DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed June 17, 2020

Administrator
Rollingwood Home
2203 Rolling Green Lane
North Mankato, MN 56003

RE: Event ID: F21E11
Project Number : HG526011C

Dear Administrator:

During this period of pandemic COVID-19 outbreak, State Agencies (MDH) are changing the process for survey prioritization and enforcement remedies. MDH is delaying revisit surveys and are exercising enforcement discretion during this prioritization period, beginning March 23, 2020. As a result, the below enforcement actions resulting from this survey cycle will be suspended until revisits are again authorized.

This letter also requests that your facility submit a plan of correction. Although revisit surveys will not be conducted during the prioritization period, you may still submit your facility's POC during this time and the case will be held. Your facility may delay submission of a POC until the prioritization period is over.

On May 11, 2020 through May 13, 2020, a complaint investigation was conducted to investigate HG526011C. Your facility was NOT IN compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.

HG526011C was found to be SUBSTANTIATED with no deficiencies issued.

Federal certification deficiencies are delineated on the enclosed form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC). Ordinarily, a provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview.

A PoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your PoC must:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed

The PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

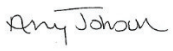
Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356
Fax: 320-223-7348

Failure to submit an acceptable written plan of correction of federal deficiencies within ten calendar days may result in decertification and a loss of federal reimbursement.

Feel free to contact me with any questions related to this letter.

Sincerely,



Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-215-9697

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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Emailed June 17, 2020

Administrator
Rollingwood Home
2203 Rolling Green Lane
North Mankato, MN 56003

Re: Project Number HG526011C
Event ID: F21E11

Dear Administrator:

On May 11, 2020 to May 13, 2020, an abbreviated investigation was conducted to investigate complaint #HG526011C. Rollingwood Home is in full compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me with any questions related to this letter.

Sincerely,

Amy Johnson

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29812	A. BUILDING: _____ B. WING _____	C 05/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLINGWOOD HOME	2203 ROLLING GREEN LANE NORTH MANKATO, MN 56003

(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
5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. On 5/11/20-5/13/20, an abbreviated investigation was conducted to investigate complaint #HG526011C. Rollingwood Home is in full compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).	5 000		

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	24G526	A. BUILDING _____ B. WING _____	C 05/13/2020

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W 000	INITIAL COMMENTS On 5/11/20 through 5/13/20, a complaint investigation was conducted to investigate HG526011C. Your facility was NOT IN compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. HG526011C was found to be SUBSTANTIATED with no deficiencies issued. However, as a result of the investigation deficiencies were identified at W153 and W154.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of neglect immediately to the designated state agency when a client was determined to be in the community unsupervised for an undetermined amount of time for 1 of 1 client (C1) reviewed for neglect. Findings include: The Observation Report dated 4/30/20, completed by direct support professional (DSP)-A, described an incident involving C1. The incident described how C1 had become physically	W 153		

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

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W 153	Continued From page 1	W 153		

and verbally aggressive towards staff and peers and eventually eloped out of the residence. C1 was found by staff on a bike in the neighbor's backyard. C1 had thrown a can of Axe body spray at the neighbor but missed. The report included: "...[C1] grabbed a bean bag and threw it at a housemates head, but missed. [C1] stood up on the couch and grabbed the blinds and tried to take them down. Staff redirected all other housemates to the staff office. [C1] kicked the door multiple times. [C1] ran outside. Staff called 911. [C1] was found on a bike in the neighbors yard. [C1] threw an Axe body spray at the neighbor but missed..." The report did not include how long C1 had been missing from the residence.

C1's Coordinated Service and Support Plan-Addendum dated 7/10/19, included: C1 is required to have a staff present within the home at all times. He can be alone in his bedroom, the bathroom, or other various common rooms of the house, but a staff member needs to be present at the home. He currently has an awake overnight staff. C1 does not have alone time in the community and is required to have staff present at all times.

C1's Self-Management Assessment dated 7/10/19, included: C1 is accompanied while in the community at all times and is assisted to desired locations.

When interviewed on 5/11/20, at 12:19 p.m. the assistant program administrator (APA) confirmed the incident on 4/30/20, involving C1 was not reported to the state agency. APA stated the reason was because C1 had never made physical contact with the other clients, only staff.

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W 153	Continued From page 2	W 153		

APA further stated staff had heard C1 exit the residence while they were in the staff office with the other clients; direct support professional (DSP)-B then went outside to look for C1 and located him in the neighbor's yard.

When interviewed on 5/11/20, at 3:26 p.m. DSP-B confirmed having worked the evening of 4/30/20. DSP-B further confirmed the incident involving C1's attempts to harm self and others. DSP-B stated C1 had tried to throw things at the other clients but staff blocked the attempts and no contact was made. DSP-B stated eventually DSP-A called the program coordinator (PC) who advised staff to take the other clients into the staff office and lock the door; if C1 didn't de-escalate, then call 911. DSP-A and DSP-B then gathered the other clients into the staff office and closed the door. When C1 realized where everyone had gone he tried to break down the office door. When he eventually realized he couldn't do it he left. DSP-B confirmed staff didn't actually hear C1 leave the residence. When everything quieted down they eventually opened the office door and went to find C1. Once they realized C1 was no longer in the residence was when DSP-A called 911 and DSP-B went outside to look for C1. DSP-B stated it was less than 5 minutes that C1 was outside before staff realized he had left the residence.

When interviewed on 5/13/20, at 9:08 a.m. DSP-A confirmed having worked the evening of 4/30/20. DSP-A further confirmed C1's attempts to harm self and others that evening. DSP-A stated she eventually called the PC who directed staff to bring all the clients into the front office. DSP-A stated this took about 20 seconds and C1 was in his room at that time. They went into the office

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W 153	Continued From page 3 and shut the door. Shortly after that C1 realized they were no longer in the living room and went to the office door and kicked the door like 9 times, "I didn't hear anything after that". DSP-A stated they waited about 5 minutes and opened the office door and the front door was open. DSP-A stated she immediately called 911 while DSP-B went outside to look for C1 and located the client in the neighbor's yard. DSP-A confirmed C1 was outside, "Maybe 5 minutes", before staff located him. When interviewed on 5/13/20, at 3:00 p.m. APA indicated not knowing C1 had been missing approximately 5 minutes the evening of 4/30/20, before staff realized he had exited the residence as that did not come out during her investigation. The policy titled, Maltreatment of Minors Reporting and Internal Review amended 3/21/19, included: If you provide care to children served by this program, you are legally required or mandated to report and cannot shift the responsibility of reporting to your supervisor or to anyone else at your licensed facility. If you know or have reason to believe a child is being or has been neglected or physically or sexually abused within the preceding three years you must immediately make a report to an outside agency.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and document review, the	W 154		

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W 154	Continued From page 4	W 154		

facility failed to conduct a thorough investigation related to elopement and lack of staff supervision for 1 of 1 client (C1) reviewed for reporting.

Findings include:

The Observation Report dated 4/30/20, completed by direct support professional (DSP)-A, described an incident involving C1. The incident described how C1 had become physically and verbally aggressive towards staff and peers and eventually eloped out of the residence. C1 was found by staff on a bike in the neighbor's backyard. C1 had thrown a can of Axe body spray at the neighbor but missed. The report included: "...[C1] grabbed a bean bag and threw it at a housemates head, but missed. [C1] stood up on the couch and grabbed the blinds and tried to take them down. Staff redirected all other housemates to the staff office. [C1] kicked the door multiple times. [C1] ran outside. Staff called 911. [C1] was found on a bike in the neighbors yard. [C1] threw an Axe body spray at the neighbor but missed..." The report did not include how long C1 had been missing from the residence.

C1's Coordinated Service and Support Plan-Addendum dated 7/10/19, included: C1 does not have alone time in the community and is required to have staff present at all times.

C1's Self-Management Assessment dated 7/10/19, included: C1 is accompanied while in the community at all times and is assisted to desired locations.

When interviewed on 5/11/20, at 12:19 p.m. the assistant program administrator (APA) stated

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W 154	Continued From page 5	W 154		

staff had heard C1 exit the residence while they were in the staff office with the other clients; direct support professional (DSP)-B then went outside to look for C1 and located him in the neighbor's yard.

When interviewed on 5/11/20, at 3:26 p.m. DSP-B confirmed having worked the evening of 4/30/20. DSP-B further confirmed the incident involving C1's attempts to harm self and others. DSP-B stated C1 had tried to throw things at the other clients but staff blocked the attempts and no contact was made. DSP-B stated eventually DSP-A called the program coordinator (PC) who advised staff to take the other clients into the staff office and lock the door; if C1 didn't de-escalate, then call 911. DSP-A and DSP-B then gathered the other clients into the staff office and closed the door. When C1 realized where everyone had gone he tried to break down the office door. When he eventually realized he couldn't do get in to the office, he left. DSP-B confirmed staff didn't actually hear C1 leave the residence. When everything quieted down they eventually opened the office door and went to find C1. Once they realized C1 was no longer in the residence was when DSP-A called 911 and DSP-B went outside to look for C1. DSP-B stated it was less than 5 minutes that C1 was outside before staff realized he had left the residence.

When interviewed on 5/13/20, at 9:08 a.m. DSP-A confirmed having worked the evening of 4/30/20. DSP-A further confirmed C1's attempts to harm self and others that evening. DSP-A stated she eventually called the PC who directed staff to bring all the clients into the front office. DSP-A stated this took about 20 seconds and C1 was in his room at that time. They went into the office

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W 154	Continued From page 6	W 154		

and shut the door. Shortly after that C1 realized they were no longer in the living room and went to the office door and kicked the door like 9 times, "I didn't hear anything after that". DSP-A stated they waited about 5 minutes and opened the office door and the front door was open. DSP-A stated she immediately called 911 while DSP-B went outside to look for C1 and located the client in the neighbor's yard. DSP-A confirmed C1 was outside, "Maybe 5 minutes", before staff located him.

When interviewed on 5/13/20, at 3:00 p.m. APA indicated not knowing C1 had been missing approximately 5 minutes the evening of 4/30/20, before staff realized he had exited the residence as that did not come out during her investigation.

The policy titled, Maltreatment of Minors Reporting and Internal Review amended 3/21/19, included: 6. Internal review a. When this program has reason to believe a report of alleged or suspected maltreatment has been made, the program must complete an internal review and take corrective action, if necessary, to protect the health and safety of children in care. b. The internal review must be completed within 30 calendar days (5 days for ICF/IID) and include an evaluation of whether: i. related policies and procedure were followed; ii. the policies and procedures were adequate; iii. there is a need for additional staff training; iv. the reported event is similar to past events with the children or the services involved; and v. there is a need for corrective action by the license holder to protect the health and safety of children in care.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 000	INITIAL COMMENTS On 5/11/20 through 5/13/20, a complaint investigation was conducted to investigate HG526011C. Your facility was NOT IN compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. HG526011C was found to be SUBSTANTIATED with no deficiencies issued. However, as a result of the investigation deficiencies were identified at W153 and W154.	W 000	Initially rejected addendum added 8/10/20 approved 8/13/20 POC dated - 8/14/20	
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of neglect immediately to the designated state agency when a client was determined to be in the community unsupervised for an undetermined amount of time for 1 of 1 client (C1) reviewed for neglect. Findings include: The Observation Report dated 4/30/20, completed by direct support professional (DSP)-A, described an incident involving C1. The incident described how C1 had become physically	W 153	The incident on 4/30/2020 was reported to Nicollet County Maltreatment of Minors on 5/13/2020. To ensure the safety of all residents at Rollingwood Home, when there are reports of residents eloping from the facility and line of sight supervision is lost, it will be immediately reported to the County Intake by Prairie Community Services. The program supervisor and QIDP are responsible for continued compliance. SL	8/14/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Emily Brandley
TITLE: Assistant Program Administrator
(X6) DATE: 6/26/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 153	Continued From page 1 and verbally aggressive towards staff and peers and eventually eloped out of the residence. C1 was found by staff on a bike in the neighbor's backyard. C1 had thrown a can of Axe body spray at the neighbor but missed. The report included: "...[C1] grabbed a bean bag and threw it at a housemates head, but missed. [C1] stood up on the couch and grabbed the blinds and tried to take them down. Staff redirected all other housemates to the staff office. [C1] kicked the door multiple times. [C1] ran outside. Staff called 911. [C1] was found on a bike in the neighbors yard. [C1] threw an Axe body spray at the neighbor but missed..." The report did not include how long C1 had been missing from the residence. C1's Coordinated Service and Support Plan-Addendum dated 7/10/19, included: C1 is required to have a staff present within the home at all times. He can be alone in his bedroom, the bathroom, or other various common rooms of the house, but a staff member needs to be present at the home. He currently has an awake overnight staff. C1 does not have alone time in the community and is required to have staff present at all times. C1's Self-Management Assessment dated 7/10/19, included: C1 is accompanied while in the community at all times and is assisted to desired locations. When interviewed on 5/11/20, at 12:19 p.m. the assistant program administrator (APA) confirmed the incident on 4/30/20, involving C1 was not reported to the state agency. APA stated the reason was because C1 had never made physical contact with the other clients, only staff.	W 153		

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ROLLINGWOOD HOME	2203 ROLLING GREEN LANE NORTH MANKATO, MN 56003

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W 153	Continued From page 2 APA further stated staff had heard C1 exit the residence while they were in the staff office with the other clients; direct support professional (DSP)-B then went outside to look for C1 and located him in the neighbor's yard. When interviewed on 5/11/20, at 3:26 p.m. DSP-B confirmed having worked the evening of 4/30/20. DSP-B further confirmed the incident involving C1's attempts to harm self and others. DSP-B stated C1 had tried to throw things at the other clients but staff blocked the attempts and no contact was made. DSP-B stated eventually DSP-A called the program coordinator (PC) who advised staff to take the other clients into the staff office and lock the door; if C1 didn't de-escalate, then call 911. DSP-A and DSP-B then gathered the other clients into the staff office and closed the door. When C1 realized where everyone had gone he tried to break down the office door. When he eventually realized he couldn't do it he left. DSP-B confirmed staff didn't actually hear C1 leave the residence. When everything quieted down they eventually opened the office door and went to find C1. Once they realized C1 was no longer in the residence was when DSP-A called 911 and DSP-B went outside to look for C1. DSP-B stated it was less than 5 minutes that C1 was outside before staff realized he had left the residence. When interviewed on 5/13/20, at 9:08 a.m. DSP-A confirmed having worked the evening of 4/30/20. DSP-A further confirmed C1's attempts to harm self and others that evening. DSP-A stated she eventually called the PC who directed staff to bring all the clients into the front office. DSP-A stated this took about 20 seconds and C1 was in his room at that time. They went into the office	W 153		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G526	A. BUILDING _____ B. WING _____	C 05/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLINGWOOD HOME	2203 ROLLING GREEN LANE NORTH MANKATO, MN 56003

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W 154	Continued From page 4 facility failed to conduct a thorough investigation related to elopement and lack of staff supervision for 1 of 1 client (C1) reviewed for reporting. Findings include: The Observation Report dated 4/30/20, completed by direct support professional (DSP)-A, described an incident involving C1. The incident described how C1 had become physically and verbally aggressive towards staff and peers and eventually eloped out of the residence. C1 was found by staff on a bike in the neighbor's backyard. C1 had thrown a can of Axe body spray at the neighbor but missed. The report included: "...[C1] grabbed a bean bag and threw it at a housemates head, but missed. [C1] stood up on the couch and grabbed the blinds and tried to take them down. Staff redirected all other housemates to the staff office. [C1] kicked the door multiple times. [C1] ran outside. Staff called 911. [C1] was found on a bike in the neighbors yard. [C1] threw an Axe body spray at the neighbor but missed..." The report did not include how long C1 had been missing from the residence. **C1's Coordinated Service and Support** Plan-Addendum dated 7/10/19, included: C1 does not have alone time in the community and is required to have staff present at all times. C1's Self-Management Assessment dated 7/10/19, included: C1 is accompanied while in the community at all times and is assisted to desired locations. When interviewed on 5/11/20, at 12:19 p.m. the assistant program administrator (APA) stated	W 154	Continued from page 4 County Intake by Prairie Community Services. Prairie Community Services will conduct a thorough internal investigation when there are alleged violations. The program supervisor and QIDP are responsible for continued compliance.	8/14/20 SH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLINGWOOD HOME	2203 ROLLING GREEN LANE NORTH MANKATO, MN 56003

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W 154	Continued From page 5 staff had heard C1 exit the residence while they were in the staff office with the other clients; direct support professional (DSP)-B then went outside to look for C1 and located him in the neighbor's yard. When interviewed on 5/11/20, at 3:26 p.m. DSP-B confirmed having worked the evening of 4/30/20. DSP-B further confirmed the incident involving C1's attempts to harm self and others. DSP-B stated C1 had tried to throw things at the other clients but staff blocked the attempts and no contact was made. DSP-B stated eventually DSP-A called the program coordinator (PC) who advised staff to take the other clients into the staff office and lock the door; if C1 didn't de-escalate, then call 911. DSP-A and DSP-B then gathered the other clients into the staff office and closed the door. When C1 realized where everyone had gone he tried to break down the office door. When he eventually realized he couldn't do get in to the office, he left. DSP-B confirmed staff didn't actually hear C1 leave the residence. When everything quieted down they eventually opened the office door and went to find C1. Once they realized C1 was no longer in the residence was when DSP-A called 911 and DSP-B went outside to look for C1. DSP-B stated it was less than 5 minutes that C1 was outside before staff realized he had left the residence. When interviewed on 5/13/20, at 9:08 a.m. DSP-A confirmed having worked the evening of 4/30/20. DSP-A further confirmed C1's attempts to harm self and others that evening. DSP-A stated she eventually called the PC who directed staff to bring all the clients into the front office. DSP-A stated this took about 20 seconds and C1 was in his room at that time. They went into the office	W 154		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 154	Continued From page 6 and shut the door. Shortly after that C1 realized they were no longer in the living room and went to the office door and kicked the door like 9 times, "I didn't hear anything after that". DSP-A stated they waited about 5 minutes and opened the office door and the front door was open. DSP-A stated she immediately called 911 while DSP-B went outside to look for C1 and located the client in the neighbor's yard. DSP-A confirmed C1 was outside, "Maybe 5 minutes", before staff located him. When interviewed on 5/13/20, at 3:00 p.m. APA indicated not knowing C1 had been missing approximately 5 minutes the evening of 4/30/20, before staff realized he had exited the residence as that did not come out during her investigation. The policy titled, Maltreatment of Minors Reporting and Internal Review amended 3/21/19, included: 6. Internal review a. When this program has reason to believe a report of alleged or suspected maltreatment has been made, the program must complete an internal review and take corrective action, if necessary, to protect the health and safety of children in care. b. The internal review must be completed within 30 calendar days (5 days for ICF/IID) and include an evaluation of whether: i. related policies and procedure were followed; ii. the policies and procedures were adequate; iii. there is a need for additional staff training; iv. the reported event is similar to past events with the children or the services involved; and v. there is a need for corrective action by the license holder to protect the health and safety of children in care.	W 154		

email submitted for approval 8/14/20

W153:
On 4/30/20, the incident involving C1 was not reported to the maltreatment intake, as information was not accurately reported by staff to the supervisor on-call. The information received by the on-call supervisor did not include that C1 had left the facility unsupervised. After the incident had de-escalated, upon the arrival of police officer, facility supervisor, and Assistant Program Administrator, it was discovered that a staff had been injured during the behavioral events that had led up to the elopement from the facility. Due to the surrounding circumstances, additional information about the incident had not been obtained at that time. Staff were provided additional training, as well as all on-call supervisory personnel, that all incidents of elopement when line of sight supervision is lost require immediate notification and a maltreatment report to be filed. Staff and supervisory personnel have been trained to clarify, on any elopement attempts, if line of sight supervision was lost. The supervisor who had instructed staff to lock themselves and the person served in the office was provided additional training on how to respond to incident and that the person served could not be left without supervision.
The incident on 4/30/2020 was reported to Nicollet County Maltreatment of Minors on 5/13/2020. To ensure the safety of all residents at Rollingwood Home, when there are reports of residents eloping from the facility and line of sight supervision is lost, it will be immediately reported to the County Intake by Prairie Community Services. C1's IAPP, CSSP-A, and SMA have been updated to reflect that there is a risk of elopement with this resident. All other resident's risk plans were reviewed and updated as necessary to reflect any elopement risk that they may present.
All staff were provided retraining on de-escalation techniques and on parameters of keeping person served safe during a behavioral altercation. Staff were instructed that they are not to leave a person served without supervision during an incident. At least one staff must remain with the person served while the other secures the safety of others.
The Program Coordinator, QIDP, and Assistant Program Administrator are responsible for continued compliance.

W154:
On 4/30/20, the incident involving C1 was not thoroughly investigated and all information pertaining to the incident was not received from direct care staff. In order to ensure that all incidents are thoroughly investigated, after an incident occurs within the facility, supervisory personnel will request an account of what happened from each staff member present during the incident to ensure all details are received.
In order to prevent future incidents not being reported due to lack of information, the facility supervisor will read through each person served daily notes and health notes each day when they come in for work. If they will not be in to work that day (weekend or time off), they will follow up upon their return to work.
All incident reports for the last 3 months were reviewed and it was determined that all incidents that met reporting criteria had been reported. A tracking document for incidents has been implemented and will be monitored, reviewed, and signed off by a corporate designee every 3 months. This designee will be someone other than the supervisor of the home and the Assistant Program Administrator in order to provide additional oversight and to ensure incidents are thoroughly investigated.
The Program Coordinator, QIDP, and Assistant Program Administrator are responsible for continued compliance. The Corporate Designee is responsible for auditing incident reports every 3 months.