Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 18 2023

Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, MN 55441

RE: CCN: 245546
Cycle Start Date: July 12, 2023

Dear Administrator:

On October 20, 2023, we notified you a remedy was imposed. On October 13, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 10, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 12, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 10, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 12, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 10, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 18 2023

Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, MN 55441

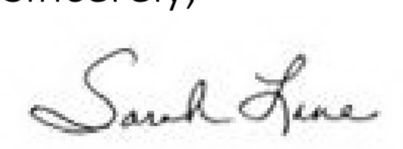
Re: Reinspection Results
Event ID: KUB012

Dear Administrator:

On September 8, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 12, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 10, 2023

Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, MN 55441

RE: CCN: 245546
Cycle Start Date: July 12, 2023

Dear Administrator:

On July 12, 2023, 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, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 October 12, 2023 (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 January 12, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

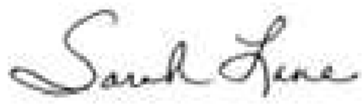
specified for compliance or the imposition of remedies.

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245546	A. BUILDING _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD 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 7/10/23 to 7/12/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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.	E 000		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or	E 039		8/18/23

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

Electronically Signed | 08/20/2023

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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E 039	Continued From page 1 (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not	E 039		

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E 039	Continued From page 2 accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community	E 039		

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E 039	Continued From page 3 based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.	E 039		

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E 039	Continued From page 4 (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional	E 039		

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E 039	Continued From page 5 exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 6 (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 7	E 039		

a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at
least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.
(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group

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E 039	Continued From page 8 discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated,	E 039		

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	245546	A. BUILDING _____ B. WING _____	C 07/12/2023

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E 039	Continued From page 9 clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct exercises to test their Emergency Preparedness Plan (EPP), at least twice per year, including participation in a full-scale table-top exercise. This had the potential to affect all 55 clients who resided in the facility, and staff who worked in the facility. Findings include: On 7/12/23, the facilities Emergency Preparedness Plan (EPP), undated, failed to address an annual full-scale, internal, or table-top exercise to test the facility's response to an emergency over the last year. On 7/12/23, at 2:35 p.m., the administrator acknowledged EPP testing had not been completed annually as required. A policy for emergency plan testing and exercises was requested while on survey and not provided.	E 039	E039 EPP Testing. Corrective action will be accomplished by conducting an unannounced table top exercise every 6 months or 2x per calendar year. This will be a staff training conducted by a facilitator using a relevant emergency scenario in a deliberate attempt to challenge the plan. Afterwards, an analysis of the exercise will be discussed and documented. Any natural disaster that happens in the event of an unplanned emergency will also be analyzed and documented. The campus safety director will schedule this in advance for every 6 months or 2x per calendar year, choose a relevant event for approval from leadership and conduct the exercise. A periodic audit of Emergency Preparedness will be conducted quarterly to determine if compliance is met and corrective action will not recur. Additional monitoring of deficiencies and corrective actions will be monitored and discussed at monthly safety meetings. In the event of an actual emergency that requires activation of the emergency plan, the event will be documented as one of the	

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E 039	Continued From page 10	E 039	two required table top exercises per calendar year.	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing,	E 041		8/18/23

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E 041	Continued From page 11 and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.	E 041		

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E 041	Continued From page 12 (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.2, 8.3.3, 8.3.4, 8.3.7, 8.4.1, 8.4.2.4, 8.4.8, 8.4.9, 8.4.9.1, and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 07/12/2023 between 12:15 PM and 04:00 PM, it was revealed by a review of available	E 041	E041 Emergency Power Plan. Emergency generator inspection and testing will be done in the following manner: a 4-hour load test will be conducted every 36 months beginning 8/31/23 and every 3rd August thereafter by an outside contracted vendor specializing in emergency power systems. A Level 1 and Level 5 inspection and maintenance plan has been contracted with an outside vendor specializing in emergency power systems to occur every August beginning in 2023. Maintenance staff will conduct a weekly visual inspection of the generator	

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E 041	Continued From page 13 documentation that the facility was unable to provide documentation that showed weekly inspections of the emergency generator were being completed. 2. On 07/12/2023 between 12:15 PM and 04:00 PM, it was revealed by a review of available documentation that the facility was unable to provide documentation showing the generator had been tested for at least four hours within the last 36 months. An interview with the Administrator and Maintenance Coordinator verified this deficient finding at the time of discovery.	E 041	and document normal observations and make and document any necessary adjustments. Maintenance staff will conduct a monthly test of the generator and document normal observations and, if any maintenance is determined to be necessary, will contract with an outside vendor who specializes in emergency power systems to correct the maintenance issues immediately. This will prevent deficient practices in the future that impact any present or future residents. All logs will be made available for review by DHS survey team at any given time.	
F 000	INITIAL COMMENTS On 7/10/23 through 7/12/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiencies issued: H55463315C (MN92429), H55463327C (MN92225), H55463328C (MN92223), H55463329C (MN88458), H55463330C (MN88455), H55463331C (MN89998) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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	F 000		

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F 000	Continued From page 14 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		8/28/23

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F 550	Continued From page 15 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to honor residents right to refuse care for 1 of 1 resident (R10) reviewed for resident rights. Findings include: R10's Minimum Data Set (MDS) was "in process". R10's medical diagnoses list dated 6/28/23, indicated R10 had diagnoses which included adjustment disorder, antisocial personality disorder, phobic anxiety disorder, generalized anxiety disorder and major depressive disorder. R10's care plan dated 6/28/23, indicated R10 was an independent smoker and was allowed to vape in his room due to his current wound issues and would be reminded of the smoking rules and would change him to a monitored smoking program per policy if he did not follow them. A general nursing order dated 7/8/23, indicated to take R10's vaping privileges away if he refused any cares such as repositioning, catheter care, getting up for lunch and wound care.	F 550	F550¿ MNH strives to treat each resident with dignity and respect in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.¿¿ DON & LSW had a discussion with R10 regarding the smoking policy and the risk of vaping in his room. DON and LSW discussed the revised smoking policy with R10 as well and he is agreeable to the policy. The charts of all residents who smoke have been¿reviewed and updated as necessary.¿ The smoking policy has been reviewed and updated where necessary.¿ All residents will have signed the new smoking policy, and all staff will be educated regarding the new policies by September 1, 2023, when mandatory state survey training is completed. Staff will also receive education to be mindful of	

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F 550	Continued From page 16 During an interview on 7/10/23 at 1:58 p.m., R10 stated the staff would punish him if he refused cares by threatening to take away his vape. R10 stated he would not do anything he did not want to for anyone. R10 stated the reason he refused cares was because he was in pain related to the wounds on his feet and he did not like to be around other people. R10 stated he felt he was given an ultimatum to comply or else he would lose his vape which helped keep him calm and reduced his anxiety. R10 stated the thought of not being able to vape was distressing and caused him to have anxiety. During an interview on 7/11/23 at 8:33 a.m., registered nurse (RN)-A stated R10 had a history of being noncompliant with activities of daily living (ADLs). RN-A stated R10 had special privileges to use his vape in his room due to the wounds on his feet. RN-A stated the facility used R10's vape privilege as an incentive and would take it away if R10 was noncompliant. RN-A stated this worked the other day because after R10 was told he would not be able to keep or use his vape if he didn't get out of bed, R10 got out of bed and sat in his chair for approximately 30 minutes. During an interview on 7/11/23 at 5:10 p.m., director of nursing (DON) stated all residents were assessed for smoking/vaping upon admission, annually and with significant change to determine if the resident could be independent or required modified assistance with smoking/vaping. DON stated residents who smoke/vape signed the smoking policy and by signing the policy acknowledged that smoking was a privilege and not a resident right, therefore smoking privileges could be taken away for	F 550	their approach when encouraging resident care. All care plans will be reviewed and revised as necessary to ensure compliance with the smoking program.¿ SS will audit for compliance (after September 1, 2023) 2x week for 2 weeks, and then monthly x 3 months. Policy Statement Mission Nursing Home facility maintains safe resident smoking practices. Policy Interpretation and Implementation MNH offers smoking of commercially available tobacco in this facility's designated smoking areas as a privilege for those who are wanting to smoke, and have the ability to do so safely, All residents are assessed for function, cognition, and financial ability to participate in the smoking program. All residents, whether independent smokers or monitored smokers, must adhere to the stipulations and rules of the program to maintain the privilege to participate in the smoking program. 1. Upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 2. Smoking is only permitted in	

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F 550	Continued From page 17 noncompliance of ADLs as indicated in said policy. DON stated the most common reason smoking privileges were taken away was for noncompliance with showers or incontinence. DON stated all staff could take away smoking/vaping privileges from a resident when necessary. DON stated the facility did not have a formal process that was followed when deciding to take away the smoking/vaping privileges. DON stated the facility did not often have to take away smoking/vaping privileges because as soon as the noncompliant resident was told their smoking/vaping privileges would be taken away if the desired task was not completed, most residents would then comply. DON reviewed smoking policy, confirmed it did not indicate smoking/vaping was a privilege, and further did not indicate a resident would not be able to smoke or vape for noncompliance with ADLs. DON stated the facility had a secondary policy that listed the ADL component but later stated no secondary policy could be located. During an interview on 7/11/23 at 5:27 p.m., the administrator stated he understood smoking and vaping was a privilege and not a resident right and could be taken away from a resident for noncompliance with ADLs. During an interview on 7/12/23 at 8:16 a.m., nursing assistant (NA)-A stated staff could take away a resident's smoking privilege if they felt it necessary to get the resident to complete a specific ADL. NA-A stated she had never taken away a resident's smoking/vaping privilege because she did not think it would be the right thing to do and felt it would be punishing the resident. "They have the right to refuse care". NA-A stated it didn't do the facility any good to	F 550	designated resident smoking areas which are located both inside and outside of the building. 3. Oxygen use is always prohibited in smoking areas. 4. Ashtrays are emptied into designated receptacles only. 5. The resident will be evaluated on admission to determine if he is a smoker or non-smoker. If a smoker, the evaluation will include: a. Current tobacco consumption. b. Method of tobacco consumption (cigarettes, e-cigs, pipes, vapes, etc). Large cigars may be smoked outside only. c. Resident's desire to quit smoking if a current smoker (cessation will be offered to all smokers). Residents are responsible for the cost of smoking cessation materials, unless covered by insurance. Only nicotine patches are allowed in-house; no nicotine lozenges, gum, or inhalers are allowed. Items will be managed as a medication and will be administered by the nursing department. Black box warnings will be adhered to closely. d. Ability to smoke safely with or without supervision (per protocol). 6. The staff shall consult with Therapy services, Social Services, and DON/ADON to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Smoking Evaluation. 7. A resident's ability to smoke safely will be re-evaluated quarterly, upon significant change (cognitive or physical), and as determined by staff.	

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F 550	Continued From page 18 take smoking/vaping privileges away because then they had to deal with angry and aggressive behaviors. NA-A stated she was unaware of staff training on the process to follow if they removed smoking/vaping privileges. During an interview on 7/12/23 at 8:33 a.m., social services (SS)-A stated the facility did not have set rules or a formal process to follow when deciding if a residents' smoking/vaping privileges would be taken away. SS-A stated she would normally give the resident a warning instead of taking away smoking/vaping privileges because that caused the residents to become angry, verbally aggressive, and disruptive to others. A facility policy requesting, refusing and/or discontinuing care or treatment dated, February 2021 indicated residents had the right to request, refuse and/or discontinue treatment and would not under any circumstance be coerced, intimidated, manipulated, or threatened for refusing care or treatment.	F 550	8. Any smoking related privileges and/or restrictions, (ex – need for smoke monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues via the smoking flow sheet. 9. The facility may impose smoking restrictions on a resident at any time if determined that the resident cannot smoke safely with available levels of support and supervision, or if they cannot follow the Rules of Participation for the Smoking Program, which are as follows: a. Residents must comply with designated rules of smoking program and compliance with designated smoking times and policies to maintain participation in the smoking program. b. Residents must buy their own cigarettes and must follow this smoking policy signed by resident and/or guardian and/or responsible party at the time of admission to maintain participation in the smoking program. c. Residents must comply with all safety recommendations determined during safety evaluation to maintain participation in the smoking program. 10. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff or family member, visitor, or volunteer worker always while smoking. 11. All residents with monitored smoking privileges must always keep cigarettes, e-cigs, vapes, pipes, tobacco, and other	

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F 550	Continued From page 19	F 550	smoking articles at the smoke monitor desk when not smoking except in certain circumstances as documented on the individuals care plan. Independent smokers will be allowed to keep their cigarettes and lighters on their person. After one infraction they will lose privileges to maintain their own smoking items to ensure safety of all residents. 12. Matches are always prohibited, whether an independent smoker or modified smoker. 13. Lighters must always be kept at the front desk. Flame of any kind is never allowed past the front desk for the safety of everyone residing and working at MNH. 14. Residents are not permitted to give smoking articles to other residents, or they will lose their smoking privileges in increments, based on previous infractions. First offense: warning only; 2nd offense lose their smoking privileges for the rest of the day. 3rd or greater infractions will increase to loss of smoking privileges for 3 days per offense per offense. 15. Smoking hours are subject to change based on weather, activities, staffing issues, and other unforeseen circumstances. 16. Smoking cannabis, marijuana, hemp, products containing tetrahydrocannabinol (THC) or cannabidiol (CBD) and unauthorized vapes, on MNH property is absolutely prohibited (whether you have a permit or card). Items will be confiscated, and the police will be notified, as necessary, of your first offense. You will be immediately discharged if caught a second time.	

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	245546	A. BUILDING _____ B. WING _____	C 07/12/2023

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F 550	Continued From page 20	F 550	17. Staff members and volunteer workers are not permitted to purchase and/or provide any smoking articles for residents, unless arranged by designated staff. 18. This facility reserves the right to confiscate smoking articles found in violation of our smoking policies. 19. This policy and process is subject to change at any time depending on the surrounding consequences. My signature below indicates that I have read, understand, and agree to follow the stipulations put forth in the MNH Smoking Policy. Failure to provide a signature indicates that you are giving up the privilege to smoke on the premises of MNH. Resident/guardian/Responsible Party Signature Date Facility Representative Date	

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	245546	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/12/2023**

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MISSION NURSING HOME	**3401 EAST MEDICINE LAKE BOULEVARD** **PLYMOUTH, MN 55441**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/12/2023. 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/20/2023

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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 65 beds and had a census of 57 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain clear path of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/12/2023 at 02:55 PM, it was revealed by observation that there were wheelchairs, old mattresses, and laundry carts stored on both sides of the egress corridor in the basement near the physical therapy room. During an interview with the Maintenance Coordinator, he stated that the wheelchairs were waiting to be repaired and were non-operational. An interview with the Administrator and Maintenance Coordinator verified this deficient finding at the time of discovery.	K 211	All means of egress will be cleared to allow for swift and safe evacuation. Wheelchairs in need of repair will be placed inside a storage room located in the basement level to allow egress to remain cleared for evacuation. Laundry carts will be placed inside laundry room or soiled laundry room, or a designated side of the hallway allowing for egress to remain cleared for evacuation. The Maintenance and Housekeeping departments will be responsible for observing this rule and maintaining the cleared egress. Regularly scheduled inspections will be conducted by Maintenance and Housekeeping, and reported on in each monthly Safety Committee meeting. A checklist form will be established to document these observations and kept in the Life Safety manual for NFPA inspections. Correction of this violation will begin immediately.	8/20/23

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K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwells per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1, 19.2.2.3, 7.2.1.4.5.1, and 7.2.2.5.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/12/2023 at 02:38 PM, it was revealed by observation that the door exiting out of stairwell "C" in the West Wing was difficult to open exceeding 30lbf to open. 2. On 07/12/2023 at 02:53 PM, it was revealed by observation that there was a ladder stored in stairwell "A". An interview with the Administrator and Maintenance Coordinator verified this deficient finding at the time of discovery.	K 225	All corridors and stairwells will remain cleared of ladders and other tools for the purpose of repairs, and will be cleared at the end of each work day regardless of the status of the repair. A work order to correct the exiting door to stairwell C has been entered in to the Tels system and will be corrected immediately by the Maintenance department. Follow up will be conducted on 8/21/23 by Director of Facilities with maintenance staff. Monthly inspections of exiting doors will be conducted by Director of Facilities or maintenance staff and documented through Tels to show evidence that life safety code is critical for protecting residents and staff.	8/20/23
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour	K 321		8/20/23

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K 321	Continued From page 4 fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, 7.2.1.8.1, and 7.2.1.8.2. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 07/12/2023 at 02:28 PM, it was revealed by	K 321	Hazardous rooms being held open by magnets must drop when fire alarm panel is activated. The fire alarm panel will be re-inspected immediately by UHL to test for magnet drop and annually thereafter. A test will be conducted for magnet drop of maintenance shop door and storage room door. If it found that those magnets are not releasing when the fire panel is activated, a repair will be made that day by UHL. Fire alarm panel testing and	

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K 321	Continued From page 5 observation that the door to the Maintenance Shop on the lower level was being held open by a magnet that does not drop with the fire alarm panel. 2. On 07/12/2023 at 02:29 PM, it was revealed by observation that the door to the storage room on the lower level was being held open by a magnet that does not drop with the fire alarm panel. An interview with the Administrator and Maintenance Coordinator verified these deficient findings at the time of discovery.	K 321	inspection will include magnet drop going forward, and documented on annual inspection form. In addition, magnet drop will be noted during monthly fire drills throughout the building during each month□s drill, and documented on fire drill form.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		8/20/23

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K 324	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9)(C) and 19.3.2.5.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/12/2023 between 12:15 PM and 04:00 PM, it was revealed by observation that the stove in the physical therapy office did not have a locked switch that incorporated a timer. An interview with the Administrator and Maintenance Coordinator verified this deficient finding at the time of discovery.	K 324	Safety features for cooking equipment located within smoke compartments will have a locked switch with a timer, in the case where cooking equipment could be left on unintentionally. A request has been made for Hobart to come and inspect the equipment for the potential of installing a timer switch, and if one cannot be installed, the cooking equipment will be removed from that compartment, or replaced with a compatible unit so as to be in compliance with NFPA regulations. Hobart will be in the facility during the week of 8/28/23 to estimate the project and solve.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 353		8/20/23

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K 353	Continued From page 7 b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, observation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2, 5.2.1.1.1, 5.2.1.1.2, and 5.2.1.1.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/12/2023 between 12:15 PM and 04:00 PM, it was revealed by a review of available documentation that the facility did not have documentation showing that an inspection of the fire sprinkler system was completed during the fourth quarter of 2022. 2. On 07/12/2023 at 02:19 PM, it was revealed by observation that one of the sprinklers located in the first floor dining room had a large amount of dust built up on it. An interview with the Administrator and Maintenance Coordinator verified these deficient findings at the time of discovery.	K 353	The sprinkler system is inspected quarterly and annually under contract with Ahern Co. It was determined in the 4th quarter of 2022 that the inspection could not be completed due to ice buildup in the drain line, however Ahern failed to provide inspection documentation stating that result. A follow-up with Ahern will be made by the Director of Facilities to obtain that documentation, and all documentation of quarterly and annual inspections will be collected and placed in the Life Safety manual, so as to be available for NFPA inspections. Proper functioning of the sprinkler system will be prioritized to protect the lives of residents and staff in the event of a fire.	

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K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.1.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/12/2023 at 02:49 PM, it was revealed by observation and a review of available documentation that there were no monthly inspections completed on the fire extinguisher located in the laundry room in the basement. 2. On 07/12/2023 at 03:08 PM, it was revealed by observation and a review of available documentation that the fire extinguisher located at the beginning of the north wing on the second floor did not have monthly inspections completed during May or June of 2023. 3. On 07/12/2023 at 03:16 PM, it was revealed by observation and a review of available documentation that the fire extinguisher located near linen room 221 did not have monthly	K 355	All fire extinguishers located in the building will be inspected to observe for any malfunction and to note that they are fully charged and ready for use in the event of a fire. All inspections will be documented with the day of the month of the inspection on the tags attached to the extinguishers to provide evidence of inspection for NFPA inspections. A monthly reminder for will be set in the Tels task module so inspections and documentation will be kept up to date. Inspections will be conducted by a designated member of the maintenance staff and will be followed-up by Director of Facilities to ensure process is being adhered to. Regular monthly inspections will begin immediately in August 2023 and will continue each month thereafter.	8/20/23

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K 355	Continued From page 9 inspections completed during April, May, and June of 2023. 4. On 07/12/2023 at 03:28 PM, it was revealed by observation and a review of available documentation that the fire extinguisher located near dining room 108 did not have monthly inspections completed during May or June of 2023. An interview with the Administrator and Maintenance Coordinator verified these deficient findings at the time of discovery.	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or	K 363		8/20/23

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K 363	Continued From page 10 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.1 and 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/12/2023 at 03:29 PM, it was revealed by observation that the door to resident room 137 would not close and latch when attempted. An interview with the Administrator and Maintenance Coordinator verified this deficient finding at the time of discovery.	K 363	All corridor doors shall be tested for proper latching and gap between the bottom of the door and the floor, not to exceed 1. Room 137 was observed to not have the ability to latch. Room 137 corridor door failure to latch was remedied on July 31st, 2023. Housekeeping staff will be responsible for reporting any door not latching by entering a work order in Tels. Maintenance will be responsible to treat this request with high priority, as the door acts as a smoke barrier and protects the residents that reside in the rooms. All doors will be tested and observed for compliance that they latch properly and do not exceed the required gap on the bottom for smoke protection. Every door on a designated floor will be inspected quarterly so that every door in the building will be inspected at least annually for proper latching and bottom gap. Results	

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	245546	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/12/2023**

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MISSION NURSING HOME	**3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441**

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K 363	Continued From page 11	K 363	will be documented in Tels for evidence of inspection and/or repair.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/12/2023 at 02:26 PM, it was revealed by observation that there was a penetration in the smoke barrier above the smoke barrier doors near room B36 classroom. An interview with the Administrator and Maintenance Coordinator verified this deficient finding at the time of discovery.	K 372	All smoke barrier doors are inspected for gaps that would cause penetration by smoke. The smoke barrier door near classroom B36 will be repaired or replaced so as to provide proper protection from smoke penetration as a result of a fire. Inspections will be conducted each quarter and results documented in Tels, for access during an NFPA inspection. The penetration repair of the smoke barrier door near classroom B36 will be completed by 8/31/23. Maintenance will conduct the inspections of each smoke barrier door going forward and document the results, which will be followed up on by the Director of Facilities.	8/20/23

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K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical equipment per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 07/12/2023 at 03:04 PM, it was revealed by observation that the electrical panels located near room 243 soiled utility were unlocked. 2. On 07/12/2023 at 03:09 PM, it was revealed by observation that the electrical panels located near room 205 were unlocked. 3. On 07/12/2023 at 03:17 PM, it was revealed by observation that the electrical panels located near room 225 were unlocked. 4. On 07/12/2023 at 03:25 PM, it was revealed by observation that the electrical panels located near	K 511	Electrical panels located throughout the building will be locked and remain locked at all times. Inspections of panels will be conducted daily by maintenance staff to check for proper locking. The electrical panel located near room 243 has been locked. The electrical panel located near 205 has been locked. The electrical panel located near room 255 has been locked. The electrical panel located near room 121 has been locked. The electrical panel located near room 123 has been locked. Panels must be locked to guard against any danger to the residents and staff.	8/20/23

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K 511	Continued From page 13 room 121 were unlocked. 5. On 07/12/2023 at 03:26 PM, it was revealed by observation that the electrical panels located near room 123 were unlocked. An interview with the Administrator and Maintenance Coordinator verified these deficient findings at the time of discovery.	K 511		
K 712 SS=F	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 REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/12/2023 between 12:15 PM and 04:00 PM, it was revealed by a review of available documentation that the facility did not have	K 712	Fire drills are conducted one time per month during either 1st, 2nd, or 3rd shift. From 9pm to 6am, a silent walk-thru will be held in lieu of audible notification as allowed per NFPA regulations during the quarterly 3rd shift fire drill. Other months during 1st and 2nd shift fire drills, audible and visual notifications will be required to comply with life safety policy and to protect the residents and staff from possible widespread harm. Documentation for first quarter of 2023	8/20/23

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K 712	Continued From page 14 documentation showing that they conducted fire drills during the first, second, or third shifts during the first quarter of 2023. An interview with the Administrator and Maintenance Coordinator verified this deficient finding at the time of discovery.	K 712	fire drills will be located and turned in to Fire Marshal Hubbard for proof that those drills were conducted. Immediate 2nd shift fire drills will be conducted in August 2023 and shifts will be aligned with the proper calendar months thereafter. Then results of the drills will be noted on forms provided by the fire marshal and kept in the life safety book as well as documented electronically through Tels.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.2.1 and 5.2.4.2. These deficient findings could have a widespread impact on the residents within the facility.	K 761	Any fire doors and openings are subject to inspection. All smoke barrier doors and exit doors in the building will be inspected for latch and gap every 6 months and documented in Tels. Inspection of all doors will be conducted during 2nd half of 2023, and ongoing every 6 months thereafter. Inspections will be conducted	8/20/23

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K 761	Continued From page 15 Findings include: 1. On 07/12/2023 between 12:15 PM and 04:00 PM, it was revealed by a review of available documentation that the fire door inspection report that the facility provided did not include the items that were checked during the inspection. 2. On 07/12/2023 between 12:15 PM and 04:00 PM, it was revealed by a review of available documentation and staff interview that they were not inspecting all the fire doors in the facility. While looking at the fire door inspection form it was noticed that only stairwell exit doors were being inspected, and the Maintenance Coordinator stated that he did not know what doors needed to be inspected. An interview with the Administrator and Maintenance Coordinator verified these deficient findings at the time of discovery.	K 761	by a skilled maintenance technician that possesses the knowledge needed to meet compliance and make any necessary repairs, and will submit results to Director of Facilities to determine whether an outside contractor is need to make necessary repairs. The fire door inspection forms will be kept in the computer in Tels and made available for annual NFPA inspection.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 901		8/20/23

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K 901	Continued From page 16 Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/12/2023 between 12:15 PM and 04:00 PM, it was revealed by a review of available documentation that the facility was unable to provide an NFPA 99 Risk Assessment. An interview with the Administrator and Maintenance Coordinator verified this deficient finding at the time of discovery.	K 901	Facility Risk Assessment has been completed, and will be maintained per regulations. Available upon request.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are	K 914		8/20/23

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K 914	Continued From page 17 maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, sections 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/12/2023 between 12:15 PM and 04:00 PM, it was revealed by a review of available documentation that the electrical receptacle inspection form that the facility provided did not include physical integrity, continuity of grounding, polarity, and retention force. An interview with the Administrator and Maintenance Coordinator verified this deficient finding at the time of discovery.	K 914	Receptacle testing will be conducted annually and documentation will list physical integrity, continuity of grounding, polarity, and retention force. LIM circuits are tested after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. Results will be held in electronic form in Tels and made available for the fire marshal NFPA inspection when requested. All receptacle testing will be completed by 12/31/23 and will be conducted annually going forward. The maintenance technician on staff will be responsible for this task as long as they are qualified to observe and understand the required testing. If no staff is qualified to conduct the test, or if LIM circuits are needed to be tested, a licensed electrician will be contracted to perform the needed tests by the Director off Facilities.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918		8/20/23

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K 918	Continued From page 18 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.2, 8.3.3, 8.3.4, 8.3.7, 8.4.1, 8.4.2.4, 8.4.8, 8.4.9, 8.4.9.1, and 8.4.9.2. This deficient finding could have a	K 918	Emergency generator inspection and testing will be done in the following manner: a 4-hour load test will be conducted every 36 months beginning 8/31/23 and every 3rd August thereafter by an outside contracted vendor specializing in emergency power systems. A Level 1 and Level 5 inspection and maintenance plan has been contracted	

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K 918	Continued From page 19 widespread impact on the residents within the facility. Findings include: 1. On 07/12/2023 between 12:15 PM and 04:00 PM, it was revealed by a review of available documentation that the facility was unable to provide documentation that showed weekly inspections of the emergency generator were being completed. 2. On 07/12/2023 between 12:15 PM and 04:00 PM, it was revealed by a review of available documentation that the facility was unable to provide documentation showing the generator had been tested for at least four hours within the last 36 months. An interview with the Administrator and Maintenance Coordinator verified this deficient finding at the time of discovery.	K 918	with an outside vendor specializing in emergency power systems to occur every August beginning in 2023. Maintenance staff will conduct a weekly visual inspection of the generator and document normal observations and make and document any necessary adjustments. Maintenance staff will conduct a monthly test of the generator and document normal observations and, if any maintenance is determined to be necessary, will contract with an outside vendor who specializes in emergency power systems to correct the maintenance issues immediately. This will prevent deficient practices in the future that impact any present or future residents. All logs will be made available for review by DHS survey team at any given time.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 10, 2023

Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, MN 55441

Re: State Nursing Home Licensing Orders
Event ID: KUB011

Dear Administrator:

The above facility was surveyed on July 10, 2023 through July 12, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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	00235	A. BUILDING: _____ B. WING _____	C 07/12/2023

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, 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 indicated below. When a rule 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. INITIAL COMMENTS: On 7/10/23 to 7/12/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00235	A. BUILDING: _____ B. WING _____	C 07/12/2023

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with no deficiencies issued: H55463315C (MN92429), H55463327C (MN92225), H55463328C (MN92223), H55463329C (MN88458), H55463330C (MN88455), H55463331C (MN89998) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with	2 302		8/18/23

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2 302	Continued From page 3 this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided written or electronic information regarding training staff had received for dementia and/or Alzheimer's care. This had the potential to affect all 55 current residents, family members, and/or guardians, and consumers. Findings include: A review of the staff training program titled Dementia management and abuse prevention, which included training for all staff providing care for residents with dementia and/or Alzheimer's was completed by all staff. During interview on 7/12/23 at 7:30 a.m., director of nursing (DON) stated all staff were trained on dementia care upon hire and annually. However, the facility didn't post the training nor notify the consumers, family members, and /or guardians either via written or electronic notification of staff training related to Alzheimer's or Dementia. During interview on 7/12/23 at 7:45 a.m., social service designee (SS-A) confirmed there was no notification of consumers, family members, and /or guardians either via written or electronic notification of staff training related to Alzheimer's or Dementia. SUGGESTED METHOD OF CORRECTION: The facility could review the Minnesota statutes for dementia training and develop a written or	2 302	Facilities for Alzheimer's Disease or Related Disorder Policy-Residents Policy Statement The facility provides annual on-line and in person training, for all employees: in the basic dementia/ Alzheimer□s topics covered below. Policy 1. Upon admission, residents and resident families/representatives shall be informed of the facility dementia training policy for all staff. 2. Areas of training include: a. Recognition of the strengths that persons with dementia retain. b. Person-centered, relationship-based care. c. Explanation of Alzheimer□s disease and related disorders d. Assistance with activities of daily living. e. Effective communication skills f. Problem solving strategies for challenging behavioral expressions. g. Interactive exercises with role-play opportunities. Mission Nursing Home serves residents with Alzheimer's disease or related disorders. This facility has reviewed the Minnesota statutes for dementia training and has developed a written means of	

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2 302	Continued From page 4 electronic means of communication for the dementia training to the consumer. The facility could implement the communication into their admission process. The facility could then create and implement an auditing system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	communication for the dementia training to the consumer. Mission Nursing Home has implemented the communication of said training into the admission process which includes giving the residents, resident families/representatives a copy of policy which states that all staff have received training and the areas of training are included (see policy). This policy will be audited as part of our Quality Assurance program to maintain compliance. Auditing will be completed with each new admission for the next six months to ensure they have received the policy and understand the training the staff receives. Current resident/families/resident representative have been given a copy of the policy effective 8/18/2023. This policy will be reviewed with each resident/families/resident representative at all future care conferences to ensure ongoing compliance and address any questions they may have. Completion date 8/18/2023.	