DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

November 16, 2021

Administrator
Homeward Bound Plymouth
13522 Sunset Trail
Plymouth, MN 55441

RE: Event ID: EJOV11

Dear Administrator:

On October 6, 2021 a survey was completed at your facility by the Minnesota Departments of Health Public Safety 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. At the time of the survey, the survey team noted one or more deficiencies.

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

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

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

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

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

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

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

DEPARTMENT OF HEALTH

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November 16, 2021

Administrator
Homeward Bound Plymouth
13522 Sunset Trail
Plymouth, MN 55441

Re: Project Number Event ID: EJOV11

Dear Administrator:

The above facility survey was completed on October 6, 2021 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56.

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

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

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

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

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November 16, 2021

Administrator
Homeward Bound Plymouth
13522 Sunset Trail
Plymouth, MN 55441

RE: Event ID: EJOV21

Dear Administrator:

On October 21, 2021 a Life Safety survey was completed at your facility by the Minnesota Departments of Public Safety 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. At the time of the survey, the survey team noted one or more deficiencies.

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

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

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

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G447	A. BUILDING _____ B. WING _____	10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWARD BOUND PLYMOUTH	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
E 000	Initial Comments On October 4th - 6th, 2021, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.	E 000		
W 000	INITIAL COMMENTS A Focused Fundamental survey was conducted on October 4th - 6th, 2021. The facility, Homeward Bound Plymouth, was found NOT to be in compliance with the requirements of the Focused Fundamental Tags at 42CFR 483 Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).	W 000		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the qualified intellectual disabilities professional (QIDP) had consistent oversight of each client's needs and individual program plans so that each client received the care and services needed to maintain their highest level of functioning for 3 of 3 clients (C1, C5, and C6) programs that were reviewed. The had the potential to affect all 6 clients residing in the facility. Findings include: The QIDP failed to ensure the client's programs were individualized, monitored, and evaluated on an ongoing basis as follows:	W 159		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 159	Continued From page 1 The facility failed to ensure formal program objectives in the Individual Program Plans included duration, number of program trials, and level of accomplishment to measure performance for learning for 3 of 6 clients (C1, C5, C6) in sample reviewed. Refer to W231 for additional information. The facility failed to provide clear instructions to staff on how to implement the individual program plan (IPP) for 3 of 6 clients (C1, C5 and C6) in the sample reviewed. Refer to W234 for additional information. During interview on 10/6/21, at 10:30 a.m. qualified intellectual disability professional (QIDP) stated he was hired during the the time of the COVID-19 shut down, and felt the training he received was hampered by implementing COVID-19 protocols and maintaining client health and safety, as well as, maintaining appropriate staffing levels. QIDP stated he did his best to maintain client programming including revising /writing programs during that time. In an interview on 10/6/21, at 10:40 a.m. program administrator of quality assurance (PAQA) stated he had been recently hired by the corporation. PAQA stated his role is to assist all the QIDPs with education on formal program writing and development.	W 159		
W 231	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(iii) The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance.	W 231		

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W 231	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure formal program objectives in the Individual Program Plans included duration, number of program trials, and level of accomplishment to measure performance for learning for 3 of 6 clients (C1, C5, C6) reviewed for active treatment. Findings include: C1 C1's Face Sheet dated 7/13, indicated client functioned at the profound level of intellectual disability. C1's Coordinated Services and Support Plan (CSSP), approval date of 4/26/21, indicated C1 would benefit from the following: 1. "[C1] will continue to stand in her stander using her AFOs (used for ankle foot support)" 2. "[C1] will continue to make connections with members in her community" C1's written formal programs identified the following: 1. "[C1] will use her stander 5 [to] 7 [times per] week on going." 2. "Whenever an outing is offered; frequency of documentation: Whenever an outing is offered. To offer choices to the individual which is meaningful [to] the person as well as opportunities to enhance their skills and promote community inclusion." C1's formal program objectives were not written in measurable terms to determine success with	W 231		

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W 231	Continued From page 3 the objective. The percentage expected to be attained and duration related to how long C1 had to achieve success was not in the program plan. The number of trials to be offered for outings was not identified in the program plan. C5 C5's Face Sheet dated 7/13, indicated client functioned at the profound level of intellectual disability. C5's Coordinated Services and Support Plan (CSSP), approval date of 6/7/21, indicated C5 would benefit from the following: 1. "[C5] will continue to maintain both his physical and mental health" 2. "[C5] will continue to improve the use of his adaptive equipment" C5's written formal programs identified the following: 1. "[C5] will accept redirection to an activity of his choice with 1 verbal prompt." 2. "[C5] will use his gait trainer 4 [to] 5 [times] on average per week." Another formal program, for adaptive equipment indicated "[C5] will use his longsitter once a day on workdays and twice a day on weekends." C5's formal program objectives were not written in measurable terms to determine success with the objective. The percentage expected to be attained and duration related to how long C5 had to achieve success was not in the program plan. The number of trials to be offered for activity of choice was not identified in the program plan.	W 231		

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W 231	Continued From page 4 C6 C6's Face Sheet dated 6/21, indicated client functioned at the moderate level of intellectual disability. C6's Coordinated Services and Support Plan (CSSP), approval date of 6/7/21, indicated C6 would benefit from the following: 1. "[C6] will continue to make connections with members in her community." C6's written formal programs identified the following: 1. "Whenever an outing is offered; frequency of documentation: Whenever an outing is offered. To offer choices to the individual which is meaningful [to] the person as well as opportunities to enhance their skills and promote community inclusion." C6's formal program objective were not written in measurable terms to determine success with the objective. The percentage expected to be attained and duration related to how long C5 had to achieve success or trials to be offered for outing was not identified in the program plan. During interview on 10/6/21, at 10:30 a.m. qualified intellectual disability professional (QIDP) stated he was hired during the the time of the COVID-19 shut down, and felt the training he received was hampered by implementing COVID-19 protocols and maintaining client health and safety, as well as, maintaining appropriate staffing levels. QIDP stated he did his best to maintain client programming including revising /writing programs during that time.	W 231		

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W 231	Continued From page 5 In an interview on 10/6/21, at 10:40 a.m. program administrator of quality assurance (PAQA) stated he had been recently hired by the corporation. PAQA stated his role is to assist all the QIDPs with education on formal program writing and development. PAQA stated the programs, as written above, do not provide objective goals that clients should be advancing towards. A policy on the development of formal programming was requested, but not provided.	W 231		
W 234	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(i) Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to provide clear instructions to staff on how to implement the individual program plan (IPP) for 3 of 6 clients (C1, C5 and C6) in the sample reviewed for active treatment. Findings include: C1 C1's Face Sheet dated 7/13 indicated client functioned at the profound level of intellectual disability. C1's individual program plan objectives, identified the following: 1. "[Television] Stand Dusting (Daily AM) - [C1] will dust the TV stand in her room average [3 to 5	W 234		

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W 234	Continued From page 6	W 234		

times a week] with partial physical assistance or less at 25% average of all opportunities for 3 consecutive."

2. "[Medication Administration]: Throw away Med Cup (Daily AM) - [3 to 5 times per week], [C1] will throw away her med cup with partial physical physical assistance or less average of 75% or less of all opportunities for 3 consecutive months."

3. "Money Management - on average of [2 times] per month, [C1] will assist with staff giving staff her payment with gestural prompts or less at 25% average for 3 consecutive months."

4. "Adaptive [equipment]: [C1]will wipe down her AFOs (used for ankle foot support) after getting out of her stander average [3 to 5 times] weekly with partial physical assistance or less at 50% average of all opportunities offered for 3 consecutive months."

5. "[C1] will accept redirection to an activity of her choice with 1 verbal prompt ongoing as she has mental health symptoms."

6. "Music Choice - Communication (Daily AM / PM): [C1] will select music and listen to [3-5 times] average weekly with a gesture prompt or less at 25% average of all opportunities for 3 consecutive months."

7. "Community Outings: To offer choices to the individual which are meaningful to the person as well as opportunities to enhance their skills and promote community inclusion."

C1's training programs, lacked methodologies

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W 234	Continued From page 7	W 234		

(instructions) as to how the facility staff were to implement each program. This resulted in facility not be being able to measure client progress towards goals.

C5
C5's Face Sheet (dated 7/13) indicated client functioned at the profound level of intellectual disability.

C5's individual program plan objectives, identified the following:

1. "Sensory Play (daily AM/PM): Staff will "play" with sensory toys with [C5] 2 times per day & evening shifts when he is home."

2. "Cash Purchase [2 times per months] - Money management: [C5] will be offered to help with handing his wallet towards a cashier when making a purchase average [2 times] a month with partial physical assistance or less 25% of all opportunities for 3 consecutive months."

3. "Positive Behavior Support Plan (Daily AM/PM): [C5] will accept redirection to an activity of his choice with 1 verbal prompt."

4. "Communication / Relaxation (Daily AM/PM): [C5] will choose where he wants to relax from two options [3 - 5 times] weekly with a partial physical prompt or less at 95% success average over 3 consecutive months."

5. Equipment Maintenance (Daily PM) Adaptive equipment: [C5] will assist with checking his handle bar are in good condition with a gestural prompt or less average of [3 - 5 times] a week at 25% average for three consecutive months."

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6. "Community Outings: To offer choices to the individual which are meaningful to the person as well as opportunities to enhance their skills and promote community inclusion."

C5's training programs, lacked methodologies (instructions) as to how the facility staff were to implement each program. This resulted in facility not be being able to measure client progress towards goals.

C6's
C6's Face Sheet (dated 6/21) indicated client functioned at the moderate level of intellectual disability

C6's individual program plan objectives, identified the following:

1. "Communication (Daily PM): [C6] will choose an activity to complete using her communication boards two times an evening on average if [5 - 7 times] weekly at 90% for 3 consecutive months."

2. "Adaptive Equipment (Daily): [C6] will get a cleaning rag and then ask staff to put cleaning spray on the rag, before independently wiping down her AFOs, her wheel chair arms, and hands brakes then put her rag in the hamper for 90% of all opportunities for three consecutive months."

3. "Medication Administration: [C6] has identified per [miralax (bowel medication)], she will pour it in her cup, state what it is for on average of 95% of opportunities [3 - 5 times] weekly for 3 consecutive months."

4. "Counting Money (Saturdays): [C6] will count

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W 234	Continued From page 9 how much money she has in her money hanger in the laundry room on average of once a week before going shopping with her sisters 90% of all opportunities offered." 5. "Extra Walk (Saturdays AM): [C6] will complete and extra walk 910 laps 0 in the morning before going on her weekly Saturday outing." 6. " Community Outing: To offer choices to the individual which are meaningful to the person as well as opportunities to enhance their skills and promote community inclusion." C6's training programs, lacked methodologies (instructions) as to how the facility staff were to implement each program. This resulted in facility not be being able to measure client progress towards goals. During observation on 10/4/21, at 5:30 a.m., direct support personnel (DSP)-A set up C6's evening medications which included a medication program for C6's miralax (powder for constipation). After being cued by DSP-A, C6 named the medication, purpose for medication then emptied her water with medication and stirred together. During observation, DSP-A stated staff run client programs on how they were taught. DSP-A stated during training observe how it is done and then demonstrate it in return. During and interview on 10/04/21, at 6:12 p.m. DSP-B stated when she started, she worked with a more experienced staff person. DSP-B further stated that after a few times of observing experienced staff person implement programs, she did it. When asked if there were any written instructions, on how to implement programs,	W 234		

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W 234	Continued From page 10 DSP-A was uncertain. During interview on 10/6/21, at 10:30 a.m. qualified intellectual disability professional (QIDP) stated he was hired during the the time of the COVID-19 shut down, and felt the training he received was hampered by implementing COVID-19 protocols and maintaining client health and safety, as well as, maintaining appropriate staffing levels. QIDP stated he did his best to maintain client programming and revising/writing their programs during that time. A policy on the development of formal programming was requested but not provided.	W 234		

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	01583	A. BUILDING: _____ B. WING _____	10/06/2021

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HOMEWARD BOUND PLYMOUTH	13522 SUNSET TRAIL PLYMOUTH, MN 55441

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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 October 4th - 6th, 2021 surveyors of this Department's staff visited the above provider to conduct a licensing visit. Homeward Bound Plymouth was in full compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).	5 000		

POC Received- 12/1/21
POC Approved- 12/19/21
Liz Silkey

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

PRINTED: 11/15/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G447	A. BUILDING _____ B. WING _____	10/06/2021

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E 000	Initial Comments On October 4th - 6th, 2021, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.	E 000	W159, 483.430(a) QIDP Plan: Program Plans for C1, C5, C6 will be updated to include duration, number of trials, and level of accomplishment. Staff will be trained on updated program plans including specific instructions on running plans. Program Manager will be trained on writing program plans and training staff to properly implement plans. Procedure for Implementing: Operations Administrator will update CSSP-A, OA and PAQA will train Program Manager, Program Manager will train direct care staff. Monitoring Procedure:Monthly audits documented on Program Manager Monthly Audit Form. Title Responsible:Operations Administrator	12/15/21
W 000	INITIAL COMMENTS A Focused Fundamental survey was conducted on October 4th - 6th, 2021. The facility, Homeward Bound Plymouth, was found NOT to be in compliance with the requirements of the Focused Fundamental Tags at 42CFR 483 Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).	W 000		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the qualified intellectual disabilities professional (QIDP) had consistent oversight of each client's needs and individual program plans so that each client received the care and services needed to maintain their highest level of functioning for 3 of 3 clients (C1, C5, and C6) programs that were reviewed. The had the potential to affect all 6 clients residing in the facility. Findings include: The QIDP failed to ensure the client's programs were individualized, monitored, and evaluated on an ongoing basis as follows:	W 159		

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

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 159	Continued From page 1 The facility failed to ensure formal program objectives in the Individual Program Plans included duration, number of program trials, and level of accomplishment to measure performance for learning for 3 of 6 clients (C1, C5, C6) in sample reviewed. Refer to W231 for additional information. The facility failed to provide clear instructions to staff on how to implement the individual program plan (IPP) for 3 of 6 clients (C1, C5 and C6) in the sample reviewed. Refer to W234 for additional information. During interview on 10/6/21, at 10:30 a.m. qualified intellectual disability professional (QIDP) stated he was hired during the the time of the COVID-19 shut down, and felt the training he received was hampered by implementing COVID-19 protocols and maintaining client health and safety, as well as, maintaining appropriate staffing levels. QIDP stated he did his best to maintain client programming including revising /writing programs during that time. In an interview on 10/6/21, at 10:40 a.m. program administrator of quality assurance (PAQA) stated he had been recently hired by the corporation. PAQA stated his role is to assist all the QIDPs with education on formal program writing and development.	W 159		
W 231	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(iii) The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance.	W 231		

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W 231	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure formal program objectives in the Individual Program Plans included duration, number of program trials, and level of accomplishment to measure performance for learning for 3 of 6 clients (C1, C5, C6) reviewed for active treatment. Findings include: C1 C1's Face Sheet dated 7/13, indicated client functioned at the profound level of intellectual disability. C1's Coordinated Services and Support Plan (CSSP), approval date of 4/26/21, indicated C1 would benefit from the following: 1. "[C1] will continue to stand in her stander using her AFOs (used for ankle foot support)" 2. "[C1] will continue to make connections with members in her community" C1's written formal programs identified the following: 1. "[C1] will use her stander 5 [to] 7 [times per] week on going." 2. "Whenever an outing is offered; frequency of documentation: Whenever an outing is offered. To offer choices to the individual which is meaningful [to] the person as well as opportunities to enhance their skills and promote community inclusion." C1's formal program objectives were not written in measurable terms to determine success with	W 231	W231, 483.440(c)(4)(iii): IPP Plan: IPPs for C1, C5, C6 will be updated to include formal program objectives, duration, number of trials, and level of accomplishment. Staff will be trained on updated IPPs including specific instructions on running plans. Program Manager will be trained on writing program plans and training staff to properly implement plans. Procedure for Implementing: Operations Administrator will update IPPs, Program Manager will train direct care staff. Monitoring Procedure:Monthly audits documented on Program Manager Monthly Audit Form. Title Responsible: Operations Administrator	12/15/21

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W 231	Continued From page 3 the objective. The percentage expected to be attained and duration related to how long C1 had to achieve success was not in the program plan. The number of trials to be offered for outings was not identified in the program plan. C5 C5's Face Sheet dated 7/13, indicated client functioned at the profound level of intellectual disability. C5's Coordinated Services and Support Plan (CSSP), approval date of 6/7/21, indicated C5 would benefit from the following: 1. "[C5] will continue to maintain both his physical and mental health" 2. "[C5] will continue to improve the use of his adaptive equipment" C5's written formal programs identified the following: 1. "[C5] will accept redirection to an activity of his choice with 1 verbal prompt." 2. "[C5] will use his gait trainer 4 [to] 5 [times] on average per week." Another formal program, for adaptive equipment indicated "[C5] will use his longsitter once a day on workdays and twice a day on weekends." C5's formal program objectives were not written in measurable terms to determine success with the objective. The percentage expected to be attained and duration related to how long C5 had to achieve success was not in the program plan. The number of trials to be offered for activity of choice was not identified in the program plan.	W 231		

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W 231	Continued From page 4 C6 C6's Face Sheet dated 6/21, indicated client functioned at the moderate level of intellectual disability. C6's Coordinated Services and Support Plan (CSSP), approval date of 6/7/21, indicated C6 would benefit from the following: 1. "[C6] will continue to make connections with members in her community." C6's written formal programs identified the following: 1. "Whenever an outing is offered; frequency of documentation: Whenever an outing is offered. To offer choices to the individual which is meaningful [to] the person as well as opportunities to enhance their skills and promote community inclusion." C6's formal program objective were not written in measurable terms to determine success with the objective. The percentage expected to be attained and duration related to how long C5 had to achieve success or trials to be offered for outing was not identified in the program plan. During interview on 10/6/21, at 10:30 a.m. qualified intellectual disability professional (QIDP) stated he was hired during the the time of the COVID-19 shut down, and felt the training he received was hampered by implementing COVID-19 protocols and maintaining client health and safety, as well as, maintaining appropriate staffing levels. QIDP stated he did his best to maintain client programming including revising /writing programs during that time.	W 231		

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W 231	Continued From page 5 In an interview on 10/6/21, at 10:40 a.m. program administrator of quality assurance (PAQA) stated he had been recently hired by the corporation. PAQA stated his role is to assist all the QIDPs with education on formal program writing and development. PAQA stated the programs, as written above, do not provide objective goals that clients should be advancing towards. A policy on the development of formal programming was requested, but not provided.	W 231		
W 234	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(i) Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to provide clear instructions to staff on how to implement the individual program plan (IPP) for 3 of 6 clients (C1, C5 and C6) in the sample reviewed for active treatment. Findings include: C1 C1's Face Sheet dated 7/13 indicated client functioned at the profound level of intellectual disability. C1's individual program plan objectives, identified the following: 1. "[Television] Stand Dusting (Daily AM) - [C1] will dust the TV stand in her room average [3 to 5	W 234	W234, 483.440(c)(5)(i): IPP Plan: Staff will be trained on updated IPPs for C1, C5, C6, including clear instructions on how to implement the IPPs. Procedure for Implementing: Staff will be trained on the new IPPs and CSSP-As following HBIs standard training plan: Review of plans and plan changes, complete HBI standard competency assessment for C1, C5, C6. Program Manager will conduct training and Operations Administrator will review completed competency assessments. Monitoring Procedure: Operations Administrator will review and update all program plans at least annually during the annual meeting and review process. Title Responsible: Operations Administrator	12/15/21

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times a week] with partial physical assistance or less at 25% average of all opportunities for 3 consecutive."

2. "[Medication Administration]: Throw away Med Cup (Daily AM) - [3 to 5 times per week], [C1] will throw away her med cup with partial physical physical assistance or less average of 75% or less of all opportunities for 3 consecutive months."

3. "Money Management - on average of [2 times] per month, [C1] will assist with staff giving staff her payment with gestural prompts or less at 25% average for 3 consecutive months."

4. "Adaptive [equipment]: [C1]will wipe down her AFOs (used for ankle foot support) after getting out of her stander average [3 to 5 times] weekly with partial physical assistance or less at 50% average of all opportunities offered for 3 consecutive months."

5. "[C1] will accept redirection to an activity of her choice with 1 verbal prompt ongoing as she has mental health symptoms."

6. "Music Choice - Communication (Daily AM / PM): [C1] will select music and listen to [3-5 times] average weekly with a gesture prompt or less at 25% average of all opportunities for 3 consecutive months."

7. "Community Outings: To offer choices to the individual which are meaningful to the person as well as opportunities to enhance their skills and promote community inclusion."

C1's training programs, lacked methodologies

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(instructions) as to how the facility staff were to implement each program. This resulted in facility not be being able to measure client progress towards goals.

C5
C5's Face Sheet (dated 7/13) indicated client functioned at the profound level of intellectual disability.

C5's individual program plan objectives, identified the following:

1. "Sensory Play (daily AM/PM): Staff will "play" with sensory toys with [C5] 2 times per day & evening shifts when he is home."

2. "Cash Purchase [2 times per months] - Money management: [C5] will be offered to help with handing his wallet towards a cashier when making a purchase average [2 times] a month with partial physical assistance or less 25% of all opportunities for 3 consecutive months."

3. "Positive Behavior Support Plan (Daily AM/PM): [C5] will accept redirection to an activity of his choice with 1 verbal prompt."

4. "Communication / Relaxation (Daily AM/PM): [C5] will choose where he wants to relax from two options [3 - 5 times] weekly with a partial physical prompt or less at 95% success average over 3 consecutive months."

5. Equipment Maintenance (Daily PM) Adaptive equipment: [C5] will assist with checking his handle bar are in good condition with a gestural prompt or less average of [3 - 5 times] a week at 25% average for three consecutive months."

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6. "Community Outings: To offer choices to the individual which are meaningful to the person as well as opportunities to enhance their skills and promote community inclusion."

C5's training programs, lacked methodologies (instructions) as to how the facility staff were to implement each program. This resulted in facility not be being able to measure client progress towards goals.

C6's
C6's Face Sheet (dated 6/21) indicated client functioned at the moderate level of intellectual disability

C6's individual program plan objectives, identified the following:

1. "Communication (Daily PM): [C6] will choose an activity to complete using her communication boards two times an evening on average if [5 - 7 times] weekly at 90% for 3 consecutive months."

2. "Adaptive Equipment (Daily): [C6] will get a cleaning rag and then ask staff to put cleaning spray on the rag, before independently wiping down her AFOs, her wheel chair arms, and hands brakes then put her rag in the hamper for 90% of all opportunities for three consecutive months."

3. "Medication Administration: [C6] has identified per [miralax (bowel medication)], she will pour it in her cup, state what it is for on average of 95% of opportunities [3 - 5 times] weekly for 3 consecutive months."

4. "Counting Money (Saturdays): [C6] will count

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W 234	Continued From page 9 how much money she has in her money hanger in the laundry room on average of once a week before going shopping with her sisters 90% of all opportunities offered." 5. "Extra Walk (Saturdays AM): [C6] will complete and extra walk 910 laps 0 in the morning before going on her weekly Saturday outing." 6. " Community Outing: To offer choices to the individual which are meaningful to the person as well as opportunities to enhance their skills and promote community inclusion." C6's training programs, lacked methodologies (instructions) as to how the facility staff were to implement each program. This resulted in facility not be being able to measure client progress towards goals. During observation on 10/4/21, at 5:30 a.m., direct support personnel (DSP)-A set up C6's evening medications which included a medication program for C6's miralax (powder for constipation). After being cued by DSP-A, C6 named the medication, purpose for medication then emptied her water with medication and stirred together. During observation, DSP-A stated staff run client programs on how they were taught. DSP-A stated during training observe how it is done and then demonstrate it in return. During and interview on 10/04/21, at 6:12 p.m. DSP-B stated when she started, she worked with a more experienced staff person. DSP-B further stated that after a few times of observing experienced staff person implement programs, she did it. When asked if there were any written instructions, on how to implement programs,	W 234		

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W 234	Continued From page 10 DSP-A was uncertain. During interview on 10/6/21, at 10:30 a.m. qualified intellectual disability professional (QIDP) stated he was hired during the the time of the COVID-19 shut down, and felt the training he received was hampered by implementing COVID-19 protocols and maintaining client health and safety, as well as, maintaining appropriate staffing levels. QIDP stated he did his best to maintain client programming and revising/writing their programs during that time. A policy on the development of formal programming was requested but not provided.	W 234		

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K 000	INITIAL COMMENTS FIRE SAFETY The facility had an E-Score of > 5.0 "IMPRACTICAL", as determined by Form CMS-2786V, Scoresheet F-2C. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Home Bound Plymouth was found NOT in compliance with the requirements for participation in Medicaid as an Intermediate Care Facility for the Mentally Retarded at 42 CFR, Subpart 483.470(j), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 33 Existing Residential Board and Care THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT	K 000		

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HOMEWARD BOUND PLYMOUTH	**13522 SUNSET TRAIL** **PLYMOUTH, MN 55441**

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K 000	Continued From page 1 REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Homeward Bound Plymouth is a 1-story building with no basement. It was determined to be of Type V(111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with	K 000		

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	24G447	A. BUILDING **01** B. WING _____	**10/21/2021**

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K 000	Continued From page 2 complete smoke detection that is monitored for automatic fire department notification. The facility has a license capacity of 6 beds and had a census of 6 at the time of the survey. The requirements at 42 CFR, Subpart 483.470(j) are NOT MET as evidenced by:	K 000		
K0346	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6 This STANDARD is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service in accordance with the NFPA 101 (2012 edition) The Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/21/2021, at 9:52 AM, during a records	K0346		

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K0346	Continued From page 3 review and an interview with a Program Director, the facility could not provide an acceptable fire alarm system out of service policy at the time of the inspection. An interview with the Program Director verified this deficient finding at the time of discovery.	K0346		
K0353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3).	K0353		

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K0353	Continued From page 4 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.)	K0353		

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K0353	Continued From page 5 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide test and maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, sections 5.1.1.1 and 13.4.4.2.9. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 10/21/2021, at 9:15 AM, the facility could not provide any current annual fire sprinkler testing documentation. 2. On 10/21/2021, at 9:15 AM, the facility could only provide 2 of 4 quarterly fire sprinkler flow testing documentation. 3. On 10/21/2021, at 9:40 AM, it was revealed by observation that the air compressor for the dry pipe fire sprinkler system was cycling on and off continuously during the facility inspection. It was also observed that there was a water trickling sound emanating from within the clapper valve housing. It was further noted that with the lack of any historical testing and maintenance documentation whether or not that this condition has been identified, diagnosed, and/or addressed by a fire sprinkler technician. This situation could be exacerbated with the weather turning colder and the possibility of frozen or burst pipes in the event there is an underlying maintenance issue	K0353		

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K0353	Continued From page 6 causing this situation. An interview with the Program Director verified these deficient findings at the time of discovery.	K0353		
K0354	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service 2012 EXISTING (Prompt) Where a required automatic sprinkler system is out of service for more than 10 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 33.2.3.5.3, 9.7.6.1, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed if the Fire Alarm system has to be placed out-of-service in accordance with the NFPA 101 (2012 edition) The Life Safety Code, section 9.7.6, and NFPA 25 (2011 edition) the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2 (4). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/21/2021, at 9:52 AM, during a records review and an interview with a Program Director, the facility could not provide an acceptable fire	K0354		

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K0354	Continued From page 7 sprinkler system out of service policy at the time of the inspection. An interview with the Program Director verified this deficient finding at the time of discovery.	K0354		
K0359	Sprinkler System - Installation CFR(s): NFPA 101 Sprinkler System - Installation 2012 EXISTING (Impractical) All Impractical Evacuation Capability facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 33.2.3.5.3. The system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with 9.6, as modified below. The adequacy of the water supply shall be documented. In Impractical Evacuation Capability Facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in one-and-two-Family Dwellings and Manufactured Homes, with a 30 minute water supply, shall be permitted. All habitable areas and closets shall be sprinklered. Automatic Sprinklers shall not be required in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials provided a 15-minute thermal barrier. In Impractical Evacuation Capability Facilities up to and including four stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, shall be permitted.	K0359		

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K0359	Continued From page 8 All habitable areas and closets shall be sprinklered. Automatic sprinklers shall not be required in bathrooms not exceeding 55 square feet provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier. Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6. Attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected, by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following: 1. Protected by heat detection system to activate the fire alarm system according to 9.6 by July 5, 2019. 2. Protected by automatic sprinkler system according to 9.7, by July 5, 2019. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. 33.2.3.5.3, 33.2.3.5.3.2, 33.2.3.5.3.5 through 33.2.3.5.3.7, 42 CFR 483.470(j)(1)(ii) This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to install and maintain the fire sprinkler system per NFPA 101 (2012 edition), The Life Safety Code, section 9.7.1.1, and NFPA 25 (2011 edition), the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, section 5.2.1.1.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K0359		

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K0359	Continued From page 9 On 10/21/2021, at 9:36 AM, it was revealed that there were two escutcheon rings missing within the dining room and one escutcheon ring missing by the main entry door. An interview with the Program Director verified this deficient finding at the time of discovery.	K0359		

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	01583	A. BUILDING: _____ B. WING _____	10/06/2021

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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 October 4th - 6th, 2021 surveyors of this Department's staff visited the above provider to conduct a licensing visit. Homeward Bound Plymouth was in full compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).	5 000		