1's ISP.	M 424		
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 every prescription medication was securely stored in 1 of 1 refrigerator. Resident 1's Zepbound was not securely stored in the refrigerator. Findings include: This facility was licensed on 10/01/2021 to serve up to 4 non-ambulatory residents in the client groups of developmentally disabled, alcohol/drug dependent, terminally ill, irreversible dementia/Alzheimer's, physically disabled, and advanced aged.	M 458		

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M 458	Continued From page 7 On 06/25/2026 between approximately 10:36 AM and 12:00 PM, Surveyor toured the adult family home (AFH). Surveyor observed an opened box of Zepbound located in the door of the refrigerator. The refrigerator was in the home's kitchen. The box contained unused vials of Zepbound. On 06/25/2026 at approximately 12:00 PM, Surveyor interviewed House Lead B. House Lead B reported the Zepbound belonged to Resident 1. House Lead B contacted the main office of the adult family home to ask for a lockbox to be delivered to the home. House Lead B informed the main office that the lockbox was for Resident 1's Zepbound that was in the refrigerator. On 06/26/2026 at approximately 1:28 PM, Surveyor interviewed Director of Human Resources A. Director of Human Resources A acknowledged Resident 1's Zepbound was not locked up. Director of Human Resources A stated he/she has purchased a locked bag that is to be used for Resident 1's Zepbound.	M 458		
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	M 570		

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M 570	Continued From page 8 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 ensure a safe physical environment for 1 (Resident 1) of 1 resident. The dryer vent was not connected to the dryer. Findings include: On 06/25/2026 at approximately 10:36 AM, Surveyor toured the adult family home. Surveyors observed the washer and dryer located in the basement of the adult family home. Surveyors observed the rigid dryer vent disconnected from the dryer. On 06/26/2026 at approximately 1:28 PM, Surveyor interviewed Director of Human Resources A. Director of Human Resources A stated the dryer vent often comes apart from the dryer. It is unclear as to why the dryer vent continues to detach from the dryer. Director of Human Resources A will contact someone to re-attach the dryer vent to the dryer.	M 570		