



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

April 10, 2026

Administrator
Homeward Bound Plymouth
13522 SUNSET TRAIL
PLYMOUTH, MN 55441

RE: Event ID: DLKD11

Dear Administrator:

On March 31, 2026 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Sincerely,

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G447		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/31/2026	
NAME OF PROVIDER OR SUPPLIER HOMEWARD BOUND PLYMOUTH				STREET ADDRESS, CITY, STATE, ZIP CODE 13522 SUNSET TRAIL , PLYMOUTH, Minnesota, 55441			
(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) COMPLETION DATE
W0000	INITIAL COMMENTS On 3/31/26, an onsite revisit was conducted to follow up on deficiencies issued related to standard abbreviated survey exited on 2/18/26. Your facility was IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.			W0000			

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/31/2026	
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50000	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 3/31/26, an onsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 2/18/26, by the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		50000				

Office of Primary Care and Health Systems Management

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April 10, 2026

Administrator

HOMEWARD BOUND PLYMOUTH

13522 SUNSET TRAIL
PLYMOUTH, MN 55441

Re: Enclosed Re-inspection Results - Event ID: DLKD-H2

Dear Administrator:

On March 31, 2026 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a re-inspection of your facility, to determine correction of orders found on the survey completed on February 18, 2026. At this time these correction orders were found corrected.

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

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email
March 11, 2026

Administrator
Homeward Bound Plymouth
13522 Sunset Trail
Plymouth, MN 55441

RE: Event ID: DLKD11

Dear Administrator:

On February 18, 2026, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. This survey found one or more deficiencies which indicated that a situation of "Immediate Jeopardy" existed for your clients as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567).

During the survey we reviewed your allegation of compliance and determined that your facility had taken appropriate actions to remove the "Immediate Jeopardy" as detailed in the deficiencies cited at on the electronically delivered "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy effective February 16, 2026.

One or more of these deficiencies do not meet the requirements of Section 1905(d) of the Social Security Act and the following Condition(s) of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID):

W318 42 CFR § 483.460 Health Care Services

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).

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

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

Your PoC must include:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

An equal opportunity employer.

Homeward Bound Plymouth

March 11, 2026

Page 2

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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, Regional Operations Supervisor, Rapid Response

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

Upon acceptance of your PoC, we will revisit the facility to verify necessary corrections. If you have not corrected the situation(s) that resulted in the findings of Conditions of Participation being found not met by April 4, 2026, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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

Sincerely,



Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

cc: Licensing and Certification File

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W 000	INITIAL COMMENTS On, 2/11/26, 2/12/26, 2/17/26 and 2/18/26, a standard abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The following complaints were reviewed: HG4475482C (MN116222), (MN116232), and (MN116229) with deficiencies issued at W318, W331, and W342. Deficient practice was idetified related to incidental finding at W149, W153 and W154. The Condition of Participation: at 42 CFR 483.460 Health Care Services, was not met when facility failed to implement physician-ordered interventions for seizure protocol for 2 of 4 clients. An Immediate Jeopardy (IJ) was identified at W331 on 2/12/26 at 4:30 p.m. The IJ began on 1/30/26, when the facility failed to ensure medications were administered in accordance with physician's orders C1. This delay in administration of ordered rescue medication placed C1 at risk for prolonged seizure activity and potential complications as evidenced by his hospitalization from 1/30/26 to 2/3/26 for seizures. The IJ was removed on 2/16/25 at 5:00 p.m., when the facility's approved removal plan was verified onsite by the State Agency (SA). Upon receipt of an acceptable electronic POC, an			W 000			

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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 000	Continued From page 1	W 000			
W 112	onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. CLIENT RECORDS CFR(s): 483.410(c)(2) The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to safeguard client records against unauthorized access and failed to ensure the confidentiality of client information. This deficient practice was evidenced by unsecured paper medical records for 6 of 6 clients (C1, C2, C3, C4, C5, and C6) that were stored in a garage area accessible through an unlocked office, making the records accessible to unauthorized individuals. Findings include: On 2/12/26 at 4:35 p.m., observation of the facility garage revealed multiple boxes labeled with client names containing paper medical records for C1, C2, C3, C4, C5, and C6. The boxes were stored on the concrete floor and were not maintained in locked file cabinets. The garage was accessible through an interior office. Observation revealed the office door was unlocked and unattended at the time of observation. The garage door was also unlocked, allowing access to the stored records. During an interview on 2/12/26 at 4:37 p.m., the director of program and operations (DPO) confirmed the records belonged to current clients	W 112			

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W 112	Continued From page 2 of the facility. The DPO acknowledged the records were not stored in a locked cabinet and stated the office and garage are routinely unlocked during business hours. During an interview on 2/17/26 at 12:10 p.m., the Vice President of Operations stated the office should always be locked and that guardians, family members, and visitors should not have access to the office. The Vice President confirmed the door to the office should remain locked to prevent unauthorized access. Facility undated signage entitled, "Visitor Guidelines," identified visitors may not access the office or medication cabinet as this is where personal health information for service recipients is located and only authorized personnel may access service recipient records. Visitors are not permitted to request or view these records unless there is a signed authorization on file. Facility policy regarding client records are to be maintained in a secure location with access limited to authorized personnel was requested and not received.	W 112			
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to implement abuse policies and procedures consistent with federal regulations by not reporting allegations of neglect to the State Agency (SA) and investigating and implementing	W 149			

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W 149	Continued From page 3 immediate protections for 1 of 1 client (C1) whose seizure protocol was not adminstrated timely as ordered. Findings include: C1's Emergency Data Form (EDF), updated 7/6/21, identified C1 had diagnosis of had Angelman syndrome (a rare genetic condition present at birth that causes developmental delays, little or no speech, balance problems and seizures) and seizure disorder. In addition, C1 was nonverbal, required assistance with all activities of daily living (ADL's) and used a wheelchair for mobility. C1's physician orders, signed 8/25/25, directed staff to administer lorazepam Intensol 2 milligrams/milliliters (mg/ml), 1 ml buccally (inside the cheek), if C1 was vomiting or gagging. The medication could be repeated once after 10 minutes if symptoms continued, with a maximum of 2 ml per day or 5 ml per week. Lorazepam 1 ml (2 mg) buccally was also ordered for one generalized tonic/clonic seizure or two complex partial seizures, including retching episodes, and could be repeated once after 10 minutes, with the same daily and weekly limits. Staff were required to document all seizure activity every shift in the seizure health tracking section of Therap (electronic health record). C1's medication administration record (MAR), dated January 2026, identified on 1/30/26 at 9:30 p.m., C1 was given 1 ml of lorazepam. This was noted to be documented on 2/9/26. A Facility Reported Incident (FRI) report dated 2/6/26 at 2:35 p.m., identified on 1/30/26 at			W 149			

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W 149	Continued From page 4 approximately 9:00 p.m., C1 began gagging, coughing, and vomiting after going to bed at 8:00 p.m. Staff assisted, changed clothing, and continued monitoring. At approximately 9:30 p.m., staff determined C1 was experiencing a seizure and administered lorazepam 1 ml per seizure protocol. 911 was called at 9:48 p.m., and Guardian (G)-A was notified at approximately 9:50 p.m. C1 was transported to the hospital and diagnosed with aspiration pneumonia and breakthrough seizure activity. C1's physician-ordered seizure protocol directed administration of 1 ml buccally for one generalized tonic-clonic seizure or two complex partial seizures (including retching episodes), with a repeat dose permitted after 10 minutes if needed. C1 also had a nausea/vomiting protocol for Ondansetron (Zofran) 4 mg every 8 hours as needed. The investigation identified that staff administered the initial PRN (as needed) seizure medication but did not administer a second dose despite continued retching episodes. The PRN was not documented in the EMAR at the time of administration as required. The investigation further identified that the seizure and nausea/vomiting protocols lacked clarity for staff in distinguishing between emesis and seizure-related retching. An internal investigation was initiated. The Ombudsman was notified of the hospitalization related to seizure and aspiration pneumonia. Follow-up appointments and revision of the seizure plan were identified as needed. Guardian (G)-A expressed concern that C1 may have aspirated during the episode due to inability to reposition independently. Staff reported C1 was transferred to an upright seated position following the initial emesis episode until EMS arrival.			W 149			

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W 149	Continued From page 5 Facility, "internal investigation," dated 2/6/26, revealed a reported seizure and medical response involving C1 on 1/30/26. Staff reported C1 went to bed between 7:30-8:00 p.m., and later exhibited gagging, coughing, and vomiting. Staff assisted and monitored C1. At approximately 9:15 p.m., staff identified the situation as a medical emergency. At approximately 9:30 p.m., staff believed C1 was experiencing a seizure, administered PRN lorazepam, and called 911 at approximately 9:48 p.m., C1 was transported by emergency medical services (EMS) to the hospital at approximately 10:20 p.m. Guardians were notified. The investigation identified discrepancies between staff and guardian accounts regarding the timing of PRN administration and hospital destination communication. Guardians expressed concerns regarding documentation accuracy, including seizure history and contact information. Staff reported difficulty reaching the nurse case manager (NCM) On-Call, who responded after the general event report (GER) was submitted. Areas identified for review included accuracy of medical documentation, adherence to on-call notification procedures, clarity of hospital transport protocols, and verification of guardian contact information. During an interview on 2/17/26 at 2:39 p.m., the Operations Administrator (OA) indicated that C1's seizure event on 1/30/26, was not reported to the state until 2/6/26 at 2:30 p.m., after concerns were raised by the guardian. OA indicated reporting and an investigation should have occurred immediately in accordance with facility policy, confirming that the abuse and neglect policy and required timelines were not followed.	W 149			

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W 149	Continued From page 6 Facility, "Policy and Procedure on Reporting and Internal Review of Maltreatment And Injuries Of Unknown Origin Of Vulnerable Adults," revised 9/16/24, indicated that all staff are mandated reporters of suspected neglect or injuries of unknown origin. Staff must immediately report concerns to the Minnesota Adult Abuse Reporting Center (MAARC) and internally to the Nurse Case Manager (NCM) or Operations Administrator (OA), or after hours to the NCM on Call (NCMOC). If the NCM or OA may be involved, the Director of Program and Operations (DOPO) or Director of Nursing (DON) must be notified. The policy requires notification of the county case manager and legal guardian within 24 hours, a reporter status update within 2 working days, and completion of an internal review within 5 working days. The internal review includes ensuring completion of an Incident and Emergency Report, coordinating with the lead investigative agency, evaluating whether related policies were followed, determining corrective actions, assessing the need for staff training, and documenting the findings and notifications to appropriate parties, including state agencies and the original reporter.	W 149			
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 immediately report a neglect incident to the State Agency (SA) when 1 of 1	W 153			

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W 153	Continued From page 7 clients (C1) did not receive a physicain ordered rescue seizure medication timely which led to extended seizure activity requiring a five day hospitalization. Findings include: C1's Emergency Data Form (EDF), updated 7/6/21, identified C1 had diagnosis of had Angelman syndrome (a rare genetic condition present at birth that causes developmental delays, little or no speech, balance problems and seizures) and seizure disorder. In addition, C1 was nonverbal, required assistance with all activities of daily living (ADL's) and used a wheelchair for mobility. C1's physician orders, signed 8/25/25, directed staff to administer lorazepam Intensol 2 mg/ml, 1 ml buccally (inside the cheek), if C1 was vomiting or gagging. The medication could be repeated once after 10 minutes if symptoms continued, with a maximum of 2 ml per day or 5 ml per week. Lorazepam 1 ml (2 mg) buccally was also ordered for one generalized tonic/clonic seizure or two complex partial seizures, including retching episodes, and could be repeated once after 10 minutes, with the same daily and weekly limits. Staff were required to document all seizure activity every shift in the seizure health tracking section of Therap (electronic health record). C1's medication administration record (MAR), dated January 2026, identified on 1/30/26 at 9:30 p.m., C1 was given 1 ml of lorazepam. This was noted to be documented on 2/9/26. A Facility Reported Incident (FRI) report dated 2/6/26 at 2:35 p.m., identified on 1/30/26 at	W 153			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 24G447		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/18/2026	
NAME OF PROVIDER OR SUPPLIER HOMEWARD BOUND PLYMOUTH				STREET ADDRESS, CITY, STATE, ZIP CODE 13522 SUNSET TRAIL PLYMOUTH, MN 55441			
(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) COMPLETION DATE
W 153	Continued From page 8 approximately 9:00 p.m., C1 began gagging, coughing, and vomiting after going to bed at 8:00 p.m. Staff assisted, changed clothing, and continued monitoring. At approximately 9:30 p.m., staff determined C1 was experiencing a seizure and administered lorazepam 1 ml per seizure protocol. 911 was called at 9:48 p.m., and Guardian (G)-A was notified at approximately 9:50 p.m. C1 was transported to the hospital and diagnosed with aspiration pneumonia and breakthrough seizure activity. C1's physician-ordered seizure protocol directed administration of 1 ml buccally for one generalized tonic-clonic seizure or two complex partial seizures (including retching episodes), with a repeat dose permitted after 10 minutes if needed. C1 also had a nausea/vomiting protocol for Ondansetron (Zofran) 4 mg every 8 hours as needed. The investigation identified that staff administered the initial PRN (as needed) seizure medication but did not administer a second dose despite continued retching episodes. The PRN was not documented in the EMAR at the time of administration as required. The investigation further identified that the seizure and nausea/vomiting protocols lacked clarity for staff in distinguishing between emesis and seizure-related retching. An internal investigation was initiated. The Ombudsman was notified of the hospitalization related to seizure and aspiration pneumonia. Follow-up appointments and revision of the seizure plan were identified as needed. Guardian (G)-A expressed concern that C1 may have aspirated during the episode due to inability to reposition independently. Staff reported C1 was transferred to an upright seated position following the initial emesis episode until EMS arrival.			W 153			

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W 153	Continued From page 9 Facility, "internal investigation," dated 2/6/26, revealed a reported seizure and medical response involving C1 on 1/30/26. Staff reported C1 went to bed between 7:30-8:00 p.m., and later exhibited gagging, coughing, and vomiting. Staff assisted and monitored C1. At approximately 9:15 p.m., staff identified the situation as a medical emergency. At approximately 9:30 p.m., staff believed C1 was experiencing a seizure, administered PRN lorazepam, and called 911 at approximately 9:48 p.m. C1 was transported by emergency medical services (EMS) to the hospital at approximately 10:20 p.m. Guardians were notified. The investigation identified discrepancies between staff and guardian accounts regarding the timing of PRN administration and hospital destination communication. Guardians expressed concerns regarding documentation accuracy, including seizure history and contact information. Staff reported difficulty reaching the nurse case manager (NCM) On-Call, who responded after the general event report (GER) was submitted. Areas identified for review included accuracy of medical documentation, adherence to on-call notification procedures, clarity of hospital transport protocols, and verification of guardian contact information. During an interview on 2/17/26 at 2:39 p.m., the Operations Administrator (OA) stated that C1's seizure event on 1/30/26 was not reported to the state until 2/6/26 at 2:30 p.m., after concerns were raised by the guardian. OA indicated reporting should have occurred immediately in accordance with facility policy, confirming that the policy and required timelines were not followed. Facility, "Policy and Procedure on Reporting and			W 153			

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W 153	Continued From page 10 Internal Review of Maltreatment And Injuries Of Unknown Origin Of Vulnerable Adults," revised 9/16/24, indicated that all staff are mandated reporters of suspected neglect or injuries of unknown origin. Staff must immediately report concerns to the Minnesota Adult Abuse Reporting Center (MAARC) and internally to the Nurse Case Manager (NCM) or Operations Administrator (OA), or after hours to the NCM on Call (NCMOC). If the NCM or OA may be involved, the Director of Program and Operations (DOPO) or Director of Nursing (DON) must be notified. The policy requires notification of the county case manager and legal guardian within 24 hours, a reporter status update within 2 working days, and completion of an internal review within 5 working days.	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 record review, the facility failed to thoroughly investigate a seizure incident for 1 of 1 client (C1) and implement corrective actions sufficiently to prevent recurrence. Findings include: C1's Emergency Data Form (EDF), updated 7/6/21, identified C1 had diagnosis of had Angelman syndrome (a rare genetic condition present at birth that causes developmental delays, little or no speech, balance problems and seizures) and seizure disorder. In addition, C1 was nonverbal, required assistance with all activities of daily living (ADL's) and used a	W 154			

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W 154	Continued From page 11 wheelchair for mobility. C1's physician orders, signed 8/25/25, directed staff to administer lorazepam Intensol 2 mg/ml, 1 ml buccally (inside the cheek), if C1 was vomiting or gagging. The medication could be repeated once after 10 minutes if symptoms continued, with a maximum of 2 ml per day or 5 ml per week. Lorazepam 1 ml (2 mg) buccally was also ordered for one generalized tonic/clonic seizure or two complex partial seizures, including retching episodes, and could be repeated once after 10 minutes, with the same daily and weekly limits. Staff were required to document all seizure activity every shift in the seizure health tracking section of Therap (electronic health record). C1's medication administration record (MAR), Dated January 2026, identified on 1/30/26 at 9:30 p.m., C1 was given 1 ml of lorazepam. This was noted to be documented on 2/9/26. A Facility Reported Incident (FRI) report dated 2/6/26 at 2:35 p.m., identified on 1/30/26 at approximately 9:00 p.m., C1 began gagging, coughing, and vomiting after going to bed at 8:00 p.m. Staff assisted, changed clothing, and continued monitoring. At approximately 9:30 p.m., staff determined C1 was experiencing a seizure and administered lorazepam 1 ml per seizure protocol. 911 was called at 9:48 p.m., and Guardian (G)-A was notified at approximately 9:50 p.m. C1 was transported to the hospital and diagnosed with aspiration pneumonia and breakthrough seizure activity. C1's physician-ordered seizure protocol directed administration of 1 ml buccally for one generalized tonic-clonic seizure or two complex partial seizures (including retching episodes), with			W 154			

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W 154	Continued From page 12 a repeat dose permitted after 10 minutes if needed. C1 also had a nausea/vomiting protocol for Ondansetron (Zofran) 4 mg every 8 hours as needed. The investigation identified that staff administered the initial PRN (as needed) seizure medication but did not administer a second dose despite continued retching episodes. The PRN was not documented in the EMAR at the time of administration as required. The investigation further identified that the seizure and nausea/vomiting protocols lacked clarity for staff in distinguishing between emesis and seizure-related retching. An internal investigation was initiated. The Ombudsman was notified of the hospitalization related to seizure and aspiration pneumonia. Follow-up appointments and revision of the seizure plan were identified as needed. Guardian (G)-A expressed concern that C1 may have aspirated during the episode due to inability to reposition independently. Staff reported C1 was transferred to an upright seated position following the initial emesis episode until EMS arrival. Facility, "internal investigation," dated 2/6/26, revealed a reported seizure and medical response involving C1 on 1/30/26. Staff reported C1 went to bed between 7:30-8:00 p.m., and later exhibited gagging, coughing, and vomiting. Staff assisted and monitored C1. At approximately 9:15 p.m., staff identified the situation as a medical emergency. At approximately 9:30 p.m., staff believed C1 was experiencing a seizure, administered PRN lorazepam, and called 911 at approximately 9:48 p.m. C1 was transported by emergency medical services (EMS) to the hospital at approximately 10:20 p.m. Guardians were notified. The investigation identified discrepancies between staff and guardian	W 154			

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W 154	Continued From page 13 accounts regarding the timing of PRN administration and hospital destination communication. Guardians expressed concerns regarding documentation accuracy, including seizure history and contact information. Staff reported difficulty reaching the nurse case manager (NCM) On-Call, who responded after the general event report (GER) was submitted. Areas identified for review included accuracy of medical documentation, adherence to on-call notification procedures, clarity of hospital transport protocols, and verification of guardian contact information. The facility's internal investigation of C1's seizure episode on 1/30/26 lacked critical elements necessary for a thorough review. While it documented the timeline of events and noted discrepancies between staff and guardian accounts, it failed to address why staff did not immediately administer the physician-ordered rescue seizure medication when C1 initially exhibited vomiting and retching. The investigation did not assess full compliance with C1's seizure protocol, nor did it analyze the root causes of delayed medication administration, documentation errors, or difficulties reaching the on-call nurse. Additionally, the review did not include clear corrective actions, staff retraining, or verification that documentation and guardian notifications were accurate and complete, leaving gaps in ensuring proper follow-up and prevention of future incidents for clients who may exhibit signs and symptoms of seizures. During an interview on 2/17/26 at 2:39 p.m., the Operations Administrator (OA) indicated that C1's seizure event on 1/30/26 was not reported to the state until 2/6/26 at 2:30 p.m., after concerns	W 154			

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W 154	Continued From page 14 were raised by the guardian. A full investigation should have occurred in accordance with facility policy, confirming that the abuse and neglect policy and required timelines were not followed. Facility, "Policy and Procedure on Reporting and Internal Review Of Maltreatment And Injuries Of Unknown Origin Of Vulnerable Adults," revised 9/16/24, indicated that all staff are mandated reporters of suspected neglect or injuries of unknown origin. Staff must immediately report concerns to the Minnesota Adult Abuse Reporting Center (MAARC) and internally to the Nurse Case Manager (NCM) or Operations Administrator (OA), or after hours to the NCM on Call (NCMOC). If the NCM or OA may be involved, the Director of Program and Operations (DOPO) or Director of Nursing (DON) must be notified. The policy requires notification of the county case manager and legal guardian within 24 hours, a reporter status update within 2 working days, and completion of an internal review within 5 working days. The internal review includes ensuring completion of an Incident and Emergency Report, coordinating with the lead investigative agency, evaluating whether related policies were followed, determining corrective actions, assessing the need for staff training, and documenting the findings and notifications to appropriate parties, including state agencies and the original reporter.	W 154			
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met.	W 318			

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W 318	Continued From page 15 This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.460 Health Care Services, was not met when facility failed to ensure medications were administered in accordance with physician's orders and direct care staff recognized and report a significant change in condition. Findings include: See W331: The facility failed to provide necessary nursing services to ensure timely recognition and treatment of seizure activity for 2 of 2 clients (C1 and C2) when facility staff were not competently trained to administer rescue medications. This resulted in an Immediate Jeopardy (IJ) for C1 when staff delayed the administration of lorazepam intensol (rescue seizure medication) in accordance with physician orders for C1 during seizure activity, causing a significant delay in treatment and C1was hospitalized from 1/30/26 to 2/3/26. Additionally, the facility failed to ensure staff awareness and competency regarding seizure protocols for C2, placing C2 at risk for likely delayed intervention.			W 318			
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing			W 331			

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W 331	Continued From page 16 services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide necessary nursing services to ensure timely recognition and treatment of seizure activity for 2 of 2 clients (C1 and C2) when facility staff were not competently trained to administer rescue medications. This resulted in an Immediate Jeopardy (IJ) for C1 when staff delayed the administration of lorazepam intensol (rescue seizure medication) in accordance with physician orders for C1 during seizure activity, causing a significant delay in treatment and C1 was hospitalized from 1/30/26 to 2/3/26. Additionally, the facility failed to ensure staff awareness and competency regarding seizure protocols for C2, placing C2 at risk for likely delayed intervention. The IJ began on 1/30/26, when the facility failed to ensure C1's seizure rescue medication was administered in accordance with physician's orders following the onset of seizure activity. Staff failed to recognize seizure activity and failed to administer ordered rescue medication within minutes as directed, resulting in a delay in treatment. This delay placed C1 at risk for prolonged seizure activity and serious complications and resulted in actual harm, C1's hospitalization from 1/30/26 through 2/3/26 for seizure management. On 2/12/26 at 4:30 p.m., the Director of Program and Operations (DOPO) was notified of the IJ determination. The IJ was removed on 2/16/26 at 5:00 p.m., when the facility's approved removal plan was verified onsite by the State Agency (SA). Findings include:	W 331			

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W 331	Continued From page 17 C1's Emergency Data Form (EDF), updated 7/6/21, identified C1 had diagnoses of Angelman syndrome (a rare genetic condition present at birth that causes developmental delays, little or no speech, balance problems and seizures) and seizure disorder. In addition, C1 was nonverbal, required assistance with all activities of daily living (ADL's) and used a wheelchair for mobility. C1's physician orders, signed 8/25/25, directed staff to administer lorazepam Intensol 2 milligrams (mg) /milliliter (ml), 1 ml buccally (inside the cheek), if C1 was vomiting or gagging. The medication could be repeated once after 10 minutes if symptoms continued, with a maximum of 2 ml per day or 5 ml per week. Lorazepam 1 ml (2 mg) buccally was also ordered for one generalized tonic/clonic seizure or two complex partial seizures, including retching episodes, and could be repeated once after 10 minutes, with the same daily and weekly limits. Staff were required to document all seizure activity every shift in the seizure health tracking section of Therap (electronic health record). C1's medication administration record (MAR), dated January 2026, identified on 1/30/26 at 9:30 p.m., C1 was given 1 ml of lorazepam. This was noted to be documented on 2/9/26 (late entry). A Facility Reported Incident (FRI) report dated 2/6/26 at 2:35 p.m., identified on 1/30/26 at approximately 9:00 p.m., C1 began gagging, coughing, and vomiting after going to bed at 8:00 p.m. Staff assisted, changed clothing, and continued monitoring. At approximately 9:30 p.m., staff determined C1 was experiencing a seizure and administered lorazepam 1 ml per seizure protocol. 911 was called at 9:48 p.m., and			W 331			

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W 331	Continued From page 18 Guardian (G)-A was notified at approximately 9:50 p.m. C1 was transported to the hospital and diagnosed with aspiration pneumonia and breakthrough seizure activity. C1's physician-ordered seizure protocol directed administration of 1 ml buccally for one generalized tonic-clonic seizure or two complex partial seizures (including retching episodes), with a repeat dose permitted after 10 minutes if needed. C1 also had a nausea/vomiting protocol for Ondansetron (Zofran) 4 mg every 8 hours as needed. The investigation identified that staff administered the initial PRN (as needed) seizure medication but did not administer a second dose despite continued retching episodes. The PRN was not documented in the EMAR at the time of administration as required. The investigation further identified that the seizure and nausea/vomiting protocols lacked clarity for staff in distinguishing between emesis and seizure-related retching. An internal investigation was initiated. Follow-up appointments and revision of the seizure plan were identified as needed. Guardian (G)-A expressed concern that C1 may have aspirated during the episode due to inability to reposition independently. Staff reported C1 was transferred to an upright seated position following the initial emesis episode until EMS arrival. C1's Ambulance Report dated 1/30/26, identified upon arrival at 9:52 p.m., EMS personnel arrived to find C1 seated in his wheelchair dry heaving. Group home staff stated he had a seizure and that this was typical post-seizure behavior, and that guardian (G)-A was on her way. Before G-A arrived, C1 vomited twice. Upon arrival G-A informed EMS that this was not typical postictal behavior but rather how his active seizures	W 331			

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W 331	Continued From page 19 present. EMS lifted C1 to the cot, moved him to the ambulance, obtained vitals, placed a 20-gauge IV (intervenious) in his left forearm, and administered 5 mg of Versed (medication used to abort a seizure). EMS also gave Zofran (medication used to stop nausea and vomiting) for continuing dry heaving and began routine transport to the hospital. Review of C1's seizure logs, treatment (T)-logs or vital sign tracking for 1/30/26, revealed that staff did not document any seizure activity or vital signs from 8:00 p.m. to 10:00 p.m. C1's hospitalization record dated 1/30/26 at 10:51 p.m., identified that C1, who has Angelman syndrome, severe intellectual disability, nonverbal status, and localization-related epilepsy, presented with recurrent focal seizures characterized by retching and vomiting. His seizures typically began with eye closure, facial grimacing, and occasional bruxism (teeth grinding), and he was unable to follow commands. He received antiseizure medications three times daily, with tablets opened and sprinkled on food, and his seizures were usually well controlled when medications were administered reliably. On the night of 1/30/26, after being put to bed at the group home around 8:00 p.m., he experienced persistent retching and vomiting, consistent with increased seizure activity noted in prior similar episodes that required hospitalization. Hospital documentation indicated that vomiting was triggered by uncontrolled seizures, and G-A expressed uncertainty as to whether facility staff had administered all prescribed seizure medications, highlighting the risk associated with inconsistent medication administration. An			W 331			

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W 331	Continued From page 20 electroencephalogram (EEG) performed on 2/1/26, which measures the brain's electrical activity using sensors placed on the scalp, showed abnormal brain activity on the left side that matched his seizure symptoms and confirmed he was actively having seizures in the hospital. On 2/3/26 at 2:22 p.m., C1 was discharged back to the group home with new orders, including an increase in Keppra (antiseizure medication) from 1500 mg twice a day to 1500 mg in the morning and 2000 mg in the evening, and instructions to follow up with neurology in 6 to 8 weeks. Facility, "internal investigation," dated 2/6/26, revealed a reported seizure and medical response involving C1 on 1/30/26. Staff reported C1 went to bed between 7:30-8:00 p.m. and later exhibited gagging, coughing, and vomiting. Staff assisted and monitored C1. At approximately 9:15 p.m., staff identified the situation as a medical emergency. At approximately 9:30 p.m., staff believed C1 was experiencing a seizure, administered PRN Lorazepam, and called 911 at approximately 9:48 p.m. C1 was transported by emergency medical services (EMS) to the hospital at approximately 10:20 p.m. Guardians were notified. The investigation identified discrepancies between staff and guardian accounts regarding the timing of PRN administration and hospital destination communication. Guardians expressed concerns regarding documentation accuracy, including seizure history and contact information. Staff reported difficulty reaching the nurse case manager (NCM) On-Call, who responded after the general event report (GER) was submitted. Areas identified for review included accuracy of medical documentation, adherence to on-call	W 331			

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W 331	Continued From page 21 notification procedures, clarity of hospital transport protocols, and verification of guardian contact information. After reviewing the facility's internal investigation of C1's seizure episode on 1/30/26, it lacked critical elements necessary for a thorough review. While it documented the timeline of events and noted discrepancies between staff and guardian accounts, it failed to address why staff did not immediately administer the physician-ordered rescue seizure medication when C1 initially exhibited vomiting and retching resulting in medication errors. The investigation did not assess full compliance with C1's seizure protocol, nor did it analyze the root causes of delayed medication administration, documentation errors, or difficulties reaching the on-call nurse. Additionally, the review did not include clear corrective actions, staff retraining, or verification that documentation and guardian notifications were accurate and complete, leaving gaps in ensuring proper follow-up and prevention of future incidents for clients who may exhibit signs and symptoms of seizures. C1's GER report, last updated on 2/10/26, identified that on 1/30/26, C1 went to bed at 8:00 p.m. Around 9:00 p.m., C1 began gagging, coughing, and throwing up. Staff ran to check on him, changed his pajamas, and cleaned him up. Around 9:30 p.m., C1 started coughing and gagging again, at which time staff recognized he was having a seizure. At 9:48 p.m., staff administered 1 ml of lorazepam and called 911. At 9:50 p.m., staff called G-A and attempted to reach the on-call NCM five times. The NCM returned the call after C1 had left for the hospital at 10:20 p.m. The report identified a medication			W 331			

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W 331	Continued From page 22 error, noting that Lorazepam was given at 9:48 p.m., and indicated that staff failed to document the administration of seizure medication and seizure tracking for the incident that occurred on 1/30/26. The PRN order states to administer a second 1 ml dose of Lorazepam 10 minutes after the initial administration if the seizure is still occurring. The report also indicated that policies and procedures were followed and that no additional training was required. The plan for future corrective actions included scheduling and conducting a multidisciplinary team meeting with C1's neurologist, guardians, nursing, and program leadership to review C1's seizure history and current presentation; updating the seizure protocol to include clear, step-by-step instructions for staff to follow during a seizure or suspected seizure; and creating a Documentation Error Report to be completed with staff who worked on 1/30/26. Any missing documentation, including seizure tracking and EMAR entries, must be completed. C1's GER resolution report summary updated 2/9/26, identified a discrepancy between guardian and staff reports regarding PRN seizure rescue medication administration. Guardians reported that the PRN was not administered until they arrived, while staff reported administering the PRN prior to calling the guardians and EMS. The summary also noted that staff had not received seizure protocol training to help them identify signs and symptoms of seizures, nor to identify which clients have seizures and what each client's individualized seizure protocol entails. During an interview on 2/11/26 at 12:14 p.m., direct support professional (DSP)-C stated that he knew C1 had a history of seizures but was			W 331			

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W 331	Continued From page 23 unaware of C1's recent hospitalization for seizures. He reported that he did not know where C1's seizure protocol was located and that multiple attempts to find it in the home folders were unsuccessful. He explained that he could not access Therap, where seizure information was maintained, because of the current Wi-Fi issues. Once the protocol was pointed out in the lower right portion of the medication cabinet, DSP-C acknowledged that he did not fully understand the purpose of lorazepam and did not know the difference between complex partial and generalized seizures. He reported that he had not reviewed or practiced the protocol and did not fully understand when to call the nurse case manager, administer emergency medication, or call 911. DSP-C stated that staff had received seizure response training during orientation but that the information had been provided all at once and he could not remember it. He knew the on-call nurse number but could not confirm the identity of the on-call nurse, leaving him uncertain about whom to contact for immediate support during seizure events. DSP-C reported he was not ware of any other clients who had a seizure history including C2. During a phone interview on 2/11/26 at 10:27 a.m., guardian (G)-A reported that direct support professional (DSP)-A contacted her shortly before 10:00 p.m. on 1/30/26, stating C1 was vomiting, and an ambulance had been called. G-A stated C1's retching episodes are consistent with his seizure activity and that staff should have immediately initiated the emergency seizure protocol, including administration of rescue medication at the onset of retching. G-A reported on 1/30/26, at around 10:52 p.m., she instructed DSP-A over the phone to follow the seizure	W 331			

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W 331	Continued From page 24 protocol located inside the medication cabinet. G-A stated, "I kept repeating to her that he needed the medication administered now as she had not given it to him yet." Upon arrival at home, G-A observed that only one dose of rescue medication had been administered and believed it was given shortly before her arrival, rather than at the onset of symptoms. G-A expressed concern that staff did not promptly recognize C1's retching as seizure-related activity and did not administer medication in accordance with the protocol, contributing to the severity of the episode and subsequent hospitalization. During an interview on 2/11/26 at 2:30 p.m., DSP-A stated that she worked on 1/30/26 and was responsible for C1's care. DSP-A reported that she put C1 to bed around 7:30 p.m., and at approximately 8:50 p.m., she heard him retching and choking while completing charting. She went to C1's room, observed vomit, cleaned him, changed his clothes and bedding, and returned him to bed. DSP-A acknowledged that she did not administer C1's physician-ordered rescue seizure medication, take vital signs, or call the on-call nurse manager at that time and recognized that she should have. She further reported that at approximately 9:20 p.m., C1 was coughing and had vomited a larger amount. Staff cleaned him up and assisted him in his wheelchair, but the retching worsened around 9:22 p.m. DSP-A stated she then called 911, contacted the guardian, and administered lorazepam after consulting the guardian and was unsure of the exact times but had thought she had administered the lorazepam around 9:30 p.m. DSP-A noted that staff require better training on seizure recognition, which clients have seizures, and the appropriate protocols for response as	W 331			

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W 331	Continued From page 25 she was unsure which clients for sure has history of seizures or what their protocols were. DSP-A indicated she did not document what time she gave C1 his rescue medication until 2/9/26 when one of the staff members told her the PRN medication needed to be documented. DSP-A admitted she did give the lorazepam after she had called G-A and the guardian directed her to give it. During an interview on 2/11/26 at 3:54 p.m., DSP-E stated he was working with C1 today and was agency staff. DSP-E indicated he still had training in Therap to complete. DSP-E was unaware of any clients who had current seizure protocols including C2. DSP-E denied receiving any recent education of current clients who have seizures or what their current protocols were. During an interview on 2/11/26 at 4:21 p.m., DSP-D stated he was working with C1 today and was agency staff. DSP-D was unaware of any clients who had current seizure protocols. DSP-D denied receiving any recent education of current clients who have seizures or what their current protocols were including C2. During a phone interview on 2/12/26 at 10:47 a.m., DSP-B stated that he worked with DSP-A on 1/30/26 and verified that C1 had ongoing seizure activity between approximately 8:00 and 10:00 p.m. DSP-B could not recall exact times but stated that staff eventually transferred C1 to a wheelchair due to vomiting, and that DSP-A administered C1's lorazepam immediately before G-A arrived at the home. DSP-B reported he was not aware of any other clients with a history of seizures and had not received seizure protocol training in seven years. He was unable to			W 331			

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W 331	Continued From page 26 articulate the seizure protocols for C1 or C2. During an interview on 2/12/26 at 12:57 p.m., the assistant director of nursing (ADON) stated that the moment C1 began retching and vomiting, his rescue seizure medication should have been administered at 8:50 p.m., as vomiting was a symptom of his seizures. The ADON explained that vital signs should have been taken immediately after, and the on-call nurse manager should have been contacted. She noted that the onset of vomiting represented a significant change in C1's condition due to his high risk of seizures and was at high risk of impairment or death. ADON confirmed there had been to further staff training to address seizure protocols for all clients, where to document seizures in Therap and when to document PRN medications, to ensure DSP staff knew how to identify a seizure and what to do when a client experiences one. ADON verified 4 of their 6 clients have a seizure diagnosis and 2 of 6 clients have a seizure protocol to give rescue medication PRN which was C1 and C2. Following a call to C1's neurologist, a voicemail message was received from the neurology registered nurse (CNN), on 2/13/26 at 10:38 a.m. The voicemail message provided the following instructions for C1: With vomiting or retching, administer lorazepam Intensol 1 ml ducally for one generalized tonic-clonic seizure or for two complex partial seizures, which include the retching episodes. The dose may be repeated after 10 minutes if needed. Do not exceed 2 ml per day or 5 ml per week. The message further stated that lorazepam intensol was used as a rescue medication to abort an acute generalized tonic-clonic seizure or if the patient is	W 331			

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W 331	Continued From page 27 experiencing recurrent complex partial seizures. It was a PRN medication and may be given within minutes of seizure onset. The medication is absorbed through the oral mucosal membranes and does not require the patient to be awake or actively swallowing. If the medication is not available, it cannot be administered, or if the patient continues to experience seizures despite administration, 911 should be called and the patient transported to the emergency room. An additional attempt to contact C1's neurologist was made on 2/17/26 at 4:29 p.m., with no return call back. Review of the facility policy "Guidelines for Medication Administration," revised 2/6/26, indicated the purpose of the policy is to ensure the safe and effective administration of medications. The policy directed that all medications must be administered in compliance with physician orders and according to the individual 's medication administration protocol. The policy further required staff to follow established protocols when administering PRN medications, ensure medications are given exactly as prescribed, and verify when PRN medications were last administered prior to giving an additional dose. The policy also required staff to document medication administration promptly in the electronic Medication Administration Record (eMAR) following administration and to review the MAR to ensure medications were administered and documented correctly. Additionally, the policy required staff to notify the nurse, Nurse Case Manager (NCM), or NCM On-Call if a medication was not administered as ordered and to report	W 331			

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W 331	Continued From page 28 medication administration errors or concerns promptly. The Immediate Jeopardy, which began on 1/30/26, was removed on 2/15/26 at 5:00 p.m. when the facility educated staff on facility procedures related to individualized seizure protocols and provided instruction on when and how to administer rescue medications. In addition, all clients with seizures were identified as high risk, seizure protocols were updated and posted in three accessible locations, and staff received education and competency training on each client's seizure protocol, including how to recognize seizure signs and administer rescue medications appropriately. C2's EDF, updated 4/19/21, identified that C1 had diagnoses of profound cerebral palsy and seizure disorder. C1 was nonverbal, required assistance with all activities of daily living (ADLs), and used a wheelchair for mobility. C2's physician orders, dated 8/28/25, identified Lorazepam 2 mg/ml to be administered at 0.25 ml buccally if seizures last longer than three minutes. Staff are instructed to call 911 after five minutes to transport C2 to the ER. If the seizures stop before paramedics arrive, she should not be sent; however, if they stop and restart before paramedics arrive, she should still be transported. The orders describe C2's seizure presentation as eye-rolling, pale skin, body tremors, and drooling. The last recorded seizure in the orders was March 2009.	W 331			
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii)	W 342			

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W 342	Continued From page 29 Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure direct care staff promptly recognized and reported a significant change in condition, including retching and vomiting, for 1 of 1 client (C1) with a known seizure disorder, resulting in delayed medical intervention. Findings include: C1's Emergency Data Form (EDF), updated 7/6/21, identified C1 had diagnosis of had Angelman syndrome (a rare genetic condition present at birth that causes developmental delays, little or no speech, balance problems and seizures) and seizure disorder. In addition, C1 was nonverbal, required assistance with all activities of daily living (ADL's) and used a wheelchair for mobility. C1's physician orders, signed 8/25/25, directed staff to administer lorazepam Intensol 2 mg/ml, 1 ml buccally (inside the cheek), if C1 was vomiting or gagging. The medication could be repeated once after 10 minutes if symptoms continued, with a maximum of 2 ml per day or 5 ml per week. Lorazepam 1 ml (2 mg) buccally was also ordered for one generalized tonic/clonic seizure or two complex partial seizures, including retching episodes, and could be repeated once after 10	W 342			

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W 342	Continued From page 30 minutes, with the same daily and weekly limits. Staff were required to document all seizure activity every shift in the seizure health tracking section of Therap (electronic health record). C1's medication administration record (MAR), Dated January 2026, identified on 1/30/26 at 9:30 p.m., C1 was given 1 ml of lorazepam. This was noted to be documented on 2/9/26. A Facility Reported Incident (FRI) report dated 2/6/26 at 2:35 p.m., identified on 1/30/26 at approximately 9:00 p.m., C1 began gagging, coughing, and vomiting after going to bed at 8:00 p.m. Staff assisted, changed clothing, and continued monitoring. At approximately 9:30 p.m., staff determined C1 was experiencing a seizure and administered lorazepam 1 ml per seizure protocol. 911 was called at 9:48 p.m., and Guardian (G)-A was notified at approximately 9:50 p.m. C1 was transported to the hospital and diagnosed with aspiration pneumonia and breakthrough seizure activity. C1's physician-ordered seizure protocol directed administration of 1 ml buccally for one generalized tonic-clonic seizure or two complex partial seizures (including retching episodes), with a repeat dose permitted after 10 minutes if needed. C1 also had a nausea/vomiting protocol for Ondansetron (Zofran) 4 mg every 8 hours as needed. The investigation identified that staff administered the initial PRN (as needed) seizure medication but did not administer a second dose despite continued retching episodes. The PRN was not documented in the EMAR at the time of administration as required. The investigation further identified that the seizure and nausea/vomiting protocols lacked clarity for staff in distinguishing between emesis and			W 342			

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W 342	Continued From page 31 seizure-related retching. An internal investigation was initiated. The Ombudsman was notified of the hospitalization related to seizure and aspiration pneumonia. Follow-up appointments and revision of the seizure plan were identified as needed. Guardian (G)-A expressed concern that C1 may have aspirated during the episode due to inability to reposition independently. Staff reported C1 was transferred to an upright seated position following the initial emesis episode until EMS arrival. Facility, "internal investigation," dated 2/6/26, revealed a reported seizure and medical response involving C1 on 1/30/26. Staff reported C1 went to bed between 7:30-8:00 p.m., and later exhibited gagging, coughing, and vomiting. Staff assisted and monitored C1. At approximately 9:15 p.m., staff identified the situation as a medical emergency. At approximately 9:30 p.m., staff believed C1 was experiencing a seizure, administered PRN lorazepam, and called 911 at approximately 9:48 p.m. C1 was transported by emergency medical services (EMS) to the hospital at approximately 10:20 p.m. Guardians were notified. The investigation identified discrepancies between staff and guardian accounts regarding the timing of PRN administration and hospital destination communication. Guardians expressed concerns regarding documentation accuracy, including seizure history and contact information. Staff reported difficulty reaching the nurse case manager (NCM) On-Call, who responded after the general event report (GER) was submitted. Areas identified for review included accuracy of medical documentation, adherence to on-call notification procedures, clarity of hospital transport protocols, and verification of guardian	W 342			

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NAME OF PROVIDER OR SUPPLIER HOMEWARD BOUND PLYMOUTH				STREET ADDRESS, CITY, STATE, ZIP CODE 13522 SUNSET TRAIL PLYMOUTH, MN 55441			
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W 342	Continued From page 32 contact information. The facility's internal investigation of C1's seizure episode on 1/30/26 lacked critical elements necessary for a thorough review. While it documented the timeline of events and noted discrepancies between staff and guardian accounts, it failed to address why staff did not immediately administer the physician-ordered rescue seizure medication when C1 initially exhibited vomiting and retching or why staff did not immediately notify the on call nurse due to a change in condition. The investigation did not assess full compliance with C1's seizure protocol, nor did it analyze the root causes of delayed medication administration, documentation errors, or difficulties reaching the on-call nurse. Additionally, the review did not include clear corrective actions, staff retraining, or verification that documentation and guardian notifications were accurate and complete, leaving gaps in ensuring proper follow-up and prevention of future incidents for clients who may exhibit signs and symptoms of seizures. During a phone interview on 2/11/26 at 10:27 a.m., guardian (G)-A reported that direct support professional (DSP)-A contacted her shortly before 10:00 p.m. on 1/30/26, stating C1 was vomiting, and an ambulance had been called. G-A stated C1's retching episodes are consistent with his seizure activity and that staff should have immediately initiated the emergency seizure protocol, including administration of rescue medication at the onset of retching. G-A reported she instructed DSP-A over the phone to follow the seizure protocol located inside the medication cabinet. G-A stated, I kept repeating to her that he needed the medication administered now."			W 342			

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

PRINTED: 03/11/2026
FORM APPROVED
OMB NO. 0938-0391

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W 342	Continued From page 33 Upon arrival at the home, G-A observed that only one dose of rescue medication had been administered and believed it was given shortly before her arrival, rather than at the onset of symptoms. G-A expressed concern that staff did not promptly recognize C1's retching as seizure-related activity and did not administer medication in accordance with the protocol, contributing to the severity of the episode and subsequent hospitalization. During an observation on 2/11/26 at 2:22 p.m., C1 was seated in his wheelchair at the table, independently eating a snack. During an interview on 2/11/26 at 2:30 p.m., DSP-A stated that she worked on 1/30/26, and was responsible for C1's care. She explained that she put C1 to bed around 7:30 p.m., and at approximately 8:50 p.m., she heard him retching and choking in his bed while she was seated to complete charting. DSP-A stated that she went to his room, observed that he had vomited, cleaned him up, changed his clothes and bedding, and put him back to bed. She acknowledged that she did not take give C1's rescue seizure medication as ordered by physician, check vital signs or call the on-call nurse manager at that time and recognized that she should have. During an interview on 2/12/26 at 12:57 p.m., the assistant director of nursing (ADON) stated that the moment C1 began retching and vomiting, his rescue seizure medication should have been administered, as vomiting is a symptom of his seizures. The ADON explained that vital signs should have been taken immediately after, and the on-call nurse manager should have been contacted. She noted that the onset of vomiting			W 342			

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W 342	Continued From page 34 represented a significant change in C1's condition due to his high risk of seizures. Facility policy, "Policy and Procedure on Health Service Coordination, revised 4/27/23, required staff to promptly identify and respond to any change in an individual's mental or physical health that may affect their health service needs. Staff must notify the Nurse Case Manager (NCM), the legal representative, and the case manager both verbally and in writing, with the date documented in progress notes. The policy emphasizes monitoring health conditions according to written instructions from licensed health care professionals and taking appropriate action, including administering medications, using medical equipment safely, or coordinating follow-up care. Staff are responsible for reporting changes in physical or mental status, seizure patterns, new injuries or illnesses, changes in medication or treatment orders, medication side effects, and medication/treatment errors. The NCM or on-call nurse ensures that follow-up occurs for all reported changes.	W 342			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

March 11, 2026

Administrator
Homeward Bound Plymouth
13522 Sunset Trail
Plymouth, MN 55441

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: DLKD11

Dear Administrator:

The above facility was surveyed on February 11, 2026 through February 18, 2026 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Supervised Living Facilities.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

The first page of the state orders should be signed and submitted to:

Homeward Bound Plymouth

March 11, 2026

Page 2

Susie Haben, Regional Operations Supervisor, Rapid Response

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact the supervisor listed above. A written plan for correction of licensing orders is not required.

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

Sincerely,



Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

Minnesota Department of Health

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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 2/11/26, 2/12/26, 2/17/26, 2/18/26, a standard abbreviated survey was conducted. Your facility was found to be not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). The following complaints were reviewed: HG4475482C (MN116222), (MN116232), and (MN116229) with licensing orders issued at 0380,	5 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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5 000	Continued From page 1 0465, and 0815. When corrections are completed, please sign and date, make a copy of these orders and electronically return to: susie.haben@state.mn.us	5 000			
5 380	MN Rule 4665.3300 PURPOSE OF HEALTH SERVICES. Health services shall be utilized to maintain an optimal general level of health and to maximize function, prevent disability, and promote optimal development of each resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide necessary nursing services to ensure timely recognition and treatment of seizure activity for 2 of 2 clients (C1 and C2) when facility staff were not competently trained to administer rescue medications. Additionally, the facility failed to ensure staff awareness and competency regarding seizure protocols for C2, placing C2 at risk for likely delayed intervention. Findings include: C1's Emergency Data Form (EDF), updated 7/6/21, identified C1 had diagnoses of Angelman syndrome (a rare genetic condition present at birth that causes developmental delays, little or no speech, balance problems and seizures) and seizure disorder. In addition, C1 was nonverbal, required assistance with all activities of daily living (ADL's) and used a wheelchair for mobility.	5 380			

Minnesota Department of Health

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5 380	Continued From page 2 C1's physician orders, signed 8/25/25, directed staff to administer lorazepam Intensol 2 milligrams (mg) /milliliter (ml), 1 ml buccally (inside the cheek), if C1 was vomiting or gagging. The medication could be repeated once after 10 minutes if symptoms continued, with a maximum of 2 ml per day or 5 ml per week. Lorazepam 1 ml (2 mg) buccally was also ordered for one generalized tonic/clonic seizure or two complex partial seizures, including retching episodes, and could be repeated once after 10 minutes, with the same daily and weekly limits. Staff were required to document all seizure activity every shift in the seizure health tracking section of Therap (electronic health record). C1's medication administration record (MAR), dated January 2026, identified on 1/30/26 at 9:30 p.m., C1 was given 1 ml of lorazepam. This was noted to be documented on 2/9/26 (late entry). C2's EDF, updated 4/19/21, identified that C1 had diagnoses of profound cerebral palsy and seizure disorder. C1 was nonverbal, required assistance with all activities of daily living (ADLs), and used a wheelchair for mobility. C2's physician orders, dated 8/28/25, identified Lorazepam 2 mg/ml to be administered at 0.25 ml buccally if seizures last longer than three minutes. Staff are instructed to call 911 after five minutes to transport C2 to the ER. If the seizures stop before paramedics arrive, she should not be sent; however, if they stop and restart before paramedics arrive, she should still be transported. The orders describe C2's seizure presentation as eye-rolling, pale skin, body tremors, and drooling. The last recorded seizure in the orders was March 2009.	5 380			

Minnesota Department of Health

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5 380	Continued From page 3 A Facility Reported Incident (FRI) report dated 2/6/26 at 2:35 p.m., identified on 1/30/26 at approximately 9:00 p.m., C1 began gagging, coughing, and vomiting after going to bed at 8:00 p.m. Staff assisted, changed clothing, and continued monitoring. At approximately 9:30 p.m., staff determined C1 was experiencing a seizure and administered lorazepam 1 ml per seizure protocol. 911 was called at 9:48 p.m., and Guardian (G)-A was notified at approximately 9:50 p.m. C1 was transported to the hospital and diagnosed with aspiration pneumonia and breakthrough seizure activity. C1's physician-ordered seizure protocol directed administration of 1 ml buccally for one generalized tonic-clonic seizure or two complex partial seizures (including retching episodes), with a repeat dose permitted after 10 minutes if needed. C1 also had a nausea/vomiting protocol for Ondansetron (Zofran) 4 mg every 8 hours as needed. The investigation identified that staff administered the initial PRN (as needed) seizure medication but did not administer a second dose despite continued retching episodes. The PRN was not documented in the EMAR at the time of administration as required. The investigation further identified that the seizure and nausea/vomiting protocols lacked clarity for staff in distinguishing between emesis and seizure-related retching. An internal investigation was initiated. Follow-up appointments and revision of the seizure plan were identified as needed. Guardian (G)-A expressed concern that C1 may have aspirated during the episode due to inability to reposition independently. Staff reported C1 was transferred to an upright seated position following the initial emesis episode until EMS arrival.	5 380			

Minnesota Department of Health

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5 380	Continued From page 4 C1's Ambulance Report dated 1/30/26, identified upon arrival at 9:52 p.m., EMS personnel arrived to find C1 seated in his wheelchair dry heaving. Group home staff stated he had a seizure and that this was typical post-seizure behavior, and that guardian (G)-A was on her way. Before G-A arrived, C1 vomited twice. Upon arrival G-A informed EMS that this was not typical postictal behavior but rather how his active seizures present. EMS lifted C1 to the cot, moved him to the ambulance, obtained vitals, placed a 20-gauge IV (intervenious) in his left forearm, and administered 5 mg of Versed (medication used to abort a seizure). EMS also gave Zofran (medication used to stop nausea and vomiting) for continuing dry heaving and began routine transport to the hospital. Review of C1's seizure logs, treatment (T)-logs or vital sign tracking for 1/30/26, revealed that staff did not document any seizure activity or vital signs from 8:00 p.m. to 10:00 p.m. C1's hospitalization record dated 1/30/26 at 10:51 p.m., identified that C1, who has Angelman syndrome, severe intellectual disability, nonverbal status, and localization-related epilepsy, presented with recurrent focal seizures characterized by retching and vomiting. His seizures typically began with eye closure, facial grimacing, and occasional bruxism (teeth grinding), and he was unable to follow commands. He received antiseizure medications three times daily, with tablets opened and sprinkled on food, and his seizures were usually well controlled when medications were administered reliably. On the night of 1/30/26, after being put to bed at the group home around 8:00 p.m., he experienced persistent retching and vomiting, consistent with increased seizure	5 380			

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5 380	Continued From page 5 activity noted in prior similar episodes that required hospitalization. Hospital documentation indicated that vomiting was triggered by uncontrolled seizures, and G-A expressed uncertainty as to whether facility staff had administered all prescribed seizure medications, highlighting the risk associated with inconsistent medication administration. An electroencephalogram (EEG) performed on 2/1/26, which measures the brain's electrical activity using sensors placed on the scalp, showed abnormal brain activity on the left side that matched his seizure symptoms and confirmed he was actively having seizures in the hospital. On 2/3/26 at 2:22 p.m., C1 was discharged back to the group home with new orders, including an increase in Keppra (antiseizure medication) from 1500 mg twice a day to 1500 mg in the morning and 2000 mg in the evening, and instructions to follow up with neurology in 6 to 8 weeks. Facility, "internal investigation," dated 2/6/26, revealed a reported seizure and medical response involving C1 on 1/30/26. Staff reported C1 went to bed between 7:30-8:00 p.m. and later exhibited gagging, coughing, and vomiting. Staff assisted and monitored C1. At approximately 9:15 p.m., staff identified the situation as a medical emergency. At approximately 9:30 p.m., staff believed C1 was experiencing a seizure, administered PRN Lorazepam, and called 911 at approximately 9:48 p.m. C1 was transported by emergency medical services (EMS) to the hospital at approximately 10:20 p.m. Guardians were notified. The investigation identified discrepancies between staff and guardian accounts regarding the timing of PRN administration and hospital destination communication. Guardians expressed concerns	5 380			

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5 380	Continued From page 6 regarding documentation accuracy, including seizure history and contact information. Staff reported difficulty reaching the nurse case manager (NCM) On-Call, who responded after the general event report (GER) was submitted. Areas identified for review included accuracy of medical documentation, adherence to on-call notification procedures, clarity of hospital transport protocols, and verification of guardian contact information. After reviewing the facility's internal investigation of C1's seizure episode on 1/30/26, it lacked critical elements necessary for a thorough review. While it documented the timeline of events and noted discrepancies between staff and guardian accounts, it failed to address why staff did not immediately administer the physician-ordered rescue seizure medication when C1 initially exhibited vomiting and retching resulting in medication errors. The investigation did not assess full compliance with C1's seizure protocol, nor did it analyze the root causes of delayed medication administration, documentation errors, or difficulties reaching the on-call nurse. Additionally, the review did not include clear corrective actions, staff retraining, or verification that documentation and guardian notifications were accurate and complete, leaving gaps in ensuring proper follow-up and prevention of future incidents for clients who may exhibit signs and symptoms of seizures. C1's GER report, last updated on 2/10/26, identified that on 1/30/26, C1 went to bed at 8:00 p.m. Around 9:00 p.m., C1 began gagging, coughing, and throwing up. Staff ran to check on him, changed his pajamas, and cleaned him up. Around 9:30 p.m., C1 started coughing and gagging again, at which time staff recognized he	5 380			

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5 380	Continued From page 7 was having a seizure. At 9:48 p.m., staff administered 1 ml of lorazepam and called 911. At 9:50 p.m., staff called G-A and attempted to reach the on-call NCM five times. The NCM returned the call after C1 had left for the hospital at 10:20 p.m. The report identified a medication error, noting that Lorazepam was given at 9:48 p.m., and indicated that staff failed to document the administration of seizure medication and seizure tracking for the incident that occurred on 1/30/26. The PRN order states to administer a second 1 ml dose of Lorazepam 10 minutes after the initial administration if the seizure is still occurring. The report also indicated that policies and procedures were followed and that no additional training was required. The plan for future corrective actions included scheduling and conducting a multidisciplinary team meeting with C1's neurologist, guardians, nursing, and program leadership to review C1's seizure history and current presentation; updating the seizure protocol to include clear, step-by-step instructions for staff to follow during a seizure or suspected seizure; and creating a Documentation Error Report to be completed with staff who worked on 1/30/26. Any missing documentation, including seizure tracking and EMAR entries, must be completed. C1's GER resolution report summary updated 2/9/26, identified a discrepancy between guardian and staff reports regarding PRN seizure rescue medication administration. Guardians reported that the PRN was not administered until they arrived, while staff reported administering the PRN prior to calling the guardians and EMS. The summary also noted that staff had not received seizure protocol training to help them identify signs and symptoms of seizures, nor to identify which clients have seizures and what each	5 380			

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5 380	Continued From page 8 client's individualized seizure protocol entails. During an interview on 2/11/26 at 12:14 p.m., direct support professional (DSP)-C stated that he knew C1 had a history of seizures but was unaware of C1's recent hospitalization for seizures. He reported that he did not know where C1's seizure protocol was located and that multiple attempts to find it in the home folders were unsuccessful. He explained that he could not access Therap, where seizure information was maintained, because of the current Wi-Fi issues. Once the protocol was pointed out in the lower right portion of the medication cabinet, DSP-C acknowledged that he did not fully understand the purpose of lorazepam and did not know the difference between complex partial and generalized seizures. He reported that he had not reviewed or practiced the protocol and did not fully understand when to call the nurse case manager, administer emergency medication, or call 911. DSP-C stated that staff had received seizure response training during orientation but that the information had been provided all at once and he could not remember it. He knew the on-call nurse number but could not confirm the identity of the on-call nurse, leaving him uncertain about whom to contact for immediate support during seizure events. DSP-C reported he was not ware of any other clients who had a seizure history including C2. During a phone interview on 2/11/26 at 10:27 a.m., guardian (G)-A reported that direct support professional (DSP)-A contacted her shortly before 10:00 p.m. on 1/30/26, stating C1 was vomiting, and an ambulance had been called. G-A stated C1's retching episodes are consistent with his seizure activity and that staff should have immediately initiated the emergency seizure	5 380			

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5 380	Continued From page 9 protocol, including administration of rescue medication at the onset of retching. G-A reported on 1/30/26, at around 10:52 p.m., she instructed DSP-A over the phone to follow the seizure protocol located inside the medication cabinet. G-A stated, "I kept repeating to her that he needed the medication administered now as she had not given it to him yet." Upon arrival at home, G-A observed that only one dose of rescue medication had been administered and believed it was given shortly before her arrival, rather than at the onset of symptoms. G-A expressed concern that staff did not promptly recognize C1's retching as seizure-related activity and did not administer medication in accordance with the protocol, contributing to the severity of the episode and subsequent hospitalization. During an interview on 2/11/26 at 2:30 p.m., DSP-A stated that she worked on 1/30/26 and was responsible for C1's care. DSP-A reported that she put C1 to bed around 7:30 p.m., and at approximately 8:50 p.m., she heard him retching and choking while completing charting. She went to C1's room, observed vomit, cleaned him, changed his clothes and bedding, and returned him to bed. DSP-A acknowledged that she did not administer C1's physician-ordered rescue seizure medication, take vital signs, or call the on-call nurse manager at that time and recognized that she should have. She further reported that at approximately 9:20 p.m., C1 was coughing and had vomited a larger amount. Staff cleaned him up and assisted him in his wheelchair, but the retching worsened around 9:22 p.m. DSP-A stated she then called 911, contacted the guardian, and administered lorazepam after consulting the guardian and was unsure of the exact times but had thought she had administered the lorazepam around 9:30 p.m.	5 380			

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5 380	Continued From page 10 DSP-A noted that staff require better training on seizure recognition, which clients have seizures, and the appropriate protocols for response as she was unsure which clients for sure has history of seizures or what their protocols were. DSP-A indicated she did not document what time she gave C1 his rescue medication until 2/9/26 when one of the staff members told her the PRN medication needed to be documented. DSP-A admitted she did give the lorazepam after she had called G-A and the guardian directed her to give it. During an interview on 2/11/26 at 3:54 p.m., DSP-E stated he was working with C1 today and was agency staff. DSP-E indicated he still had training in Therap to complete. DSP-E was unaware of any clients who had current seizure protocols including C2. DSP-E denied receiving any recent education of current clients who have seizures or what their current protocols were. During an interview on 2/11/26 at 4:21 p.m., DSP-D stated he was working with C1 today and was agency staff. DSP-D was unaware of any clients who had current seizure protocols. DSP-D denied receiving any recent education of current clients who have seizures or what their current protocols were including C2. During a phone interview on 2/12/26 at 10:47 a.m., DSP-B stated that he worked with DSP-A on 1/30/26 and verified that C1 had ongoing seizure activity between approximately 8:00 and 10:00 p.m. DSP-B could not recall exact times but stated that staff eventually transferred C1 to a wheelchair due to vomiting, and that DSP-A administered C1's lorazepam immediately before G-A arrived at the home. DSP-B reported he was not aware of any other clients with a history of	5 380			

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5 380	Continued From page 11 seizures and had not received seizure protocol training in seven years. He was unable to articulate the seizure protocols for C1 or C2. During an interview on 2/12/26 at 12:57 p.m., the assistant director of nursing (ADON) stated that the moment C1 began retching and vomiting, his rescue seizure medication should have been administered at 8:50 p.m., as vomiting was a symptom of his seizures. The ADON explained that vital signs should have been taken immediately after, and the on-call nurse manager should have been contacted. She noted that the onset of vomiting represented a significant change in C1's condition due to his high risk of seizures and was at high risk of impairment or death. ADON confirmed there had been to further staff training to address seizure protocols for all clients, where to document seizures in Therap and when to document PRN medications, to ensure DSP staff knew how to identify a seizure and what to do when a client experiences one. ADON verified 4 of their 6 clients have a seizure diagnosis and 2 of 6 clients have a seizure protocol to give rescue medication PRN which was C1 and C2. Following a call to C1's neurologist, a voicemail message was received from the neurology registered nurse (CNN), on 2/13/26 at 10:38 a.m. The voicemail message provided the following instructions for C1: With vomiting or retching, administer lorazepam Intensol 1 ml ducally for one generalized tonic-clonic seizure or for two complex partial seizures, which include the retching episodes. The dose may be repeated after 10 minutes if needed. Do not exceed 2 ml per day or 5 ml per week. The message further stated that lorazepam intensol was used as a rescue medication to abort an acute generalized	5 380			

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5 380	Continued From page 12 tonic-clonic seizure or if the patient is experiencing recurrent complex partial seizures. It was a PRN medication and may be given within minutes of seizure onset. The medication is absorbed through the oral mucosal membranes and does not require the patient to be awake or actively swallowing. If the medication is not available, it cannot be administered, or if the patient continues to experience seizures despite administration, 911 should be called and the patient transported to the emergency room. An additional attempt to contact C1's neurologist was made on 2/17/26 at 4:29 p.m., with no return call back. Review of the facility policy "Guidelines for Medication Administration," revised 2/6/26, indicated the purpose of the policy is to ensure the safe and effective administration of medications. The policy directed that all medications must be administered in compliance with physician orders and according to the individual 's medication administration protocol. The policy further required staff to follow established protocols when administering PRN medications, ensure medications are given exactly as prescribed, and verify when PRN medications were last administered prior to giving an additional dose. The policy also required staff to document medication administration promptly in the electronic Medication Administration Record (eMAR) following administration and to review the MAR to ensure medications were administered and documented correctly. Additionally, the policy required staff to notify the nurse, Nurse Case Manager (NCM), or NCM On-Call if a medication was not administered as ordered and to report	5 380			

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5 465	Continued From page 14 On 2/12/26 at 4:35 p.m., observation of the facility garage revealed multiple boxes labeled with client names containing paper medical records for C1, C2, C3, C4, C5, and C6. The boxes were stored on the concrete floor and were not maintained in locked file cabinets. The garage was accessible through an interior office. Observation revealed the office door was unlocked and unattended at the time of observation. The garage door was also unlocked, allowing access to the stored records. During an interview on 2/12/26 at 4:37 p.m., the director of program and operations (DPO) confirmed the records belonged to current clients of the facility. The DPO acknowledged the records were not stored in a locked cabinet and stated the office and garage are routinely unlocked during business hours. During an interview on 2/17/26 at 12:10 p.m., the Vice President of Operations stated the office should always be locked and that guardians, family members, and visitors should not have access to the office. The Vice President confirmed the door to the office should remain locked to prevent unauthorized access. Facility undated signage entitled, "Visitor Guidelines," identified visitors may not access the office or medication cabinet as this is where personal health information for service recipients is located and only authorized personnel may access service recipient records. Visitors are not permitted to request or view these records unless there is a signed authorization on file. Facility policy regarding client records are to be maintained in a secure location with access limited to authorized personnel was requested	5 465			

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5 465	Continued From page 15 and not received. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 465			
5 815	MN Statute 626.557 Subd. 3. VA Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has	5 815			

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5 815	Continued From page 16 reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report a neglect incident to the State Agency (SA) when 1 of 1 clients (C1) did not receive a physicaïn ordered rescue seizure medication timely which led to extended seizure activity requiring a five day hospitalization. Findings include: C1's Emergency Data Form (EDF), updated 7/6/21, identified C1 had diagnosis of had Angelman syndrome (a rare genetic condition present at birth that causes developmental delays, little or no speech, balance problems and seizures) and seizure disorder. In addition, C1 was nonverbal, required assistance with all activities of daily living (ADL's) and used a wheelchair for mobility. C1's physician orders, signed 8/25/25, directed	5 815			

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5 815	Continued From page 17 staff to administer lorazepam Intensol 2 mg/ml, 1 ml buccally (inside the cheek), if C1 was vomiting or gagging. The medication could be repeated once after 10 minutes if symptoms continued, with a maximum of 2 ml per day or 5 ml per week. Lorazepam 1 ml (2 mg) buccally was also ordered for one generalized tonic/clonic seizure or two complex partial seizures, including retching episodes, and could be repeated once after 10 minutes, with the same daily and weekly limits. Staff were required to document all seizure activity every shift in the seizure health tracking section of Therap (electronic health record). C1's medication administration record (MAR), dated January 2026, identified on 1/30/26 at 9:30 p.m., C1 was given 1 ml of lorazepam. This was noted to be documented on 2/9/26. A Facility Reported Incident (FRI) report dated 2/6/26 at 2:35 p.m., identified on 1/30/26 at approximately 9:00 p.m., C1 began gagging, coughing, and vomiting after going to bed at 8:00 p.m. Staff assisted, changed clothing, and continued monitoring. At approximately 9:30 p.m., staff determined C1 was experiencing a seizure and administered lorazepam 1 ml per seizure protocol. 911 was called at 9:48 p.m., and Guardian (G)-A was notified at approximately 9:50 p.m. C1 was transported to the hospital and diagnosed with aspiration pneumonia and breakthrough seizure activity. C1's physician-ordered seizure protocol directed administration of 1 ml buccally for one generalized tonic-clonic seizure or two complex partial seizures (including retching episodes), with a repeat dose permitted after 10 minutes if needed. C1 also had a nausea/vomiting protocol for Ondansetron (Zofran) 4 mg every 8 hours as needed. The investigation identified that staff	5 815			

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5 815	Continued From page 18 administered the initial PRN (as needed) seizure medication but did not administer a second dose despite continued retching episodes. The PRN was not documented in the EMAR at the time of administration as required. The investigation further identified that the seizure and nausea/vomiting protocols lacked clarity for staff in distinguishing between emesis and seizure-related retching. An internal investigation was initiated. The Ombudsman was notified of the hospitalization related to seizure and aspiration pneumonia. Follow-up appointments and revision of the seizure plan were identified as needed. Guardian (G)-A expressed concern that C1 may have aspirated during the episode due to inability to reposition independently. Staff reported C1 was transferred to an upright seated position following the initial emesis episode until EMS arrival. Facility, "internal investigation," dated 2/6/26, revealed a reported seizure and medical response involving C1 on 1/30/26. Staff reported C1 went to bed between 7:30-8:00 p.m., and later exhibited gagging, coughing, and vomiting. Staff assisted and monitored C1. At approximately 9:15 p.m., staff identified the situation as a medical emergency. At approximately 9:30 p.m., staff believed C1 was experiencing a seizure, administered PRN lorazepam, and called 911 at approximately 9:48 p.m. C1 was transported by emergency medical services (EMS) to the hospital at approximately 10:20 p.m. Guardians were notified. The investigation identified discrepancies between staff and guardian accounts regarding the timing of PRN administration and hospital destination communication. Guardians expressed concerns regarding documentation accuracy, including seizure history and contact information. Staff	5 815			

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5 815	Continued From page 19 reported difficulty reaching the nurse case manager (NCM) On-Call, who responded after the general event report (GER) was submitted. Areas identified for review included accuracy of medical documentation, adherence to on-call notification procedures, clarity of hospital transport protocols, and verification of guardian contact information. During an interview on 2/17/26 at 2:39 p.m., the Operations Administrator (OA) stated that C1's seizure event on 1/30/26 was not reported to the state until 2/6/26 at 2:30 p.m., after concerns were raised by the guardian. OA indicated reporting should have occurred immediately in accordance with facility policy, confirming that the policy and required timelines were not followed. Facility, "Policy and Procedure on Reporting and Internal Review of Maltreatment And Injuries Of Unknown Origin Of Vulnerable Adults," revised 9/16/24, indicated that all staff are mandated reporters of suspected neglect or injuries of unknown origin. Staff must immediately report concerns to the Minnesota Adult Abuse Reporting Center (MAARC) and internally to the Nurse Case Manager (NCM) or Operations Administrator (OA), or after hours to the NCM on Call (NCMOC). If the NCM or OA may be involved, the Director of Program and Operations (DOPO) or Director of Nursing (DON) must be notified. The policy requires notification of the county case manager and legal guardian within 24 hours, a reporter status update within 2 working days, and completion of an internal review within 5 working days. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 815			

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