DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 8, 2026

Administrator
Mission Nursing Home
3401 EAST MEDICINE LAKE BOULEVARD
PLYMOUTH, MN 55441

RE: CCN:245546

Cycle Start Date: May 22, 2026

Dear Administrator:

On May 22, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- 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. 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 state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 426-0175

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 22, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 22, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department’s informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245546	A. BUILDING B. WING	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD , 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
E0000	Initial Comments On 5/19/26 through 5/22/26, a survey for compliance with CFR §483.73(b)(6), Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E0000		06/30/2026
F0000	INITIAL COMMENTS On 5/19/26 through 5/22/26 , a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H (iQIES #). NO deficiencies were cited. H55462430c/iqies2667972 H55462428c/iqies2699092 H55462428c/iqies2714191/iqies2714299 H55462424c/iqies2998104 H55462431C Iqies: 2599397- Not in compliance- NO citations. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments	F0000		06/30/2026

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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F0000	Continued from page 1 acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		06/30/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the	F0628	F0628- Ombudsman notifications R6 was corrected ombudsman transfer notice was sent on 06/09/2026 Residents and/or resident representatives have the right to notification of transfer and discharge information, including notification to the Ombudsman as required. The facility identified that documentation of Ombudsman notification and verification of fax transmission was not consistently maintained for residents discharged to the hospital or discharged from the facility. Corrective action for residents identified: Any resident currently discharged or transferred without documented Ombudsman notification was reviewed. The required transfer/discharge forms were completed and fax verification documentation obtained and filed in the medical record and/or designated discharge log when applicable. Systemic changes implemented: Effective immediately, the facility will ensure that all hospital transfers and facility discharges include: Completion of the required transfer/discharge notification form. Fax transmission of the Ombudsman notification at the time of transfer/discharge when required. Retention of fax confirmation verification in the resident record or centralized discharge tracking binder/log. The Social Services Director, Designee, or Admissions/Medical Records staff, HUC and Nurses	06/30/2026

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F0628 SS = D	Continued from page 2 reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged;	F0628	Continued from page 2 responsible for discharge processing were educated on the revised process, including requirements for documentation and retention of fax verification. Monitoring process: The facility will audit all hospital transfers and discharges weekly for four weeks, then monthly for two months, to ensure: Transfer/discharge forms were completed. Ombudsman notifications were sent as required. Fax verification confirmations are present. Any identified concerns will be addressed immediately through re-education and corrective action. The results of these audits will be reviewed during the facility's Quality Assurance and Performance Improvement (QAPI) meetings to ensure ongoing compliance. Completion date of 06/30/2026	06/30/2026

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F0628 SS = D	Continued from page 3 (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the	F0628		06/30/2026

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F0628 SS = D	Continued from page 4 resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to ensure the State Ombudsman for Long Term Care (LTC) was notified of a transfer to the hospital for 1 of 3 residents (R6) when transferred to the hospital for medical treatment.	F0628		06/30/2026

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F0628 SS = D	Continued from page 5 Findings include: R6's Continuity of Care document undated, indicated diagnosis of schizophrenia, diabetes, and epilepsy. A progress note dated 9/4/25 at 9:16 p.m., indicated R6 went to the hospital for seizure activity. The facility notified the provider and family of the hospitalization. R6's medical record lacked evidence the State Ombudsman for LTC was notified of the transfer. The facility Bed Hold Policy and Notification of Transfer dated 9/4/25, indicated R6 had been sent to the hospital. However, there was no verification that the LTC Ombudsman was notified of the transfer. An interview on 5/21/26 at 11:21 a.m. the assistant director of nursing (ADON) stated they could not verify if the LTC Ombudsman had been notified unless the nurses wrote they sent it to the LTC Ombudsman the progress notes. ADON stated that sometimes the nurses will send a bed hold notification to the LTC Ombudsman but there is no way to verify that it was done. ADON stated no one was checking if the nurses were sending notification to the LTC Ombudsman. A facility policy was requested however, none was provided.	F0628		06/30/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to monitor and implement interventions per physician orders for 1 of 1 resident (R16) reviewed for heart failure. Findings include: R16's quarterly Minimum Data Set (MDS) dated 5/4/26, indicated R16 diagnoses included congestive heart failure (CHF), hypertension, and paroxysmal atrial fibrillation (episodes of irregular heart rhythm).	F0684	Plan of Correction –F0684 Quality of care R16 was corrected PRN Lasix was scheduled by MD PRN was DC'd Corrective Action for Residents Affected: The resident(s) affected were immediately assessed to ensure PRN medications were administered according to physician orders, including indication, dosage, frequency, and required documentation. The physician and responsible party were notified as indicated. Any missing documentation or follow-up monitoring was completed immediately. Staff involved received re-education regarding adherence to physician orders and PRN medication administration requirements. Identification of Other Residents at Risk: An audit of all in house residents with PRN medication orders was completed to verify: Appropriate indications for use were documented	06/30/2026

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F0684 SS = D	Continued from page 6 R16's Physician Order Report, signed by provider 4/15/26, indicated the following orders: Lasix (furosemide) 20 milligrams (mg) daily as needed (PRN) if weight up over 3 pounds (lbs) in one day or 5 lbs/week Check weight daily and update provider if weight is up 5 lbs in one week or 3 lbs in one day R16's weight summary, printed 5/22/26, indicated R16's weight was 208.2 lbs on 4/17/26, and 212.2 lbs on 4/18/26, which indicated a weight gain of 4 lbs in one day. R16's weight continued to be elevated with weights documented as 211.6 lbs on 4/19/26, and 211.6 lbs on 4/20/26. However, R16's record lacked evidence that the provider had been notified of the weight gain. Additionally, Medication Administration Record (MAR) indicated Lasix 20mg PRN was not administered to R16 on 4/18/26, as per provider orders. R16's progress note, dated 4/18/26 at 5:31 a.m., indicated R16 had no signs or symptoms (s/s) of respiratory distress noted. R16's progress note, dated 4/18/26 at 9:29 p.m., indicated R16's lung sounds were diminished in all lobes. R16's progress note, dated 4/19/26 at 9:25 p.m., indicated R16's lung sounds were diminished in all lobes. R16's progress note, dated 4/21/26 at 7:00 a.m., indicated R16 complained of chest pain and left arm pain radiating to his neck since 4-5:00 a.m., and 911 was called. R16's Hospital Cardiology History and Physical, dated 4/21/26, indicated R16 presented with acute-on-chronic systolic heart failure. R16's Hospital Discharge Orders, dated 4/23/26, indicated R16 was hospitalized for heart failure and left shoulder/arm pain likely musculoskeletal in nature, and medication changes included a furosemide (Lasix) dose and frequency increase to furosemide 10mg daily for excess fluid.	F0684	Continued from page 6 PRN medications were administered per physician order Effectiveness monitoring and follow-up documentation were completed Time/frequency parameters were followed appropriately Any concerns identified during the audit were corrected immediately. Systemic Changes / Measures Put Into Place: Licensed nursing staff were re-educated on: Following physician orders exactly as written PRN medication parameters and indications Documentation of need and effectiveness Notification requirements for ineffective PRN use or change in condition Medication administration policy and resident rights Medication administration procedures were reviewed during clinical meetings. Random MAR/TAR reviews will be conducted to ensure compliance with physician orders. Monitoring / Quality Assurance: The DON/Designee will conduct weekly audits of 5 random residents PRN medication administration records for 4 weeks, then monthly for 2 months. Audits will include documentation of indication, administration timing, effectiveness, and compliance with physician orders. Findings will be reviewed through the facility QAPI process, and additional education or corrective action will be	06/30/2026

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F0684 SS = D	Continued from page 7 R16's Provider Hospital Follow-up Visit Progress Note, dated 4/24/26, indicated an order for weight daily; update provider if up 3 pounds in a day 5 pounds in one week for diagnosis of heart failure. R16's Physician Order Report, signed by provider 5/20/26, indicated R16's PRN Lasix was decreased to Lasix (furosemide) 10mg by mouth once a day as needed (PRN) if weight up over 3 lbs in one day or 5 lbs/week, and call to update provider was ordered 4/23/26. R16's progress note, dated 5/15/26 at 10:29 a.m., indicated R16's weight was up 3 lbs in one day, provider was notified, and Lasix 10mg PRN was administered as per orders. R16's weight summary, printed 5/22/26, indicated R16's weight was 210 lbs on 5/16/26, no weight was recorded for 5/17/26, and R16's weight was 217.8 lbs on 5/18/26, which indicated a weight gain of 7.8 lbs in two day. However, R16's record lacked evidence that the provider had been notified of the weight gain. Additionally, Medication Administration Record (MAR) indicated Lasix 10 mg PRN was not administered to R16 on 5/18/26, as per provider orders. R16's Provider Update, dated 5/21/26 at 2:45 p.m., indicated R16 had elevation in weight intermittently with previous hospitalization for acute exacerbation of CHF, chart indicated R16 sent to hospital because of chest pain with pain in left arm and neck, R16 a full code patient with order for Lasix 10mg to be given if weight up 3 lbs., and R16 had known history of ischemic cardiomyopathy (heart's decreased ability to pump blood properly) and reduced ejection fraction of 30% (sign of heart failure). Provider indicated R16 chart revealed staff had not alerted provider of elevated weights. Provider felt R16 would benefit from a scheduled dose of Lasix rather than as needed at this time. R16's Provider Order, dated 5/21/26 at 2:45 p.m., indicated order to give Lasix 20mg currently, and scheduled Lasix 20mg every Monday, Wednesday, Friday, and recheck of basic metabolic profile (BMP) next lab day. Facility staff instructed to continue to monitor for evidence of chest pain or discomfort.	F0684	Continued from page 7 implemented as needed. Completion Date: Compliance achieved on 06/30/2026 and will be maintained ongoing.	06/30/2026

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F0684 SS = D	Continued from page 8 During interview on 5/21/26 at 9:43 a.m., registered nurse (RN)-A stated she obtained R16's weight on 5/18/26 before breakfast and verified R16's weight was 217.8 lbs. RN-A verified R16's documented weight on 5/16/26 was 210 lbs, and R16's weight was not documented for 5/17/26. RN-A stated she had not notified the provider of the weight increase on 5/18/26. RN-A stated she was not aware R16 had a Lasix PRN order and she had not administered the Lasix PRN on 5/18/26 as ordered. RN-A stated the provider should have been notified of the missed weight on 5/17/26, and of the weight increase from 5/16/26 to 5/18/26. RN-A stated it was important to follow provider orders to "address before things get worse" and avoid potential rehospitalization. During interview on 5/21/26 at 10:18 a.m., licensed practical nurse (LPN)-A acknowledged she obtained and documented R16's weight on 4/18/26 as 212.2 lbs. LPN-A verified R16's weight was 207.4 lbs on 4/17/26. LPN-A stated the provider should have been notified of the weight increase as per orders, but she failed to notify the provider on 4/18/26. LPN-A stated she was not aware R16 had a Lasix 20mg PRN order at that time and had not administered it to R16 as ordered. LPN-A stated the provider should have been notified of the weight gain and the PRN Lasix should have been administered as ordered. During interview on 5/21/26 at 1:37 p.m., assistant director of nursing (ADON) verified R16's weights were 207.4 lbs on 4/17/26 and 212.2 lbs on 4/18/26. ADON stated she would have expected the nurse to have administered the Lasix 20mg PRN and to have notified the provider as ordered. ADON stated R16 could have potentially not been hospitalized had orders been followed. During continued interview with ADON on 5/21/26 at 1:37 p.m., ADON stated it was the nurses' responsibility to know resident PRN orders. ADON verified R16's weight was 210 lbs on 5/16/26, and 217.8 lbs on 5/18/26. ADON acknowledged R16's record lacked evidence a weight was obtained on 5/17/26, as per orders. ADON stated R16's record lacked evidence the nurse notified the provider of the missed weight and of the weight gain. Additionally, ADON stated R16's record lacked evidence the nurse had administered the Lasix 10mg PRN as per orders. ADON stated it was important for	F0684		06/30/2026

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F0684 SS = D	Continued from page 9 nurses to follow these orders to prevent rehospitalization. During interview on 5/21/26 at 2:23 p.m., R16's primary provider (PCP) stated facility staff should have notified the provider for elevated weights as ordered. During interview on 5/22/26 at 1:32 p.m., director of nursing (DON) verified R16's documented weights from 4/17/26 and 4/18/26 indicated a 4.8-lb weight gain. DON stated she "100% expected" the nurse to have contacted the provider with the weight increase, expected the Lasix 20mg PRN to have been given as ordered, and would have expected R16's weight to have gone down had the PRN Lasix been administered. DON stated R16's rehospitalization could have "absolutely" been prevented if orders had been followed. Additionally, DON verified R16 was sent to the hospital due to chest pain, and "chest pain is a symptom of CHF exacerbation and anxiety". During continued interview with DON on 5/22/26 at 1:32 p.m., DON verified R16's weight was not obtained on 5/17/26, and R16's documented weights from 5/16/26 and 5/18/26 indicated a 7.8-lb weight gain. DON expected the nurse to have notified the provider when a daily weight was missed, expected the nurse to have notified the provider of the elevated weight on 5/18/26, and expected the nurse to have administered Lasix 10mg PRN on 5/18/26 as ordered. DON stated the errors could have resulted in another rehospitalization. The facility's Administering Medications Policy, revised 4/19, indicated medications are administered in accordance with prescriber orders, and medications are administered in a safe and timely manner.	F0684		06/30/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880	F0880- Corrective Action for Residents Affected: All residents with urinary catheters and Enhanced Barrier Precautions were immediately assessed for proper Donning and doffing of PPE, proper catheter care, catheter securement, drainage bag positioning, tubing patency, and signs/symptoms of infection. Any identified concerns were corrected immediately. Staff involved received re-education on facility care policy and infection prevention practices. R11 and	06/30/2026

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F0880 SS = D	Continued from page 10 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F0880	Continued from page 10 R44 have been corrected. Identification of Other Residents at Risk: An audit was completed on all residents with indwelling urinary catheters and EBP to ensure proper use of PPE and catheter care was being completed per physician orders, facility policy, and standard precautions. Newly admitted residents with catheters will be included in ongoing monitoring. Systemic Changes / Measures Put into Place: Licensed nurses and nursing assistants were re-educated on: Hand hygiene before and after catheter care Proper peri-care technique Securing catheter tubing appropriately Maintaining drainage bag below bladder level Preventing tubing kinks and dependent loops Documentation requirements Reporting signs/symptoms of UTI or catheter complications Proper use of PPE Facility catheter care policy was reviewed during staff meeting and clinical huddle along with use of PPE Catheter care competency validations and education on EBP and use of PPE will be completed for current and newly hired staff and reviewed annually	06/30/2026

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F0880 SS = D	Continued from page 11 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate personal protective equipment (PPE) was used for 2 of 2 residents (R11 and R44) who required enhanced barrier precautions (EBP). In addition, the facility failed to ensure nationally accepted standards of practice for bodily fluid removal from catheter drainage bag were followed for 2 of 2 residents (R11 and R44). Findings include: R11's admission Minimum Data Set dated 1/8/26, indicated R11 diagnosis included neurogenic bladder and cancer. R11 was total assist with toilet hygiene. R11 had an indwelling urinary catheter. An observation on 5/19/26 at 4:16 p.m., R11's room had a Centers for Disease Control and Prevention (CDC) sign that indicated EBP was to be worn when staff were doing high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing brief or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, and wound care: any skin opening requiring a dressing. Nursing assistant (NA)-B when in R11's room, put on gloves and told R11 what she was going to do. NA-B did not wear a gown as directed on the sign outside R11's room. NA-B placed paper towels on the ground and put the urinal on them. NA-B opened the catheter drainage bag spout and drained urine from catheter drainage bag into the urinal measuring 750 milliliters (ml). NA-B placed the urinal	F0880	Continued from page 11 IP or designee will conduct random observations of catheter care and PPE to ensure compliance. Monitoring / Quality Assurance: The DON/Designee will complete weekly catheter care audits and PPE for 4 weeks, then monthly for 2 months to ensure ongoing compliance. Audit results will be reviewed through the facility Quality Assurance and Performance Improvement process, with additional education provided as needed. Completion Date: Compliance achieved on 6/30 and will be maintained ongoing.	06/30/2026

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F0880 SS = D	Continued from page 12 on the paper towels on the floor. NA-B took soiled gloves off and put on clean gloves. NA-B hooked the catheter drainage bag to the side of the bed. NA-B used a washcloth fresh scent wipe to wipe the spout of the catheter drainage bag and placed the spout in the holder on the catheter drainage bag. NA-B took off soiled gloves and put on clean gloves then emptied the urinal in the toilet and rinsed it out and allowed to air dry. NA-B took the soiled gloves off, washed hands, and put clean gloves on to assist R11 with a brief change. NA-B had assistance from NA-C, she put on clean gloves while assisting R11 to change position. NA-B wiped R11's bottom from a bowel movement with washcloth fresh scent wipes. NA-B took off soiled gloves and put on clean gloves to place brief and secure it in place. Both NA-B and NA-C took off soiled gloves and washed their hands with soap and water. NA-B put new gloves on and took garbage to the soiled bin in the hallway. NA-B took gloves off and used hand sanitizer. An interview on 5/19/26 at 4:40 p.m., NA-B stated she had not worn a gown while assisting R11 and neither had NA-C. C44's Continuity of Care Document, undated, indicted diagnosis of vascular dementia and benign prostatic hyperplasia. An observation on 5/19/26 at 6:14 p.m., R44's room had a Centers for Disease Control and Prevention (CDC) sign that indicated EBP was to be worn when staff were doing high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing brief or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, and wound care: any skin opening requiring a dressing. NA-A was in R44's room with gloves on emptying the urinary catheter drainage bag. NA-A was standing next to R44's wheelchair holding the urinary catheter drainage bag up to her shoulders and holding the urinal in the other hand under the spout of the catheter drainage bag. NA-A stated there was 600ml in the urinal. NA-A placed the catheter drainage bag on R44's wheelchair and put the spout in the holder. NA-A emptied the urinal in the toilet and rinsed it and let air dry. NA-A did not wipe the spout with an alcohol wipe before putting the spout back in the holder.	F0880		06/30/2026

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F0880 SS = D	Continued from page 13 An interview on 5/19/26 at 6:28 p.m., NA-A stated she had emptied the urinary catheter drainage bag while standing up. NA-A stated she did not wear the gown like the EBP sign indicated. An interview on 5/22/26 at 9:04 a.m., with the infection preventionist (IP) stated urinary catheter cares are done during a skills in-service which is mandatory for staff to attend. IP stated staff should wear gowns and gloves when draining urinary catheter drainage bags. IP indicated that staff should keep the urinary catheter drainage bag below the level of the bladder while draining it and when they secure to the bed or wheelchair. IP stated staff should be cleaning the urinary catheter drainage bag spout with alcohol wipe not a washcloth fresh scent wipe. IP stated urinary tract infections were prevalent at the facility. The facility procedure Emptying a Urinary Collection Bag dated 2001, indicated to keep the collection bag below the level of the resident's bladder. Steps in the procedure include: place the clean equipment on the bedside stand or over bed table. Arrange supplies so they can be easily reached. wash and dry hands thoroughly put on disposable gloves. place a paper towel on the floor beneath the drainage bag, position the measuring container under the collection bag. remove the drain tube from its holder. unclamp the valve on the drain spout and let the urine flow into the measuring container. after the drainage bag has emptied, clamp the valve. wipe the drain with an alcohol sponge or swab,	F0880		06/30/2026

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F0880 SS = D	Continued from page 14 discard the sponge swab into the designated container. replace the drain spout back in its holder. measure and record the urinary output, if indicated. pour urine down the commode, flush the commode. rinse the measuring container and return to its designated storage area. discard all disposable items int designated containers. remove gloves, wash and dry hands. clean the bedside stand and/or overbed table, return the overbed table to its proper position. reposition the bed covers, make resident comfortable. place the call light within easy reach of resident. wash and dry your hands.	F0880		06/30/2026
F0568 SS = A	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and	F0568		06/30/2026

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F0568 SS = A	Continued from page 15 upon request. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure resident trust account statements were provided on at least a quarterly basis for 1 of 1 residents (R43) reviewed for personal fund accounts. Findings include: R43's quarterly Minimum Data Set (MDS) dated 01/26/26, indicated R43 admitted to the facility on 4/28/25, had a BIMS of 13 indicating he was cognitively intact and had the following diagnoses: Coronary Artery Disease, High Blood Pressure, Peripheral Vascular Disease and Anxiety During interview on 5/19/26 at 2:54 p.m., R43 stated the facility managed his spending money and if he needed money, he would ask the social worker (SW) or the business office manager (BOM). R43 stated he did not receive any monthly statements or any kind of itemized statement reflecting activity on his account. During interview 5/22/26 at 1:44 p.m., Business Office Manager (BOM) stated she had not provided any resident spending account statements to any residents in the 3 months she had been employed by the facility. BOM stated the residents would come to her office and she would tell them what they have available. BOM stated the last statement should have gone out on 1/31/26, however she could not locate any document to support this. During interview on 5/22/26 at 3:26 p.m., BOM stated she was unable to locate any quarterly statements for the residents and "It wasn't done as far as I can tell". A policy was requested but not provided.	F0568		06/30/2026
F0640 SS = A	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	F0640		06/30/2026

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F0640 SS = A	Continued from page 16 (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.	F0640		06/30/2026

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F0640 SS = A	Continued from page 17 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure Minimum Data Set (MDS) assessments were submitted timely for 2 of 2 residents (R10, R48) reviewed for transmission of resident assessments. Findings include: R10's quarterly MDS assessment dated 4/17/26, indicated the MDS assessment was electronically signed by the MDS coordinator (RN)-A verifying assessment completion on 4/30/26. The facility's Case Mix Review (CMR) Validation report dated 5/20/26, indicated R10's 4/17/26, quarterly MDS was submitted on 5/18/26, which was greater than 14 days after MDS assessment completion date of 4/30/26. The Centers for Medicare and Medicaid Services (CMS) MDS 3.0 NH Final Validation Report dated 5/18/26, indicated R10's 4/17/26 MDS assessment "record submitted late" and "submission date is more than 14 days after Z0500B (completion date)". R48's quarterly MDS assessment dated 4/16/26, indicated the MDS assessment was electronically signed by RN-A verifying assessment completion on 4/29/26. The facility's Case Mix Review (CMR) Validation report dated 5/20/26, indicated R48's 4/16/26, quarterly MDS was submitted on 5/18/26, which was greater than 14 days after MDS assessment completion date of 4/29/26. The Centers for Medicare and Medicaid Services (CMS) MDS 3.0 NH Final Validation Report dated 5/18/26, indicated R48's 4/16/26, MDS "record submitted late" and "submission date is more than 14 days after Z0500B". During an interview on 5/22/26 at 1:01 p.m., RN-A stated the quarterly MDS assessments for R10 and R48 were submitted late and should have been submitted to CMS within 14 days of completion.	F0640		06/30/2026

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(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
F0640 SS = A	Continued from page 18 During an interview on 5/22/26 at 1:32 p.m., the director of nursing (DON) stated the MDS coordinator was expected to submit MDS assessments per regulations. Additionally, DON stated the facility did not have a policy regarding the submission of MDS assessments and instead referenced the Resident Assessment Instrument (RAI) manual.	F0640		06/30/2026
E0006	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan.	E0006	E0006 – Plan Based an All-Hazards Risk Assessment 1. How the corrective action will be accomplished for those residents to have been affected by the deficient practice. MNH will complete the all-hazards vulnerability assessment at the monthly Safety Team meeting. Facilities Operations Director will contact the Plymouth Fire Department to attend the monthly Safety Team meeting. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. MNH will follow its six-step HVA process to identify any systemic changes that need to be made and any residents that could be impacted by the deficient practice. 3. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected will not recur. MNH will monitor its completed All-Hazards assessment and any corrective actions at daily Interdisciplinary meetings and monthly Safety Team meetings. 4. The date each deficiency will be corrected. June 30, 2026 5. An electronic acknowledgement signature and date by an official facility representative. Will Moncrief	06/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD , 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
E0006	Continued from page 19 The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Preparedness Plan (EPP) included a comprehensive, all-hazards facility-based and community-based risk assessment. This had the potential to affect all 61 residents, visitors, and staff at the nursing home. Findings include: The facility's EPP lacked a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach. The EPP indicated a risk assessment was included in the EPP's attachments; however, no attachments were received or located. The annual facility assessment dated 6/2026, indicated the community all-hazards assessment was located under appendix B in the EPP binder, however none was located or provided. On 5/22/26 at 3:03 p.m., the administrator stated	E0006		06/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/22/2026

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E0006	Continued from page 20 they were responsible for maintaining the EPP binder and confirmed the assessment was not in the book or appendices. The policy for the EP program was requested via email on 5/22/26 at 3:28 p.m., and none was provided.	E0006		06/30/2026
E0026	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness plan (EPP) included policies and procedures to address and identify the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, (a waiver designed to waive specific regulatory requirements in order to more easily provide needed care in an emergency situation) in the provision of	E0026	E0026 – Roles Under a Waiver Declared by Secretary 1 How the corrective action will be accomplished for those residents to have been affected by the deficient practice. MNH will prepare a 1135 policy that will be included in its Emergency Preparedness manual. MNH staff will be trained in where to locate the MNH 1135 policy and procedures. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. MNH will ensure an updated 1135 policy is included in its Emergency Preparedness plan going forward. MNH will also ensure staff are trained in this policy. 3. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected will not recur. MNH will ensure an updated 1135 policy is included in its Emergency Preparedness plan going forward. 4. The date each deficiency will be corrected. June 30, 2026 5. An electronic acknowledgement signature and date by an official facility representative. Will Moncrief	06/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/22/2026

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MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD , PLYMOUTH, Minnesota, 55441

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E0026	Continued from page 21 care and treatment at an alternate care site identified by emergency management officials. This had the potential to affect all 61 residents currently residing in the facility. Findings include: Review of the facility's EPP lacked evidence of a policy or procedure for addressing the facility's role under a 1135 waiver declared by the Secretary during an emergency to provide services at an alternate site for their residents. On 5/22/26 at 3:03 p.m. the administrator verified they were the ones responsible for formulating the emergency preparedness program and confirmed they did not have the waiver in place. The policy for the EP program was requested via email on 5/22/26 at 3:28 p.m. and none was provided.	E0026		06/30/2026
E0036	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing	E0036	E0036 – EP Training and Testing 1. How the corrective action will be accomplished for those residents to have been affected by the deficient practice. MNH will develop and maintain a comprehensive Emergency Preparedness training and testing program that will include a full-scale community-based exercise and tabletop. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur. MNH will develop and maintain a comprehensive Emergency Preparedness training and testing program that will include a full-scale community-based exercise and tabletop. MNH will evaluate and adjust its training program as deemed necessary at IDT and during the monthly Safety Team meeting. 3. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected will not recur. MNH will monitor the status of its training and testing program and community-based exercise at the monthly Safety Team meeting and at daily IDT	06/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/22/2026

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E0036	Continued from page 22 program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is NOT MET as evidenced by: Based on document review and interviews, the facility failed to develop and maintain an emergency preparedness (EP) training and testing program which was based on the emergency plan, risk assessment, policies and procedures. This had the potential to affect all 61 residents residing at the facility. Findings include: During review of the facility's EP program last revised 12/30/25, it was revealed the EP program lacked evidence of a required full-scale community-based exercise. On 5/22/26 at 3:49p.m., the administrator and director of nursing confirmed they did not complete	E0036	Continued from page 22 meetings. 4. The date each deficiency will be corrected. June 30, 2026 5. An electronic acknowledgement signature and date by an official facility representative. Will Moncrief	06/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/22/2026

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E0036	Continued from page 23 the required full-scale community-based exercise. The policy for the EP program was requested via email on 5/22/26 at 3:28 p.m., and none was provided.	E0036		06/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing Home	**3401 EAST MEDICINE LAKE BOULEVARD , PLYMOUTH, Minnesota, 55441**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 05/19/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Mission Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		06/26/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email 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. Mission Nursing Home 2-story building was constructed in 1995 and was determined to be of Type II (111) construction. It has a full basement and is automatic sprinkler protected throughout. The facility has a fire alarm system that is monitored for fire department notification. The facility has a capacity of 70 beds and had a census of 60 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		06/26/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K0345	K0345 – Fire Alarm System – Testing and Maintenance 1. A detailed description of the corrective action taken or planned to correct the deficiency. MNH maintenance communicated with the fire alarm system vendor. The vendor now this in their system	06/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

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K0345 SS = F Bldg. 01	Continued from page 2 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, section 9.6.1.3 and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.2.1.2.2,14.3.1, 14.4.5, 14.4.5.3.1, 14.4.5.3.2, and 14.4.5.3.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1.On 05/19/2026at 2:00 PM, it was revealed by a review of available documentation that the annual fire alarm inspection report could not be provide at the time of inspection. 2.On 05/19/2026 at 2:00 PM, it was revealed by a review of available documentation that the facility was unable to show evidence of completion of the sensitivity testing of the smoke detectors. An interview with the Director of Facilities Maintenance and the Maintenance Technician verified these deficient findings at the time of discovery.	K0345	Continued from page 2 set up as reminder. MNH maintenance will ensure this testing takes place going forward. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. MNH maintenance communicated with the fire alarm system vendor. The vendor now this in their system set up as reminder. MNH maintenance will ensure this testing takes place going forward. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. MNH will monitor the fire alarm system testing in its work order and tickler system called TELS. 4. Identify who is responsible for the corrective actions and monitoring of compliance. MNH Maintenance and the vendor will be monitoring this going forward. 5. The actual or proposed date for completion of the remedy. Completion of the remedy occurred on 5/26/2026	06/15/2026
K0521 SS = F Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 and 6.5.12. This deficient finding could have a widespread impact on	K0521	K0521 - HVAC 1. A detailed description of the corrective action taken or planned to correct the deficiency. MNH maintenance communicated with the HVAC vendor. The vendor now this in their system set up as reminder. MNH maintenance will ensure this testing takes place going forward. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. MNH maintenance communicated with the HVAC vendor. The vendor now this in their system set up as reminder. MNH maintenance will ensure this testing takes place going forward. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.	06/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

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K0521 SS = F Bldg. 01	Continued from page 3 the residents within the facility. Findings include: On 05/19/2026 at 12:45 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the dampers were inspected since 04/22/2022. An interview with the Director of Facility Operations and the Maintenance Technician verified this deficient finding at the time of discovery.	K0521	Continued from page 3 MNH will monitor the HVAC testing in its work order and tickler system called TELS. 4. Identify who is responsible for the corrective actions and monitoring of compliance. MNH Maintenance and the vendor will be monitoring this going forward. 5. The actual or proposed date for completion of the remedy. Completion date of 6/30/2026	06/30/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/19/2026 at 12:43 PM, it was revealed by a review of available documentation that fire drills were not completed under varied conditions during the second and third shifts. An interview with the Director of Facilities Operations and the Maintenance Technician verified this deficient finding at the time of discovery.	K0712	K0712 – Fire Drills 1. A detailed description of the corrective action taken or planned to correct the deficiency. MNH will stagger fire drills monthly so the times are appropriately varied. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. MNH maintenance will monitor the timing differences and stagger the fire drills times to appropriately comply with the fire drill statute. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. MNH maintenance will create a calendar with varied scheduled times. 4. Identify who is responsible for the corrective actions and monitoring of compliance. MNH maintenance. 5. The actual or proposed date for completion of the remedy. 6/15/2026	06/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing Home	**3401 EAST MEDICINE LAKE BOULEVARD , 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
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterened impact on the residents within the facility. Findings include: 1. On 05/19/2026 at 1:44 PM, it was revealed by observation that two refrigerators were plugged into a power strip in Room 202 the nursing supplies room. 2. On 05/19/202 at 2:05 PM, it was revealed by observation that a refrigerator, microwave and a coffee pot were all plugged into a power strip in the therapy room. An interview with the Director of Facilities Operations and the Maintenance Technician verified these deficient findings at the time of discovery.	K0920	K0920 – Electrical Equipment – Power Cords and Extensions 1. A detailed description of the corrective action taken or planned to correct the deficiency. Extension cords/power strips will be monitored and checked on an ongoing basis. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. The ongoing monitoring and checking will be placed in the TELS work order system for MNH maintenance. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The TELS work order system will have this as a task for MNH maintenance to check on. 4. Identify who is responsible for the corrective actions and monitoring of compliance. MNH maintenance is responsible. 5. The actual or proposed date for completion of the remedy. 6/26/2026	06/26/2026