

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

Rollingwood Home

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,

Any Johour

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



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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,

Any Johour

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

PRINTED: 06/17/2020 FORM APPROVED

Minnesota Department of Health

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	In accordance with 144.56 and/or Minn 144.653, this correct pursuant to a surver found that the deficit herein are not corrected shall with a schedule of the Minnesota Departments of the Minnesota Departments of the number and MN Ruindicated below. We several items, failuritems will be considered to a fire violated during the corrected. You may request a that may result from orders provided that the Department with notice of assessment on 5/11/20-5/13/20 was conducted to in #HG526011C. Rollic compliance with recorrected.	hether a violation has been compliance with all a rule provided at the tag alle number or MN Statute when a rule or statute contains the to comply with any of the lered lack of compliance. It is upon re-inspection with any alle will result in the lere even if the item that was initial inspection was the aring on any assessments in non-compliance with these at a written request is made to thin 15 days of receipt of a lent for non-compliance. If an abbreviated investigation investigate complaint ingwood Home is in full quirements of Minnesota is requirements for Supervised				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

PRINTED: 06/17/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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W 153	investigation was co HG526011C. Your of compliance with 42 requirements for In- Individuals with Intel HG526011C was for with no deficiencies However, as a result deficiencies were in STAFF TREATMEN CFR(s): 483.420(d) The facility must en mistreatment, negle injuries of unknown immediately to the	CFR Part 483, subpart I, termediate Care Facilities for ellectual Disabilities. Bund to be SUBSTANTIATED is issued. If of the investigation dentified at W153 and W154. INT OF CLIENTS (2) Insure that all allegations of ect or abuse, as well as a source, are reported administrator or to other nice with State law through	W 1	53		
	Based on interview facility failed to repoint immediately to the a client was determined unsupervised for an	s not met as evidenced by: and document review, the ort allegations of neglect designated state agency when ined to be in the community a undetermined amount of t (C1) reviewed for neglect.				
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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	and verbally aggres and eventually elop was found by staff backyard. C1 had the the neighbor but "[C1] grabbed a behousemates head, the couch and grabitake them down. Shousemates to the door multiple times 911. [C1] was four yard. [C1] threw are neighbor but misse include how long Coresidence. C1's Coordinated SPlan-Addendum darequired to have a staff in the home. He curbouse, but a staff in the home. He curbouse, but a staff in the home. He curbouse, but a staff in the home. The curbouse, but a staff in the home. He curbouse, but a staff in the home interviewed in the community and is reason with the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was because and the incident on 4/30 reported to the staff reason was becau	age 1 assive towards staff and peers bed out of the residence. C1 on a bike in the neighbor's hrown a can of Axe body spray missed. The report included: bean bag and threw it at a but missed. [C1] stood up on bed the blinds and tried to staff redirected all other staff office. [C1] kicked the . [C1] ran outside. Staff called ad on a bike in the neighbors an Axe body spray at the add" The report did not 1 had been missing from the Service and Support ated 7/10/19, included: C1 is astaff present within the home an be alone in his bedroom, the various common rooms of the member needs to be present at ently has an awake overnight have alone time in the equired to have staff present ment Assessment dated C1 is accompanied while in all times and is assisted to on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the administrator (APA) confirmed on 5/11/20, at 12:19 p.m. the	W	153			

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W 153	APA further stated residence while the the other clients; di (DSP)-B then went located him in the residence him in the residence him in the residence dients but staff blo contact was made. DSP-A called the padvised staff to tak office and lock the then call 911. DSP the other clients interest the door. When C gone he tried to brow When he eventuall left. DSP-B confir C1 leave the residence quieted down they door and went to fi was no longer in the called 911 and DSF C1. DSP-B stated C1 was outside better residence. When interviewed confirmed having w DSP-A further confirmed having w DSP-A further confirmed the clients stated this took above the residence which is took above th	staff had heard C1 exit the by were in the staff office with rect support professional outside to look for C1 and	W 15	3		

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W 153	they were no longer the office door and didn't hear anything they waited about 5 office door and the stated she immediate went outside to look in the neighbor's yar outside, "Maybe 5 rhim.	Shortly after that C1 realized in the living room and went to kicked the door like 9 times, "I after that". DSP-A stated minutes and opened the front door was open. DSP-A stely called 911 while DSP-B of for C1 and located the client rd. DSP-A confirmed C1 was minutes", before staff located	W 15	3		
W 154	indicated not knowi approximately 5 min before staff realized as that did not com The policy titled, Ma Reporting and Interincluded: If you proby this program, yo mandated to report responsibility of repanyone else at your or have reason to be been neglected or pwithin the preceding	on 5/13/20, at 3:00 p.m. APA ng C1 had been missing nutes the evening of 4/30/20, d he had exited the residence e out during her investigation. Altreatment of Minors nal Review amended 3/21/19, ovide care to children served u are legally required or and cannot shift the orting to your supervisor or to licensed facility. If you know elieve a child is being or has ohysically or sexually abused g three years you must a report to an outside agency.	W 15	4		
	violations are thoro	ve evidence that all alleged ughly investigated.				
		s not met as evidenced by: and document review, the				

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W 154	facility failed to correlated to elopeme for 1 of 1 client (C1) Findings include: The Observation R completed by direct (DSP)-A, described and verbally aggreand eventually elop was found by staff backyard. C1 had at the neighbor but "[C1] grabbed at housemates head, the couch and graft take them down. Shousemates to the door multiple times 911. [C1] was four yard. [C1] threw an neighbor but misses include how long Cresidence. C1's Coordinated SPlan-Addendum dadoes not have alor required to have story and community at a desired locations. When interviewed	age 4 aduct a thorough investigation and and lack of staff supervision but and lack of staff supervision but and lack of reporting. Report dated 4/30/20, at support professional dan incident involving C1. The how C1 had become physically ssive towards staff and peers and out of the residence. C1 on a bike in the neighbor's thrown a can of Axe body spray a missed. The report included: bean bag and threw it at a but missed. [C1] stood up on a bed the blinds and tried to staff redirected all other a staff office. [C1] kicked the staff office.		54		

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W 154	staff had heard C1 were in the staff of direct support profe outside to look for neighbor's yard. When interviewed confirmed having v DSP-B further confict the clients but staff blo contact was made. DSP-A called the padvised staff to tak office and lock the then call 911. DSF the other clients interest to the office, he left didn't actually hear When everything opened the office of they realized C1 was when DSP-A coutside to look for than 5 minutes that realized he had left when interviewed confirmed having v DSP-A further confiself and others that eventually called the bring all the clients stated this took above the confirmed having w DSP-A further confiself and others that eventually called the bring all the clients stated this took above the confirmed having w DSP-A further confiself and others that eventually called the bring all the clients stated this took above the confirmed having w DSP-A further confiself and others that eventually called the bring all the clients stated this took above the confirmed having w DSP-A further confirmed having w DSP-A further confiself and others that eventually called the bring all the clients stated this took above the confirmed having w DSP-A further confirm	exit the residence while they fice with the other clients; essional (DSP)-B then went C1 and located him in the on 5/11/20, at 3:26 p.m. DSP-B worked the evening of 4/30/20. Firmed the incident involving arm self and others. DSP-B to throw things at the other cked the attempts and no DSP-B stated eventually program coordinator (PC) who see the other clients into the staff door; if C1 didn't de-escalate, P-A and DSP-B then gathered to the staff office and closed 1 realized where everyone had eak down the office door. The staff C1 leave the residence uieted down they eventually door and went to find C1. Once as no longer in the residence called 911 and DSP-B went C1. DSP-B stated it was less the C1 was outside before staff.		54		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRU NG			(X3) DATE SURVEY COMPLETED	
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W 154	and shut the door. they were no longer the office door and didn't hear anything they waited about 5 office door and the stated she immedia went outside to look in the neighbor's ya outside, "Maybe 5 r him. When interviewed of indicated not know approximately 5 miles before staff realized as that did not compared to the compared to	Shortly after that C1 realized in the living room and went to kicked the door like 9 times, "I after that". DSP-A stated minutes and opened the front door was open. DSP-A stely called 911 while DSP-B of for C1 and located the client rd. DSP-A confirmed C1 was ninutes", before staff located on 5/13/20, at 3:00 p.m. APA and C1 had been missing nutes the evening of 4/30/20, at he had exited the residence e out during her investigation. Altreatment of Minors and Review amended 3/21/19, al review a. When this in to believe a report of alleged eatment has been made, the polete an internal review and on, if necessary, to protect the final characteristic for the completed within 30 and process and owed; ii. the policies and owed; ii. the policies and dequate; iii. there is a need for the license holder to protect ty of children in care.	W 1	54				

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W 000	On 5/11/20 through investigation was c HG526011C. Your compliance with 42 requirements for In	n 5/13/20, a complaint onducted to investigate facility was NOT IN CFR Part 483, subpart I, termediate Care Facilities for	W 000	Intelly relief adder &	18/20	dolo
W 153	HG526011C was for with no deficiencies However, as a resu deficiencies were in	alt of the investigation dentified at W153 and W154. NT OF CLIENTS	W 153	The incident on 4/30/2020 was repo	rtea to	41000
	mistreatment, negli injuries of unknown immediately to the	asure that all allegations of ect or abuse, as well as a source, are reported administrator or to other ace with State law through ures.		5/13/2020. To ensure the safety of a residents at Rollingwood Home, whe are reports of residents eloping from facility and line of sight supervision is will be immediately reported to the Clintake by Prairie Community Services program supervisor and QIDP are res	II en there i the is lost, it County is. The	ŞU
	Based on interview facility failed to repoimmediately to the a client was determ unsupervised for ar	s not met as evidenced by: and document review, the ort allegations of neglect designated state agency when ined to be in the community a undetermined amount of t (C1) reviewed for neglect.		for continued compliance.	:	8/14/2
	completed by direct (DSP)-A, described	eport dated 4/30/20, support professional an incident involving C1. The now C1 had become physically	7/			æ
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and eventually eloped or was found by staff on a libackyard. C1 had thrown at the neighbor but miss "[C1] grabbed a bean is housemates head, but mithe couch and grabbed to take them down. Staff in housemates to the staff door multiple times. [C1] 911. [C1] was found on yard. [C1] threw an Axe neighbor but missed" include how long C1 had residence. C1's Coordinated Service Plan-Addendum dated 7. required to have a staff at all times. He can be a bathroom, or other various house, but a staff membouse, but a staff memb	towards staff and peers all of the residence. C1 bike in the neighbor's on a can of Axe body spray sed. The report included: bag and threw it at a missed. [C1] stood up on the blinds and tried to redirected all other office. [C1] kicked the 1] ran outside. Staff called a bike in the neighbors body spray at the The report did not di been missing from the ce and Support 7/10/19, included: C1 is present within the home alone in his bedroom, the pus common rooms of the per needs to be present at has an awake overnight alone time in the red to have staff present. Assessment dated accompanied while in es and is assisted to 11/20, at 12:19 p.m. the nistrator (APA) confirmed involving C1 was not ency. APA stated the had never made	W 4	153			

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PREFIX TAG	REGULATORY OR 1	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
1710		DO ALESTIN THIS NO DESCRIPTION	TAG	•	CROSS-REFERENCED TO THE APPROP	CAIL	Livie
	=				1 00.0007		
VV 753	Continued From pa	ge 2	W.	153	1		
	APA further stated :	staff had heard C1 exit the					
	residence while the	y were in the staff office with			1		
	the other clients: di	rect support professional					
	(DSPLR then went	outside to look for C1 and			1		
	located him in the n	contract and					
	socated that the the	leighbor a yard.					
	Milhon Intonvioused a	- EM4/00 - 10:00 DOD D					
	AALIGH HIGHARAGO	on 5/11/20, at 3:26 p.m. DSP-B			•		
	Committee naving w	orked the evening of 4/30/20.					
		irmed the incident involving					
	C1's attempts to ha	rm self and others. DSP-B					
	stated C1 had tried	to throw things at the other					
		cked the attempts and no			{		
	contact was made.	DSP-B stated eventually					
	DSP-A called the pi	rogram coordinator (PC) who					
	advised staff to take	e the other clients into the staff					
		door, if C1 didn't de-escalate.			i		
	then call 911 DSP	-A and DSP-B then gathered					
		o the staff office and closed					
	ule cool. Within C	realized where everyone had					
	gone ne med to pre	ak down the office door.			1		
	when he eventually	y realized he couldn't do it he					
	left. DSP-B confin	ned staff didn't actually hear					
		nce. When everything					
		eventually opened the office			1		
		nd C1. Once they realized C1					
	was no longer in the	e residence was when DSP-A)		
		B went outside to look for					
	C1. DSP-B stated	it was less than 5 minutes that					
	C1 was outside bef	ore staff realized he had left	•				
	the residence.						
	•					i	
	When interviewed	on 5/13/20, at 9:08 a.m. DSP-A					
		orked the evening of 4/30/20.					
	DSP-A further confl	rmed C1's attempts to harm]		
	colford other that	evening. DSP-A stated she					
İ		e PC who directed staff to					
		into the front office. DSP-A					
		out 20 seconds and C1 was in					
	his room at that tim	e. They went into the office			1		

	TO TOTT WILDIGANE	A MEDICAID SERVICES				DMR NO.	0938-0391	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24G526	B. WING			1750000	13/2020	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-	
ROLLING	GWOOD HOME				203 ROLLING GREEN LANE IORTH MANKATO, MN 56003			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	COMPLETION DATE	
W 154	facility failed to con related to elopemer for 1 of 1 client (C1 Findings include: The Observation R completed by direct (DSP)-A, described incident described and verbally aggres and eventually elop was found by staff backyard. C1 had the neighbor but "[C1] grabbed a knousemates head, the couch and grab take them down. Shousemates to the door multiple times 911. [C1] threw an neighbor but misse include how long C residence. C1's Coordinated S Plan-Addendum dadoes not have alor required to have st C1's Self-Manager 7/10/19, included: the community at a desired locations. When interviewed	duct a thorough investigation and lack of staff supervision or reviewed for reporting. eport dated 4/30/20, the support professional of an incident involving C1. The side towards staff and peers bed out of the residence. C1 on a bike in the neighbor's hrown a can of Axe body spray missed. The report included: bean bag and threw it at a but missed. [C1] stood up on bed the blinds and tried to staff redirected all other staff office. [C1] kicked the control of the neighbors of the staff office. [C1] kicked the control of the neighbors of the staff office. [C1] kicked the control of the neighbors of the staff office. [C1] kicked the control of the neighbors of the staff office. [C1] kicked the control of the neighbors of the neighbors of the neighbors of the staff office. [C1] kicked the control of the neighbors of the neighbors of the neighbors of the neighbors of the neighbors of the neighbors of the neighbors of the time in the community and is affined the neighbors of the nei	A MARIE OF THE PROPERTY OF THE	154	County Intake by Prairie Community Prairie Community Services will conthorough internal investigation who are alleged violations. The program supervisor and QIDP are responsible continued compliance.	duct a en there	8/14/2	

							NO NO. 0836-0381	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		24G526	B. WING	·		1	C 13/2020	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
					203 ROLLING GREEN LANE			
ROLLING	SWOOD HOME							
				NORTH MANKATO, MN 56003				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			EX.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ION SHOULD BE HEAPPROPRIATE		
W 154	Continued From page 5			154				
		exit the residence while they	•	107			i I	
	those in the stoff off	ice with the other clients:					1	
	Mete in the Sign Off	ce with the other clients;					1 I	
	cutoido to lock for f	ssional (DSP)-B then went C1 and located him in the				:		
		3, and located him in the						
	neighbor's yard.						[]	
	Nethern to to a series of the							
	When interviewed on 5/11/20, at 3:26 p.m. DSP-B confirmed having worked the evening of 4/30/20.							
	DCD D Suther seek	imed the incident involving						
	C1's attempts to be	rm self and others. DSP-B						
	stated C1 had tried	to throw things at the other						
	cleate but staff bloo	ked the attempts and no						
	coupart mas ways	DSD-B stated exertisely						
	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					i I	
	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						
		DSP-B confirmed staff						
		C1 leave the residence.						
		lieted down they eventually		į				
	opened the office d	oor and went to find C1. Once						
	they realized C1 wa	s no longer in the residence						
	was when DSP-Ac	alled 911 and DSP-B went						
	outside to look for (1. DSP-B stated it was less						
	than 5 minutes that	C1 was outside before staff						
	realized he had left	the residence.						
	When interviewed o	on 5/13/20, at 9:08 a.m. DSP-A						
		orked the evening of 4/30/20.						
		rmed C1's attempts to harm						
		evening. DSP-A stated she						
	eventually called the	e PC who directed staff to						
		into the front office. DSP-A						
		ut 20 seconds and C1 was in						
	his room at that tim	e. They went into the office						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/17/2020 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		24G526				C 05/13/2020	
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE	1 05/13/2020	
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 PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE COMPLETION	
W 154	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		W	154			



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.