Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 10, 2025

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

RE: CCN: 245546
Cycle Start Date: March 12, 2025

Dear Administrator:

On March 14, 2025, we informed you that we may impose enforcement remedies.

On April 24, 2025, we notified you a remedy was imposed.

On May 20, 2025, the Minnesota Department of Health 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 May 9, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 9, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of April 24, 2025, 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 May 9, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 9, 2025, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies.**

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 10, 2025

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

Re: Reinspection Results
Event ID: Y2QF12

Dear Administrator:

On April 24, 2025, 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 March 12, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

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

RE: CCN: 245546
Cycle Start Date: March 12, 2025

Dear Administrator:

On March 12, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 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 June 12, 2025 (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 September 12, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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 03/12/2025

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 3/10/25 to 3/12/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/10/25 to 3/12/25, 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. The following complaints were reviewed with NO deficiencies cited: H55469021C (MN00111092) H55469025C (MN00106045) H55469027C (MN00106074) H55469028C (MN00104860) H55469602C (MN00111262) H55469401C (MN00111265). 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 be used as verification of compliance.	F 000		

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

Electronically Signed | 03/21/2025

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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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.	F 645		4/18/25

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F 645	Continued From page 2 §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a level II pre-admission screen and resident review (PASSAR) was	F 645	1. R54 has been discharged from the facility, discharged on 3/12/25 2. Because all residents could be at risk,	

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F 645	Continued From page 3 completed prior to admission for 1 of 1 residents (R54) reviewed who required a level II PASSAR screening for mental illness. Findings include: R54 quarterly minimum data set (MDS) dated 2/26/25, indicated R54 was cognitively intact, and had experienced feeling down, hopeless or depressed, had trouble falling asleep or staying asleep, felt tired or had little energy, and had difficulty concentrating on things at least half or more days in the two weeks prior to the assessment. R54's face sheet printed 3/12/25, indicated an admission date of 11/26/25, identified R54 as a veteran and listed diagnoses to include major depressive disorder, anxiety disorder, post-traumatic stress disorder, attention deficit hyperactivity disorder and opioid dependency. R54's Minnesota Senior linkage Line preadmission screening results dated 11/25/24, indicated R54 met the requirements for a mental illness OBRA Level II assessment. The screening identified a lead agency and provided contact information. R54's medical record was reviewed on 3/10/25 and lacked documentation of results of a Level II assessment. During interview on 3/11/25 at 1:46 p.m., social services designee (SS)-A confirmed R54's chart lacked any documentation of a Level II assessment being completed. SS-A stated R54's admission PASSAR identified suicidal ideations in the six months prior to his admission	F 645	a full house review was completed to validate the PASSAR screens are accurate. 3. Social Service/admission has been educated regarding the policy and procedure related to the PASSAR screening process. 4. Audits will be conducted with each new admission/referral to determine if this was completed by DON and or designee. Results of audits will be reviewed by the quality assurance committee to ensure compliance and determine the need for ongoing auditing. 5. Date of compliance April 18, 2025	

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F 645	Continued From page 4 PASSAR assessment and a Level II PASSAR was required to offer additional resources to R54. SS-A stated it was important to have the Level II PASSAR completed to ensure residents received all available mental health services. Facility policy was requested but not provided.	F 645		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a thorough smoking assessment was completed on residents who wished to smoke for 5 of 5 residents (R54, R16, R34, R52 and R19) reviewed for smoking. Findings include: An undated facility document titled Mission Nursing Home Resident leveling and Smoking program identified R54, R16, R34, R52 and R19 as current smokers. R54's admission minimum data set (MDS) dated 12/3/24, indicated R54 admitted to the facility on 11/26/24 and had the following diagnoses: Stroke, Non-traumatic brain dysfunction, traumatic brain	F 689	1. R54, has been discharged from the facility, discharged on 3/12/25. R16, R34, R52 and R19 have all been reassessed for smoking. 2. Because any resident who smokes could be at risk, a review of residents was completed to ensure accurate smoking assessments have been completed. 3. Nursing has been educated on the smoking policy and smoking assessment process. 4. Audits will be conducted quarterly per care conference schedule by DON and or designee, for current residents and audits of new admissions who smoke to ensure smoking assessments have been completed. Results of audits will be reviewed by the quality assurance	4/18/25

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F 689	Continued From page 5 dysfunction, progressive neurological conditions, and traumatic spinal cord dysfunction. The MDS further indicated R54 was cognitively intact and identified R54 as a current tobacco user. R54's face sheet printed 3/12/25, identified R54 as a current daily smoker. R54's care plan with a last review/revision date of 3/10/25, indicated R54 was an independent smoker, had a goal of remaining safe while smoking and would be reassessed for smoking safety annually, with significant change and reviewed quarterly. R54's comprehensive smoking assessment, dated 11/27/24, indicated an "in progress" status and revealed entire sections of the assessment blank and unfinished. No further smoking assessments were completed or provided. R54's medical record contained a document titled MNH Smoking Policy which reviewed facility policies for smokers. R54's signature was on the bottom of the form next to the date of 12/27/24. A facility representative signature identified as social services (SS)-A was below R54's signature. R16's admission MDS dated 2/9/23, indicated R16 admitted to the facility on 2/3/23 and had the following diagnoses: stroke, high blood pressure, hemiplegia (paralyzed on one side of the body) anxiety and depression. The MDS further indicated R16 was cognitively intact and identified R16 as a current tobacco user. R16's face sheet printed 3/12/25, identified R16 as a current daily smoker.	F 689	committee to ensure compliance and determine the need for ongoing auditing. 5. Date of compliance April 18, 2025	

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F 689	Continued From page 6 R16's care plan with a last review/revision date of 1/21/25, indicated R16 was an independent smoker, had a goal of remaining safe while smoking and would be reassessed for smoking safety annually, with significant change and reviewed quarterly. R16 had a completed comprehensive smoking assessment completed on 6/27/23, four months after his admission. No further smoking assessments were completed or provided. R16's medical record contained a document titled MNH Smoking Policy which reviewed facility policies for smokers. R16's signature was on the bottom of the form next to the date of 12/27/24. A facility representative signature identified as SS-A was below R16's signature. R34's admission MDS dated 1/16/22, indicated R34 admitted to the facility on 1/10/22, and had the following diagnoses: progressive neurological disorders, dementia, vascular dementia and personal history of trans ischemic attack (temporary blockage of blood flow to the brain). The MDS further indicated R34 was not cognitively intact. R34's face sheet printed 3/12/25, identified R34 as a former smoker. R34's care plan with a last review/revision date of 3/3/25, indicated R34 was an independent smoker, who had previously quit but had restarted smoking, had a goal of remaining safe while smoking and would be reassessed for smoking safety annually, with significant change and reviewed quarterly.	F 689		

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F 689	Continued From page 7 R34's comprehensive smoking assessment dated 1/13/25, indicated an "in progress" status and revealed entire sections of the assessment blank and unfinished. No further smoking assessments were completed or provided. R34's medical record contained a document titled MNH Smoking Policy which reviewed facility policies for smokers. R34's signature was on the bottom of the form next to the date of 9/3/24. A facility representative signature identified as SS-A was below R34's signature R52's admission MDS dated 11/01/24, indicated R52 admitted to the facility on 10/25/24, and had the following diagnoses: anemia, high blood pressure, traumatic subdural hemorrhage, anxiety and depression. The MDS further indicated R52 was cognitively intact and identified R52 as a current tobacco user. R52's care plan with a last review/revision date of 2/4/25, indicated R52 was a dependent smoker and would need assistance to smoke as he was unable to hold a cigarette, had a goal of remaining safe while smoking and would be reassessed for smoking safety annually, with significant change and reviewed quarterly. R52's comprehensive smoking assessment, dated 12/26/24, (two months after admission) indicated an "in progress" status and revealed entire sections of the assessment blank and unfinished. No further smoking assessments were completed or provided. R52's medial record contained a document titled MNH Smoking Policy which reviewed facility	F 689		

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F 689	Continued From page 8 policies for smokers. R52's signature was absent on the bottom of the. A facility representative signature identified as SS-A was below R52's printed name and was dated 1/15/25. R19's admission minimum data set (MDS) dated 1/3/25, included an admission date of 12/27/24. R19's diagnoses included hemiplegia (weakness on one side of the body), diabetes, and chronic obstructive pulmonary disease (COPD). R19's care plan reviewed 2/6/25, included R19 was an independent smoker. Care plan included resident would be reassessed for smoking annually and with significant change. Progress note dated 1/16/25, included R19 went downstairs for smoking as scheduled. R19's comprehensive smoking assessment dated 12/28/24, was incomplete with no data entered. During an interview on 3/11/25 at 1:48 p.m., SS-A stated no one person was solely responsible for completing the smoking assessment but it was the responsibility of multiple staff including nursing, social service and therapy services. SS-A stated nursing staff completed the first portion of the assessment which included watching the resident smoke to determine safety. SS-A went on to say a smoking assessment must be completed upon admission before a resident was allowed to smoke independently and then annually and with any significant change of condition. SS-A stated certain behaviors such as smoking outside of the designated smoking areas like in a resident room, or a resident who was noted to have burn marks on their clothing would indicate a necessity to be reassessed for safe smoking.	F 689		

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	245546	A. BUILDING _____ B. WING _____	C 03/12/2025

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F 689	Continued From page 9 During an interview on 3/12/25 at 10:01 a.m., director of nursing (DON) stated if an assessment was listed as "in progress" it indicated the assessment was still open and had not been completed. DON stated the initial smoking assessment should be done as part of the admission process and needed to be completed before a resident was allowed to smoke independently. DON went on to say after nursing completed the initial assessment, social services and if necessary, therapy would complete their portion of the smoking assessment and make recommendations for independent smoking, dependent or supervised smoking or needed adaptive equipment for smoking. Further, the DON stated in addition to being assessed as part of the admission process, a smoking assessment would also be completed annually and with any change of condition. DON stated a resident who had not been assessed for smoking, or whose assessment was not completed should not be allowed to smoke either independently or supervised until the smoking assessment was completed in its entirety by all required staff. Additionally, DON stated he expected staff to complete all necessary assessments on time and to communicate the findings of those assessments with the interdisciplinary team to ensure all team members were made aware of individual needs. DON stated completing, documenting, and communicating the results of the smoking assessment was important for resident safety, and to ensure any necessary precautions were being followed to prevent potential injuries to residents. Furthermore, DON confirmed R54's smoking assessment had not been completed, R16 had been assessed four months after admission in 2023 but had not	F 689		

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F 689	Continued From page 10 received an annual assessment in 2024 or 2025, R34's smoking assessment had not been completed, R52's smoking assessment had not been started until two months after admission, but had never been completed, and R19 had never been assessed for smoking. Facility Policy title MNH Smoking Policy with a last revised date of 12/2024 indicated all residents who wished to smoke would be assessed for function, cognition, and financial ability to participate in the smoking program. The policy also indicated residents would be assessed upon admission to determine ability to smoke safely with or without supervision and would be reassessed annually, upon significant change (cognitive or physical) and as determined by staff.	F 689		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective	F 867		4/18/25

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F 867	Continued From page 11 systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and	F 867		

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F 867	Continued From page 12 (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and	F 867		

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F 867	Continued From page 13 assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a plan that defined measurable goals and create a system to collect feedback from resident and resident representatives. This had the potential to affect all 56 residents in the facility. Findings Include: During entrance interview on 3/10/25 at 12:54 p.m., a request for a copy of the Quality Assurance and Performance Improvement (QAPI) plan was made to the director of nursing (DON). On 3/13/25 at 1:37 p.m., another request was made for a copy of the QAPI plan. On 3/13/25 at 2:25 p.m., the facility's QAPI program policy was provided. On 3/12/25 at 2:44 p.m., the director of nursing (DON) provided meeting minutes for the last four quarters, but failed to provide an overall plan.	F 867	1. Unable to go back to correct deficient practice 2. Because resident and family feedback are vital to obtain goals to assist in sustainability as it relates to quality measures, a QAPI plan has been developed. An annual letter to invite family/resident representatives to form a family council has been sent to resident representatives. 3. DON and management team has been educated regarding the QAPI plan and its importance as well as educated on the QAPI policy. 4. Audits will be conducted to determine benchmarks and goals are included and measurable monthly with each QAPI meeting to include resident and family feedback. 5. Date of compliance April 18,2025	

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F 867	Continued From page 14 QAPI meeting minutes included attendees, agenda, and data related to focuses such as infections, wounds, medication errors, admission/discharges, and weight changes. The document lacked evidence of target goals for sustainability. The document failed to provided evidence that resident and resident representative feedback was obtained to assist in determining quality measures. During interview on 3/13/25 at 2:44 p.m., DON stated they do not have a document that specifically states goals and how the facility will evaluate if the focus was successful or not. The DON was unable to state how feedback was collected from residents and resident representatives. Facility QAPI policy dated March 2020, included it was the QAPI committee's duty to establish benchmarks and goals by which to measure performance improvement.	F 867		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: Y2QF11

Dear Administrator:

The above facility was surveyed on March 10, 2025 through March 12, 2025 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, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 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,

Kamala Fiske-Downing

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

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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 3/10/25 to 3/12/25, 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		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H55469021C (MN00111092) H55469025C (MN00106045) H55469027C (MN00106074) H55469028C (MN00104860) H55469602C (MN00111262) H55469401C (MN00111265). NO citations were issued. 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	2 000		

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2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the 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		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		4/2/25

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21426	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening and testing was completed for 4 of 5 residents (R19, R20, R31, R52) reviewed for TB testing. Findings include: The Centers for Disease Control (CDC) guidelines for preventing the transmission of mycobacterium tuberculosis in Health Care Settings, 2005, directed that all residents and staff must receive a baseline TB screening should consist of an assessment for TB risk factors and history, assessment for current symptoms of active TB, and testing for the presence of infection with mycobacterium tuberculosis. R19's admission minimum data set (MDS) dated 1/3/25, included an admission date of 12/27/24. R19's diagnoses included stroke, diabetes, and chronic obstructive pulmonary disease (COPD). R19's preventative health care report dated 12/23/24 to 1/22/25, included a step 1 Mantoux skin test with a results date of 12/29/24. Size was listed as 0 millimeters (mm) and interpretation was negative. Step 2 Mantoux skin test did not include results reading. R19's medication administration record (MAR) dated 12/25/24 to 1/23/25, included a result of "00" as a reading for the step 2 Mantoux. Reading failed to include an interpretation of the result. R20's annual MDS dated 1/28/25, included an	21426	Corrected	

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21426	Continued From page 4 admission date of 8/8/24. R20's diagnoses included COPD and hemiplegia (weakness on one side of the body). R20's preventative health care report dated 2/1/24 to 3/21/24, included a step 1 Mantoux skin test but did not include results reading. Step 2 Mantoux skin test included a results date of 3/1/24. Size was listed as 0 mm and interpretation was negative. R20's MAR dated 2/12/24 to 3/11/24, failed to include results for step 1. Step 2 Mantoux included a result of "negative" but failed to include a size. R31's admission MDS dated 10/10/24, included an admission date of 10/3/24. R31's diagnoses included asthma and end stage renal disease. R31's preventative health care report dated 3/11/24 to 3/11/25, included a step 1 Mantoux skin test but did not include results reading. Step 2 Mantoux skin test included a results date of 10/19/24. Size was listed as 0 mm and interpretation was negative. R31's MAR dated 10/1/24 to 10/30/24, failed to include a size and clear interpretation. Step 2 Mantoux included a result of "neg" but failed to include a size. R52's admission MDS dated 11/1/24, included an admission date of 10/25/24. R52's diagnoses included paraplegia (paralysis that affects all or part of the trunk and legs). R52's preventative health care report dated 3/11/24 to 3/11/25, included a step 1 Mantoux skin test but did not include results reading. Step	21426		

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21426	Continued From page 5 2 Mantoux skin test included a results date of 11/10/24. Size was listed as 0 mm and interpretation was negative. R52's MAR dated 10/21/24 to 11/3/24, included a reading for step 1 Mantoux on 10/27/24 of "neg" but failed to include a size. During interview with on 3/12/25 at 10:03 a.m., registered nurse (RN)-A confirmed the results did not include both the size and interpretation for the tuberculosis screening for 4 of the 5 residents. Facility policy for tuberculosis screening dated June 2024, included all resident would be screened within the first 24 hours of admission, followed by a two step Mantoux skin test. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		

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	00235	A. BUILDING: _____ B. WING _____	C 03/12/2025

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21942	Continued From page 6	21942		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family council during the past calendar year. This had the potential to affect all 56 residents in the facility. Findings include: Documentation of any attempt to establish or offer a family council was requested, and none was provided by the facility. During an interview on 3/11/25 at 1:38 p.m., the social work designee (SW)-A stated there was no family council in existence nor had there been any attempt to establish one. SW-A stated the importance of offering a family council meeting to get the families involved and make the facility a kinder and gentler place. A family council policy was requested, none was	21942	Corrected	4/2/25

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21942	Continued From page 7 provided. SUGGESTED METHOD OF CORRECTION: The administrator and/or designee should delegate an individual to be responsible for the annual attempt to establish a family council. The administrator and/or designee should audit the delegate's efforts at forming a family council, and record when a meeting (if established) or attempts at establishing the family council occurred within each calendar year. Audits on the success or inability to form resident council should be taken to the QAPI committee for oversight to ensure compliance is achieved. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21942		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245546	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 03/13/2025. 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		03/21/2025

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 70 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 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 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	K 321	Hazardous rooms must be separated	3/21/25

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K 321	Continued From page 3 facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/13/2025 at 10:32 AM, it was revealed by observation that the inactive door leaf on door B36 to the maintenance shop would not latch causing the entire door to not positively latch. An interview with the Administrator and Maintenance Technician verified this deficient finding at the time of discovery.	K 321	from other rooms when fire alarm is activated. The inactive door leaf on B36 maintenance shop door was found to be in disrepair. The repair of the inactive door leaf has been completed as of 3/21/2025. Plan will be to inspect doors monthly for proper enclosure in the event of fire, that hazardous enclosures are kept closed. All results will be logged and kept in Life Safety manual for review by Maintenance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.2.1.2.2, 14.4.5.3.1, 14.4.5.3.2, and 14.4.5.3.3. This deficient finding could have a widespread impact on the residents	K 345	The smoke detector sensitivity report on site was 2022. A new report was generated as of 3/19/2025 by UHL company. It's been determined that the fire panel is addressable for location and sensitivity percentage. A letter has been generated by UHL to attest to the panel being an addressable system. A new	3/21/25

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K 345	Continued From page 4 within the facility. Findings include: On 03/13/2025 between 09:00 AM and 11:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility provided documentation of smoke detector sensitivity testing dated 2022, but did not have any documentation for sensitivity testing completed before that date. An interview with the Administrator and Maintenance Technician verified this deficient finding at the time of discovery.	K 345	report will be pulled annually by UHL to ensure proper range is achieved.	
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain single-station smoke alarms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.2.10.1.1, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 29.10 and 14.4.8.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 03/13/2025 between 09:00 AM and 11:30 AM, it was revealed by observation that the single	K 347	The smoke detectors in resident rooms were found to be older than 10 years. New smoke detectors will be installed completely no later than 4/30/2025. Devices will be marked with the current date and replaced prior to the 10-year manufacturer recommendation. An inspection of the fire equipment will be conducted annually throughout the site by Maintenance to ensure compliance, and will not exceed the age of the manufacturer’s recommendation.	4/30/25

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K 347	Continued From page 5 station smoke alarms located in the majority of the resident rooms were older than 10 years. An interview with the Administrator and Maintenance Technician verified this deficient finding at the time of discovery.	K 347		
K 353 SS=E	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 _____ 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 and staff interview, the facility failed to 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, sections 4.1.4.1, 5.2.1.1.2, 5.2.1.2 and 5.2.1.3, and and	K 353	1. 5 sprinkler heads in smoking room to be replaced no later than 4/30/2025. Periodic observation by Maintenance will be conducted to ensure heads are clear of debris and dust, and are not corroded. 2. Box was removed by Maintenance on 3/19/2025. Maintenance will keep all sprinkler heads clear of boxes and other	4/30/25

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K 353	Continued From page 6 NFPA 13 (2010 edition), Standard for the installation of Sprinkler Systems, section 8.6.5.3.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 03/13/2025 between 09:00 AM and 11:30 AM, it was revealed by a review of available documentation that the fire sprinkler report noted "5 heads in smoking room are corroded loaded with dirt. Need Replacement', and there was no documentation available showing repairs had been made. 2. On 03/13/2025 at 10:35 AM, it was revealed by observation that the sprinkler located in the freezer in the kitchen was blocked by a cardboard box. 3. On 03/13/2025 at 10:38 AM, it was revealed by observation that the sprinkler located above the dishwashing area in the kitchen had corrosion on it. An interview with the Administrator and Maintenance Technician verified these deficient findings at the time of discovery.	K 353	clutter, and will provide no less than 18 inches of clearance below every sprinkler head in the site. Periodic inspections by Maintenance will be conducted to ensure compliance. 3. 1 sprinkler head to be replaced over dishwasher in the kitchen. Sprinkler head appears to be corroded and be replaced no later than 4/30/2025. Periodic observation by Maintenance will be conducted to ensure heads are clear of debris and dust, and are not corroded.	
K 355 SS=F	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	K 355		4/4/25

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K 355	Continued From page 7 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, sections 7.3.1.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/13/2025 between 09:00 AM and 11:30 AM, it was revealed by a review of available documentation and observation that at the time of the survey the facility could not provide documentation showing that the fire extinguishers in the building had been inspected by the fire extinguisher vendor within the last year. An interview with the Administrator and Maintenance Technician verified this deficient finding at the time of discovery.	K 355	Portable fire extinguishers are to be inspected annually. Inspection of fire extinguishers to be completed no later than 4/4/2025. Maintenance will conduct a monthly inspection for extinguisher safety and initial the tag to indicate completion. An annual inspection will be conducted by Summit Fire each January of the following year to ensure compliance.	
K 363 SS=E	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	K 363		4/4/25

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K 363	Continued From page 8 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 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, section 19.3.6.3.5 and 19.3.6.3.10. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 03/13/2025 at 10:29 AM, it was revealed by	K 363	1. Staff lounge door B43 was found to not latch. The repair of the door latch will be completed by Doorglass Co or Maintenance no later than 4/4/2025. Maintenance will conduct an inspection of all corridor doors each month and no less than annually to ensure compliance with safety. Results will be logged and kept in Life Safety Manual. 2. Director of Nursing office door to be	

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K 363	Continued From page 9 observation that the staff lounge door B43 would not latch due to the handle getting stuck down. 2. On 03/13/2025 at 11:02 AM, it was revealed by observation that the door to the Director of Nursing office was wedged open with a wooden wedge. An interview with the Administrator and Maintenance Technician verified these deficient findings at the time of discovery.	K 363	held open by magnet or kept closed. Maintenance completed this as of 3/21/2025. DON has been notified about the rule and will comply going forward. No wooden wedge will be used to hold open the corridor door.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 711	Evacuation and Relocation Plan has been revised to include “transmission of alarms to fire department”. This has been completed as of 3/21/2025. The plan will be reviewed annually by Administrator to ensure proper language is provided to staff for safety.	3/21/25

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	245546	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/13/2025**

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

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K 711	Continued From page 10 On 03/13/2025 between 09:00 AM and 11:30 AM, it was revealed by a review of available documentation that the fire safety plan that was provided at the time of the survey did not include Transmission of alarms to fire department. An interview with the Administrator and Maintenance Technician verified this deficient finding at the time of discovery.	K 711		
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 03/13/2025 between 09:00 AM and 11:30 AM, it was revealed by a review of available	K 712	Monthly fire drills will be executed by Maintenance once per month for each corresponding shift according the calendar. Facilities Director will ensure compliance is being met by filling out a fire drill form and obtaining signatures from participating staff. Facilities Director will provide quarterly updates to Administrator for QA report with drill results.	3/21/25

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K 712	Continued From page 11 documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the first and second shift during the third quarter of 2024. An interview with the Administrator and Maintenance Technician verified this deficient finding at the time of discovery.	K 712		
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 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	K 918		4/4/25

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K 918	Continued From page 12 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 maintain generators 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 8.4.1, 8.4.2.4, 8.4.2.1, and 8.4.2.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/13/2025 between 09:00 AM and 11:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the emergency generator had been tested monthly. 2. On 03/13/2025 between 09:00 AM and 11:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the emergency generator had been inspected weekly before 11/07/2024. An interview with the Administrator and Maintenance Technician verified these deficient findings at the time of discovery.	K 918	Maintenance will conduct a weekly observation of power station, document the results, and maintain the logs in the Life Safety manual. Maintenance will conduct a monthly 30-minute load test between 20-40 days from the previous load test to test for transfer time and proper operation of the power station. Results will be logged by Maintenance and kept in Life Safety manual. A 4-hour load test will be conducted every 36 months by Ziegler and a report will be generated and kept in the Life Safety manual.	

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K 920	Continued From page 13	K 920		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8. This deficient finding could have an isolated impact on the residents within the facility.	K 920	A string of Christmas lights was removed on 3/21/2025 from room 118. Maintenance will train staff to observe rooms for any extension cords or light strings that are out of compliance for fire safety. Maintenance and housekeeping will conduct their own observations of resident rooms for noting any extension cords and report those instances to Maintenance.	3/21/25

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K 920	Continued From page 14 Findings include: On 03/13/2025 at 11:06 AM, it was revealed by observation that there were Christmas lights plugged into an extension cord in resident room 118. An interview with the Administrator and Maintenance Technician verified this deficient finding at the time of discovery.	K 920		