STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0020598	A. BUILDING: _____ B. WING _____	C 12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOTS RESIDENTIAL AFH LLC 2315 GENEVA	2315 GENEVA STREET UPPER RACINE, WI 53402

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M 000	INITIAL COMMENTS On 12/12/2025, Surveyor conducted a complaint investigation, at Roots Residential AFH LLC 2315 Geneva Upper, an Adult Family Home (AFH) in Racine, WI. Two deficiencies were identified. Complaint substantiated. Census: 2	M 000		
M 134	88.03(5)(e)1 SIGNIFICANT CHANGE TO THE RESIDENT Within 24 hours, a significant change in resident status, such as but not limited to an accident requiring hospitalization, missing from the home or a reportable death. A death shall be reported if there is reasonable cause to believe the death was related to use of a physical restraint or psychotropic medications, was a suicide or was accidental. This Rule is not met as evidenced by: Based on record review and interview, the provider did not report to the department, within 24 hours, when 1 of 1 resident (Resident 1) eloped and was reported missing. Resident 1 eloped from the facility and the provider did not report to the department. Findings include: On 12/12/2025, Surveyors reviewed Resident 1's record and identified the following:	M 134		

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

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M 134	Continued From page 1 -Resident 1 was admitted to the provider's home on 09/08/2025 with diagnoses including schizoaffective disorder and post-traumatic stress disorder. -Resident 1 had a guardian. On 12/12/2025, Surveyors reviewed Racine Police Department (RAPD) report for incident involving Resident 1 and identified the following: Incident on 11/05/2025 -On 11/05/2025, RAPD officers were dispatched to Resident 1 outside bleeding from his/her foot at Jimmy Johns. -"Upon arrival RAPD officers spoke with [Resident 1] who reported [s/he] left [this home] and walked to Jimmy Johns. [Resident 1] was out with rescue prior to RAPD officers arrival. [Resident 1] reported [s/he] did not feel safe at [this home] and the staff is mean to [him/her] and doesn't let [him/her] make phone calls. [Resident 1] reported that staff get physical with [him/her] which causes [him/her] to bruise. Rescue cleared [Resident 1] to return to the home. RAPD officers spoke with [Caregiver B] who reported [Resident 1] causes the injuries to [him/herself] hitting [him/her] face and arms on items around the house. [Caregiver B] reported [s/he] fell asleep and was unaware [Resident 1] left the home. RAPD officers also spoke to [Caregiver C] who reported [Resident 1's] 1:1 staff fell asleep and was unaware [Resident 1] left the home. [Resident 1] was safely dropped off back to the home." On 12/12/2025, at approximately 9:09 AM,	M 134		

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M 134	Continued From page 2 Surveyors interviewed Director of Human Resources (DOHR) A. DOHR A reported s/he completed the assisted living facility self-report but forgot to submit it to the Department. On 12/12/2025, Surveyors completed a review of the Department facility folder. Surveyors observe a self-report, dated 11/05/2025 was submitted to the Department on 12/12/2025 at 1:29 PM (Day of survey after surveyors left the home).	M 134		
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 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 ensure 1 of 1 resident (Resident 1) reviewed had his/her individual service plan (ISP) updated when there was a change in	M 424		

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M 424	Continued From page 3 Resident 1's needs. Resident 1's ISP did not include information regarding his/her elopement, self-abusive behavior, suicidal tendencies, destructive of property and aggressive/combative behavior. Findings include: On 12/12/2025, Surveyors reviewed Resident 1's record and identified the following: -Resident 1 was admitted to the provider's home on 09/08/2025. -Resident 1 had a guardian. -Resident 1's Behavioral Incident Report, dated 11/05/2025, at 5:30 AM, documented the following: "List events/factors leading up to the incident: [Resident 1] eloped from [this home]. Describe the incident in detail: [Resident 1] had eloped from [this home]. The second staff [Caregiver C] in the home had been cleaning in the kitchen when [s/he] noticed [Resident 1] was not in [his/her] room. [Caregiver C] alerted [Resident 1's] staff [Caregiver B] and informed [him/her] that [Resident 1] had not been in the room. Leadership was immediately called and then staff began to look for [Resident 1] around the home. The owner received a call and stated that [Resident 1] was by Jimmy Johns and staff were able to pick [him/her] up and return [him/her] home. [Resident 1's] staff [Caregiver B] admitted that [s/he] had dosed off while the other staff was cleaning. Staff were able to talk with [Resident 1] and [s/he] stated that [s/he] left due to the voices in [his/her] head telling [him/her] to leave. Staff worked with [Resident 1] on [his/her] coping skills before returning to bed."	M 424		

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M 424	Continued From page 4 -Resident 1's Behavioral Incident Report, dated 11/02/2025, at 2:00 PM, documented the following: "List events/factors leading up to the incident: [Resident 1] was in [his/her] room ad [s/he] came out of the room stating that Jesus told her to attack staff. Describe the incident in detail: [Resident 1] was in [his/her] room and [s/he] came out of the room stating that Jesus told [him/her] to attack staff. [Resident 1] grabbed a chair out the kitchen and threw it onto the wall causing it to put a hole in the wall. Staff was able to redirect [Resident 1] and get the chair from them. As staff was handed the chair from [Resident 1] [s/he] struck staff in the face with a closed hand fist. Staff was able to create distance between [Resident 1] and themselves so that they did not get hit again. Staff worked with [Resident 1] on [his/her] coping skills and [Resident 1] proceeded back to [his/her] room." -Resident 1's Behavioral Incident Report, dated 10/30/2025, at 2:00 PM, documented the following: "List events/factors leading up to the incident: Staff heard [Resident 1] in the room saying ouch. When staff came in the room [Resident 1] was hitting [his/herself] on [his/her] arms and legs with [his/her] shoes trying to place bruises on [his/herself]. Describe the incident in detail: Staff heard [Resident 1] in the room saying ouch. When staff came in the room [Resident 1] was hitting [his/herself] on [his/her] arms and legs with [his/her] shoes trying to place bruises on [his/herself]. Staff were able to get [Resident 1] to stop and to hand over the shoes. Staff were able to provide [Resident 1] with a prn and [Resident 1] returned to [his/her] room. A few moments later staff heard banging again and [Resident 1] was hitting the window. Once staff made it into the room staff noticed that [Resident 1] had broken the window. [Resident 1] did not have any injuries	M 424		

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from the break. Maintenance came to the home and removed the window and its now at green glass getting repaired."

-Resident 1's Behavioral Incident Report, dated 10/26/2025, at 5:00 PM, documented the following: "List events/factors leading up to the incident: [Resident 1] returned home from the store and was cooking with staff and then stated to attempt to fight staff. Describe the incident in detail: [Resident 1] returned home from the store and was cooking with staff and then started to attempt to fight staff. [Resident 1] had been cordial for most of the day and then [Resident 1] stated that the voices were telling [him/her] to attack staff. Staff gave space and told [Resident 1] that this behavior was not appropriate and began to do a deep breathing routine with [Resident 1] and [s/he] appeared to settle down. 20 minutes later [Resident 1] began to tell staff to call leadership as [s/he] wanted to marry [Director of Human Resources (DOHR) A]. Staff redirected [him/her] and told [him/her] this conversation was not appropriate and attempted to work on crafts with [him/her] but [s/he] declined. [Resident 1] was then heard in the bathroom slamming the toilet. Once staff went into the bathroom, they noticed that the toilet was broke. Staff educated [Resident 1] on why property damage was not the best option and [Resident 1] needs to work with staff on different ways to release anger. Staff was able to take a walk with [Resident 1] throughout the community and [s/he] appeared to calm down."

-Resident 1's Behavioral Incident Report, dated 10/25/2025, at 9:00 AM, documented the following: "List events/factors leading up to the incident: [Resident 1] came out of [his/her] room stating that there was going to be an explosion,

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gases were fuming, and [s/he] was going to attack staff. Describe the incident in detail: [Resident 1] came out of [his/her] room stating that there was going to be an explosion, gases were fuming, and [s/he] was going to attack staff. Staff explained to [Resident 1] that there was no gas leak and no explosion was going to happen. Staff also remained [Resident 1] that hitting staff was not appropriate. [Resident 1] ignored staff and then [s/he] punched the female staff and asked staff to fight [him/her]. Staff gave space and then [s/he] began to punch the male staff causing [his/her] lip to swell in the process. Both staff moved to the kitchen and [Resident 1] went to [his/her] room stated that the voices told [him/her] the job was complete. While female staff was cleaning [Resident 1] came out and then began to throw bleach at the [staff] getting [his/her] shirt stained. [Resident 1] continued punching and kicking staff until [s/he] stated that the voices were not active. Staff continued to educate and work with [Resident 1] on coping skills and [s/he] is fine for the moment but with no lead or build up [s/he] attempts to attack staff."

-Resident 1's Behavioral Incident Report, dated 10/25/2025, at 4:00 PM, documented the following: "List events/factors leading up to the incident: [Resident 1] was heard in [his/her] room banging [his/her] head and face on the door and wall. Describe the incident in detail: [Resident 1] was heard in [his/her] room banging [his/her] head and face on the door and wall. Staff walked in and had a small cut on the back of [his/her] head that was taken care of with the first aid kit. Staff prompted [Resident 1] to place an ice pack around [his/her] forehead and eye as this was the area [s/he] was banging [his/her] face at. [Resident 1] was able to comply with staff after [s/he] stated that [s/he] was done with the

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M 424	Continued From page 7 self-injurious behavior." -Resident 1's Behavioral Incident Report, dated 10/24/2025, at 3:00 AM, documented the following: "List events/factors leading up to the incident: [Resident 1] came out of [his/her] room stating that staff needed to die and the plan was going through today. Describe the incident in detail: [Resident 1] came out of [his/her] room stating that staff needed to die and the plan was going through today. Staff reminded [Resident 1] that [s/he] was safe and attempted to work on coping skills with [him/her] but [s/he] declined. [Resident 1] began to throw items in the room at staff such as paint, shelves, Wi-Fi box, modem, shoes and anything else [s/he] could find. Staff were struck by a few items, but they were not hurt by the items. [Resident 1] tried to flip staff out the recliner and then punched the other staff member repeated in the chest and face. Staff gave space but this behavior continued until 7 am. A call was placed to leadership who arrived and attempted to talk to [Resident 1], and [s/he] appeared calm for the moment. Staff and leadership headed to the office with [Resident 1] to come up with a plan for the remainder of the day. [Resident 1] appeared to be calm, but [s/he] then picked up a three-hole puncher in the office and leadership had to block the three-hole puncher which resulted in the item damaging their hand and the computer monitor breaking. Additional staff were present in the main office and were able to redirect [Resident 1]. While in the office [Resident 1] continued to attack leadership and attempted to elope from the property. [Resident 1] was finally able to stop attempting to elope and attacking staff and agreed to be seen at the hospital. While at the hospital with [his/her] new staff [Resident 1] attacked staff in the hospital in front of crisis and hospital security. [Resident 1]	M 424		

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was sent back to [this home] and was not admitted despite telling them [s/he] had homicidal ideations and was going to go back home and harm staff. Upon arriving back to [this home] [Resident 1] broke the door extension and attacked staff with it and began to attack staff with chairs and [his/her] fists. Crisis was called again, and they notified staff to contact the police. Police arrived and [Resident 1] informed them that Jesus told [him/her] to harm staff and the home was going to explode. Police transported [Resident 1] to the hospital for the second time and staff arrived in their own vehicle. While at the hospital [Resident 1] was making false allegation against staff saying they harmed [him/her], but no one was in the room with [him/her]. [Resident 1] was given haloperidol and returned to the group home."

-Resident 1's Behavioral Incident Report, dated 10/23/2025, at 5:00 PM, documented the following: "List events/factors leading up to the incident: [Resident 1] had been stating that voices were telling [him/her] to attack staff. [Resident 1] also stated that [s/he] wanted staff to fight [him/her] back. Describe the incident in detail: [Resident 1] had been stating that voices were telling [him/her] to attack staff. [Resident 1] also stated that [s/he] wanted staff to fight [him/her] back. [Resident 1] was offered a prn for the voices [s/he] was hearing which [s/he] accepted. When staff were getting meds [s/he] began to attack the staff with punches and kicks to the legs and chest area. Staff were able to give space, and additional staff were able to get the medication passed to [Resident 1]. [Resident 1] continued attacks on staff throughout the shift which included punches and kicks. Staff continued to educate [Resident 1] on appropriately expressing [him/herself] and how

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[s/he] was in a safe environment. [Resident 1] continued to tell staff that this was Jesus plan and [s/he] needed to see it through."

-Resident 1's Behavioral Incident Report, dated 10/22/2025, at 10:00 AM, documented the following: "List events/factors leading up to the incident: [Resident 1] continued to state that [s/he] was hearing voices and they told [him/her] there would be house explosion and Jesus told [him/her] that staff would kill [him/her]. Describe the incident in detail: [Resident 1] continued to state that [s/he] was hearing voices and they told [him/her] there would be house explosion and Jesus told [him/her] that staff would kill [him/her]. While staff were working with [him/her] [s/he] began to punch and kick staff repeated. Staff was not injured from being hit. Staff gave space and [Resident 1] continued this throughout the shift as [s/he] repeated struck staff in the face, upper body and legs. [Resident 1] continued this behavior throughout the day with hitting staff but no real damage was done to staff."

-Resident 1's Behavioral Incident Report, dated 10/21/2025, at 3:00 PM, documented the following: "List events/factors leading up to the incident: [Resident 1] had been stating that voices were telling [him/her] to attack staff. Describe the incident in detail: [Resident 1] had been stating that voices were telling [him/her] to attack staff. Staff attempted to work with [Resident 1] on coping skills and also provided [Resident 1] with their prn for hearing voices. [Resident 1] continued to state that the voices were telling [him/her] to harm staff and then they increased to thoughts of killing staff. [Resident 1] continued to state things, but [s/he] had not acted on anything until [s/he] was given new tissue for the bathroom then [s/he] punched staff in the face with an

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uppercut. Staff were able to give space after the initial punch, but [Resident 1] continued to try to hit staff. Staff continued to give space and additional staff were able to arrive and redirect [Resident 1] to stop engaging in physical aggression."

-Resident 1's ISP, dated 09/16/2025, documented the following: "Wandering. Current Status: There is no elopement risk currently. Self-Abusive Behavior. Current Status: There is no current risk. Suicidal Tendencies. Current Status: No suicidal thoughts. Destructive of Property or Self, Physically, Mentally Abusive. Current Status: Not a current behavior. Aggressive/Combative. Current Status: No current issues with this behavior."

Resident 1's ISP did not include information regarding his/her elopement, self-abusive behavior, suicidal tendencies, destructive of property and aggressive/combative behavior.

On 12/12/2025, at approximately 9:09 AM, Surveyors interviewed DOHR A. DOHR A reported s/he was responsible for updating residents' ISPs. DOHR A confirmed Resident 1's ISP did not include information regarding his/her elopement, self-abusive behavior, suicidal tendencies, destructive of property and aggressive/combative behavior.