DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 24, 2025

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

RE: CCN: 245546
Cycle Start Date: April 24, 2025

Dear Administrator:

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

On April 10, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

In addition, at the time of this survey we've identified the following deficiency:

F0558, F0689, F0697

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 9, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 9, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 9, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 9, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Mission Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 9, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 12, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64975
625 Robert St. N
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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 04/10/2025

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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F 000	INITIAL COMMENTS On 4/8/25 through 4/10/25, a standard abbreviated survey was conducted at your facility. 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: H55462523C (MN00111912); H55462596C (MN00112040; MN00112021; MN00112033) with deficiency issued at F697 G, at PAST NON-COMPLIANCE. As a result of the investigation, additional deficiencies were issued at F558 and F689. 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. 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 558		5/9/25

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

Electronically Signed | 04/29/2025

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 558	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure call lights were within reach and accessible for 1 of 3 residents (R2) who was dependent on staff for care. Findings include: R2's admission Minimal Data Set (MDS) dated 2/26/25, indicated R2 had diagnoses which included hemiplegia and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (or stroke, a condition where a part of the brain is damaged or dies due to a lack of blood supply) affecting left non-dominant side, chronic pain syndrome, depression and anxiety disorder. R2's cognition was intact and R2 required substantial assistance by staff for toileting, dressing, and bed mobility. On 4/9/25 at 12:16 p.m., R2 was observed in his room sitting in his standard manual wheelchair. R2's call light was wrapped around the grab bar of his bed on the left side along the window and wall side of his room. R2 was in front of the television and call light was not within reach. R2 stated he would utilize the call light to get staff's attention however its on the side of the bed stating, "I tell them not to put it there but that is where it's at". R2 added sometimes he had to call his sister using his personal cell phone to have her call the facility to let the staff know he needed assistance because his call light was not accessible. Further, R2 stated he also had to self-propel himself in his wheelchair to the nurses' station to get staff to assist him, "we have had problems with that". In addition, R2 stated he was not able to stand up from his wheelchair without	F 558	1. R2s call light was and is put within reach. 2. All residents have the potential to be affected by this deficient practice. All residents were observed to ensure all residents had call light accessibility on April 25,2025. 3. Staff have been educated on facility policy and standards of practice with emphasis that staff will position the call light conveniently for residents and always keep within reach. 4. Audits will be completed by DON and or designee 3 times weekly x 1 month, weekly x 1 month and monthly thereafter to ensure call lights are within reach. Results of audits will be reviewed by DON or designee and the quality assurance committee to ensure compliance and to determine the need for ongoing auditing. 5. Completion date May 9, 2025	

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F 558	Continued From page 2	F 558		

assistance and reach across his bed to get to his call light especially since the left side of his body was immobile following a stroke.

On 4/9/25 at 12:24 p.m., registered nurse (RN)-A enters R2's room to offer R2 his lunch options. When asked about the call light, RN-A unwrapped R2's call light from the grab bar and clipped the call light to edge of the bed. RN-A stated staff were expected to ensure R2's call light was within reach if he was not in bed.

On 4/9/25 at 12:33 p.m., RN-A approached surveyor and stated she spoke with RN-B and R2's call light was supposed to be tied to the handrail so he can reach over and press it "I guess".

On 4/9/25 at 3:01 p.m., RN-B stated R2 required staff assistance with all activities of daily living (ADLs) and stated staff would be expected to remove R2's call light from the grab bar and drape it across his bed so R2 could easily grab it. RN-B stated R2 would not be able to stand up from his wheelchair independently as he required assist of two staff with a mechanical lift for transfers.

On 4/10/25 at 9:30 a.m., director of nursing (DON) stated staff were expected to ensure call lights were within reach and accessible to all residents.

Review of facility policy titled Resident Care-Call Light dated 11/24, indicated residents were provided with a means to call staff for assistance through a communication system that directly calls a staff member or centralized workstation. Further, each resident would be provided with a

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F 558	Continued From page 3 means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.	F 558		
F 689 SS=D	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 adaptive equipment was provided for 1 of 2 residents (R3) reviewed for safety while smoking. Findings include: R3's significant change Minimal Data Set (MDS) dated 3/14/25, indicated R3 had diagnoses which included chronic obstructive pulmonary disease, schizophrenia, and R3 was cognitively intact. R3's Smoking Assessment dated 3/24/25, indicated R3 used 6-10 cigarettes a day and did not have a preference on time of day he liked to smoke. R3 was assessed to need a smoking apron for adaptive equipment while smoking. Further, interdisciplinary team reviewed and determined R3 had a modified smoking plan, wears an apron for safety and had not been observed falling asleep with current assessment.	F 689	1. R3 was provided with smoking apron. 2. All residents who smoke have the potential to be affected by this deficient practice. All residents who smoke have been reviewed by the IDT team to determine need for smoking apron on April 25, 2025. 3. All staff were retrained on how residents were assessed for smoking safety and the importance of following their invention. A visual cheat sheet was created and placed by the smoking door. Staff have been educated on a policy titled Mission Nursing Home Resident Leveling and Smoke program on April 25, 2025. 4. Audits will be completed by DON and or designee 3 times weekly x 1 month, weekly x 1 month and monthly thereafter to ensure smoking aprons are in place as needed. Results of audits will	5/9/25

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F 689	Continued From page 4 Review of facility document titled Mission Nursing Home Resident Leveling and Smoke Program, undated, identified R3 as a smoker, on a modified smoking program, and required a smoking apron. On 4/8/25 at approximately 10:00 a.m., R3 was observed to self-propel in his wheelchair to the smoking-room door, where door monitor (DM)-A removed R3's oxygen concentrator and assisted R3 inside the smoking room. R3 was then observed to independently smoke a cigarette. DM-A did not assist R3 with a smoking apron. On 4/8/25 at 11:24 a.m., DM-A stated he was responsible for unlocking the smoking room for the residents and assist with any adaptive equipment that the resident required for smoking safety such as apron. DM-A stated he had a list of residents who smoked and what adaptive equipment they required and referred to the facility document titled Mission Nursing Home Resident Leveling and Smoke Program. Further, DM-A confirmed he did not assist R3 with a smoking apron and stated R3 required an apron for smoking outside but did not require an apron if R3 was smoking in the smoking room. DM-A stated he did not have any safety concerns related to R3 smoking and there had been no incidents he was aware of that resulted in R3 sustaining any burns from smoking. On 4/9/25 at 12:28 p.m., R3 confirmed he did not wear an apron while smoking yesterday and stated some staff put an apron on him and some don't. R3 stated he had not sustained any burns or injuries while smoking. On 4/9/25 at 2:37 p.m., assistant director of nursing (ADON) stated upon admission and as	F 689	be reviewed by DON or designee and the quality assurance committee to ensure compliance and to determine the need for ongoing auditing. 5. Date of completion May 9, 2025	

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F 689	Continued From page 5 needed staff complete a smoking assessment with a resident who was wanting to smoke, after the assessment was completed the interdisciplinary team (IDT) would then review the assessment and discuss if the adaptive equipment identified in the assessment was appropriate. ADON stated each DM had a list of all residents who smoke and what adaptive equipment was required, and the DM would be responsible to implement those interventions and assist with the adaptive equipment to ensure the resident was safe while smoking. On 4/9/25 at 3:01 p.m., registered nurse (RN)-B stated R3 was alert and orientated and required staff assistance with activities of daily living (ADLs). RN-B stated R3 was identified as a smoker and required an apron while smoking inside or outside to prevent any burns. RN-B stated there had been no incidents or burns for R3 that she was aware of. Further RN-B stated a smoking assessment would be completed with the resident and brought to the IDT meeting to review and determine interventions and adaptive equipment needs. RN-B stated the DMs would then be given a list that would identify interventions and adaptive equipment each resident required, and the DMs would be responsible to implement. On 4/10/25 at 9:30 a.m., director of nursing (DON) stated upon admission a smoking assessment would be completed to determine any adaptive equipment needs and the assessment would then be reviewed at the IDT meeting. DON stated a list, which DON identified as the facility document titled Mission Nursing Home Resident Leveling and Smoke Program, would be provided to the DMs and on the list	F 689		

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F 689	Continued From page 6 adaptive equipment required would be identified and DMs would be expected to implement and assist the resident. Review of facility policy titled Mission Nursing Home (MNH) Smoking Policy implemented 2024, indicated any resident with adaptive equipment to safely smoke would be set up by staff, monitoring shall occur by a staff or family member, visitor or volunteer as needed.	F 689		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pain medications were re-ordered and available for administration per physician orders for 1 of 3 residents (R2), who had chronic pain and utilized pain medication. This resulted in actual harm when R2 was not administered the physicians ordered pain medication before a pre-scheduled surgery prior to leaving the facility for surgery, and arrived at the surgery center tearful and in severe pain. The facility implemented immediate corrective action prior to the survey and was therefore issued at past non-compliance. Findings include: R2's admission Minimal Data Set (MDS) dated	F 697	Past noncompliance: no plan of correction required.	

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F 697	Continued From page 7 2/26/25, indicated R2 had diagnoses which included hemiplegia and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (or stroke, a condition where a part of the brain is damaged or dies due to a lack of blood supply) affecting left non-dominant side, chronic pain syndrome, depression and anxiety disorder. R2's cognition was intact. Further, MDS assessment revealed almost constant pain 8/10. R2's Medication Administration Record (MAR) dated 4/9/25, indicated R2 had a physician order for Acetaminophen 325 mg every 6 hours as needed, and Hydrocodone-acetaminophen 10-325 mg four times daily as well as an order for two additional doses as needed (PRN) per day for pain. Further, R1's MAR revealed an order directing staff to administer the following on the morning of surgery date 4/3/25: Acetaminophen 650 milligrams (mg) and Hydrocodone-acetaminophen 10-325 mg PRN 10-325 mg. Registered nurse (RN)-C signed off on the order indicating the medications were administered, however neither medication was administered (no evidence of supply), and no rationale was identified in the resident's record. After review of R2's orders, R2 could receive up to 6 tabs of Hydrocodone-acetaminophen 10-325 mg a day depending on pain level. Review of facility document titled 2nd Floor 24 Hour Report dated 4/1/25, revealed R2 needed a new Norco script. Review of facility document titled 2nd Floor 24 Hour Report dated 4/2/25, revealed R2 had a doctor appointment on 4/3/35 and leaving the facility at 5:00 a.m. Document lacked evidence of staff following up related to obtaining Norco	F 697		

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 04/10/2025

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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F 697	Continued From page 8 script. R2's Provider On- call Encounter dated 4/2/25, indicated at 9:11 p.m. floor nurse requested new script for oxycodone-acetaminophen script be sent to pharmacy. The order was reviewed and confirmed to be accurate by floor nurse and new script was sent. Nurse Practitioner signed the document on 4/3/25 at 1:15 p.m. R2's Individual Narcotic Record revealed on 3/27/25, 30 tabs of Hydrocodone 10-325 mg were received and on 4/2/25, the last one was administered to R2 at 11:39 p.m. Review of R2's Narcotic Record, on 4/1/25 when staff first identified R1 needed a new script there were 10 tabs of Hydrocodone-acetaminophen remaining which would cover at minimum 2.5 days if R2 did not require an as needed dose. On 4/9/25 at 1:18 p.m., combined interview with anonymous complainant (AC)-A, AC-B, and AC-C indicated R2 had a pre-scheduled surgery and upon arrival to hospital R2 was "sobbing" with pain, and R2 reported the facility staff did not administer his pain medications. Further, complainants reported R2 was in "severe" pain and appeared to be cognitively intact and R2 expressed due to staff not administering his pain medication, R2 did not want to return to the facility following surgery. Complainants reported they were able to administer R2 Tylenol upon arrival to assist with pain and R2 received other pain medications related to surgery later. Complainants reached out to facility regarding R2's concerns and facility staff reported pharmacy did not deliver R2's medications. On 4/9/25 at 3:01 p.m., registered nurse (RN)-B	F 697		

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F 697	Continued From page 9 stated R2 had a pre-scheduled surgery and she had entered an order into R2's chart regarding specific medications that were to be administered before surgery which included Hydrocodone-acetaminophen. RN-B stated after reviewing R2's MAR the Hydrocodone-acetaminophen was not administered prior to R2's surgery and there was no evidence in R2's record regarding administration or reason for not administering. RN-B stated the importance of R2 receiving the Hydrocodone-acetaminophen and Tylenol prior to surgery would be for pain management, as R2 was traveling a longer distance for the surgery. RN-B reviewed R2's narcotic record and recalled there was an issue with the pharmacy not delivering the Hydrocodone-acetaminophen prior to R2 leaving the facility the morning of 4/3/35 for his surgery. RN-B confirmed there were zero tabs left. R2 had received the last dose the night before surgery and pharmacy delivered 30 tabs on 4/3/25, after R2 had already left the facility. RN-B stated she had retrained all licensed nursing staff on that day, 4/3/25, regarding ordering medications timely from the pharmacy to avoid running out of a medication. On 4/9/25 at 6:43 p.m., registered nurse (RN)-C stated she was R2's nurse during the overnight shift leading into the day of his surgery on 4/3/25. RN-C stated R2 had an order to administer specific medications and his pain medication prior to leaving the facility for his surgery. RN-C stated R2 had received a Hydrocodone-acetaminophen at approximately 1:00 a.m. on 4/3/24, and that was the last one available so RN-C called the pharmacy twice and was told they would be delivered. However, the medication was not delivered to the facility prior to R2 leaving at 4:00	F 697		

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F 697	Continued From page 10 a.m., Further, RN-C stated R2 was "upset" and R2 did not want to go to the surgery because, "he said he had pain and was afraid for the 45-minute ride and sitting that long". RN-C stated R2 then left the facility without pain medication being administered and R2 had refused Tylenol, but RN-C did not document the refusal. RN-C stated staff were expected to notify pharmacy when there are no less than 8 pills remaining and if a new script would be needed ordering would need to be done sooner, especially if the resident was taking the medication more than once daily. RN-C stated she was not sure what happened, and staff should have ordered the medication sooner. RN-C confirmed she did not reach out to R2's provider for direction or the director of nursing (DON). In addition, RN-C stated RN-B had re-educated staff on 4/3/25, regarding ordering medications timely to avoid running out of the medication. On 4/10/25 at 9:30 a.m., DON indicated medications were refilled weekly on Wednesday or 7 days prior to the medication completion. DON stated there was an emergency medication kit at the facility if needed, however Hydrocodone-acetaminophen was not included in the kit. Further, DON stated the pharmacy delivered to the facility up to four times a day and if there were an urgent situation staff were expected to notify the DON. DON stated he was aware of the incident regarding R2 not receiving the medication and DON stated staff did notify pharmacy on multiple occasions however, the pharmacy did not deliver but was unsure why there was a delay. On 4/10/24 at 11:27 a.m., assistant director of nursing (ADON) stated on 4/1/25, staff passed on	F 697		

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F 697	Continued From page 11 in report R2 needed a new script for Hydrocodone-acetaminophen and that was what staff were directed to do when a medication was running low, and the following day on 4/2/25, the nurse on day shift called to obtain the script. ADON stated R2 received 4 doses of Hydrocodone-acetaminophen at minimum a day and then two additional doses as needed for pain, so R2 could run out faster if he needed the PRN medication. ADON stated if staff identified the end of the medication with no refills or needing a new script, they would be expected to call 7 days prior. ADON indicated they educated all licensed staff on 4/3/25, following the incident with R2 regarding ordering medications timely. Review of facility policy titled Mission Nursing Home 14-Day Easypak Inservice, undated, indicated medication that much be reordered by nursing include all controlled medication these would be dispensed on 30-day punch cards. Further, it was recommended that medications are reordered when there is a 3-5-day supply left to allow for any clarifications or needed prescription renewals (5-7 days for controlled medications). Refill orders that are faxed, will have a delay of about 24 hours before the information is available for viewing on the Portal.	F 697		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 24, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: S1IZ11

Dear Administrator:

The above facility was surveyed on April 8, 2025, through April 10, 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64975
625 Robert St. N
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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 _____	04/10/2025

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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 4/8/25 through 4/10/25, a complaint 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 licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H55462523C (MN00111912); H55462596C (MN00112040; MN00112021; MN00112033). As a result of the investigation, licensing orders were issued at 0830 and 1810. 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 surveyor ' s 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 14-01, available at 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	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adaptive equipment was provided for 1 of 2 residents (R3) reviewed for safety while smoking. Findings include:	2 830	Corrected	5/21/25

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2 830	Continued From page 3 R3's significant change Minimal Data Set (MDS) dated 3/14/25, indicated R3 had diagnoses which included chronic obstructive pulmonary disease, schizophrenia, and R3 was cognitively intact. R3's Smoking Assessment dated 3/24/25, indicated R3 used 6-10 cigarettes a day and did not have a preference on time of day he liked to smoke. R3 was assessed to need a smoking apron for adaptive equipment while smoking. Further, interdisciplinary team reviewed and determined R3 had a modified smoking plan, wears an apron for safety and had not been observed falling asleep with current assessment. Review of facility document titled Mission Nursing Home Resident Leveling and Smoke Program, undated, identified R3 as a smoker, on a modified smoking program, and required a smoking apron. On 4/8/25 at approximately 10:00 a.m., R3 was observed to self-propel in his wheelchair to the smoking-room door, where door monitor (DM)-A removed R3's oxygen concentrator and assisted R3 inside the smoking room. R3 was then observed to independently smoke a cigarette. DM-A did not assist R3 with a smoking apron. On 4/8/25 at 11:24 a.m., DM-A stated he was responsible for unlocking the smoking room for the residents and assist with any adaptive equipment that the resident required for smoking safety such as apron. DM-A stated he had a list of residents who smoked and what adaptive equipment they required and referred to the facility document titled Mission Nursing Home Resident Leveling and Smoke Program. Further, DM-A confirmed he did not assist R3 with a smoking apron and stated R3 required an apron	2 830		

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2 830	Continued From page 4 for smoking outside but did not require an apron if R3 was smoking in the smoking room. DM-A stated he did not have any safety concerns related to R3 smoking and there had been no incidents he was aware of that resulted in R3 sustaining any burns from smoking. On 4/9/25 at 12:28 p.m., R3 confirmed he did not wear an apron while smoking yesterday and stated some staff put an apron on him and some don't. R3 stated he had not sustained any burns or injuries while smoking. On 4/9/25 at 2:37 p.m., assistant director of nursing (ADON) stated upon admission and as needed staff complete a smoking assessment with a resident who was wanting to smoke, after the assessment was completed the interdisciplinary team (IDT) would then review the assessment and discuss if the adaptive equipment identified in the assessment was appropriate. ADON stated each DM had a list of all residents who smoke and what adaptive equipment was required, and the DM would be responsible to implement those interventions and assist with the adaptive equipment to ensure the resident was safe while smoking. On 4/9/25 at 3:01 p.m., registered nurse (RN)-B stated R3 was alert and orientated and required staff assistance with activities of daily living (ADLs). RN-B stated R3 was identified as a smoker and required an apron while smoking inside or outside to prevent any burns. RN-B stated there had been no incidents or burns for R3 that she was aware of. Further RN-B stated a smoking assessment would be completed with the resident and brought to the IDT meeting to review and determine interventions and adaptive equipment needs. RN-B stated the DMs would	2 830		

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2 830	Continued From page 5 then be given a list that would identify interventions and adaptive equipment each resident required, and the DMs would be responsible to implement. On 4/10/25 at 9:30 a.m., director of nursing (DON) stated upon admission a smoking assessment would be completed to determine any adaptive equipment needs and the assessment would then be reviewed at the IDT meeting. DON stated a list, which DON identified as the facility document titled Mission Nursing Home Resident Leveling and Smoke Program, would be provided to the DMs and on the list adaptive equipment required would be identified and DMs would be expected to implement and assist the resident. Review of facility policy titled Mission Nursing Home (MNH) Smoking Policy implemented 2024, indicated any resident with adaptive equipment to safely smoke would be set up by staff, monitoring shall occur by a staff or family member, visitor or volunteer as needed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure residents who smoke not on the smoke-free campus are supervised appropriately for safety and provided the appropriate adaptive equipment. The administrator or designee should also ensure if smoking is allowed, residents are supplied with a smoking receptacle to discard cigarettes. The facility should re-educate all staff identified to policies and procedures, and audit residents who smoke to determine safety and supervision occured. The results of those audits should be taken to the Quality Assurance Performance	2 830		

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2 830	Continued From page 6 Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	2 830		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure call lights were within reach and accessible for 1 of 3 residents (R2) who was dependent on staff for care. Findings include: R2's admission Minimal Data Set (MDS) dated 2/26/25, indicated R2 had diagnoses which included hemiplegia and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (or stroke, a condition where a part of the brain is damaged or dies due to a lack of blood supply) affecting left non-dominant side, chronic pain syndrome, depression and anxiety disorder. R2's cognition was intact and R2 required substantial assistance by staff for toileting, dressing, and bed mobility.	21810	Corrected	5/21/25

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 _____	04/10/2025

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) COMPLETE DATE
21810	Continued From page 7 On 4/9/25 at 12:16 p.m., R2 was observed in his room sitting in his standard manual wheelchair. R2's call light was wrapped around the grab bar of his bed on the left side along the window and wall side of his room. R2 was in front of the television and call light was not within reach. R2 stated he would utilize the call light to get staff's attention however its on the side of the bed stating, "I tell them not to put it there but that is where it's at". R2 added sometimes he had to call his sister using his personal cell phone to have her call the facility to let the staff know he needed assistance because his call light was not accessible. Further, R2 stated he also had to self-propel himself in his wheelchair to the nurses' station to get staff to assist him, "we have had problems with that". In addition, R2 stated he was not able to stand up from his wheelchair without assistance and reach across his bed to get to his call light especially since the left side of his body was immobile following a stroke. On 4/9/25 at 12:24 p.m., registered nurse (RN)-A enters R2's room to offer R2 his lunch options. When asked about the call light, RN-A unwrapped R2's call light from the grab bar and clipped the call light to edge of the bed. RN-A stated staff were expected to ensure R2's call light was within reach if he was not in bed. On 4/9/25 at 12:33 p.m., RN-A approached surveyor and stated she spoke with RN-B and R2's call light was supposed to be tied to the handrail so he can reach over and press it "I guess". On 4/9/25 at 3:01 p.m., RN-B stated R2 required staff assistance with all activities of daily living (ADLs) and stated staff would be expected to	21810		

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 _____	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 8 remove R2's call light from the grab bar and drape it across his bed so R2 could easily grab it. RN-B stated R2 would not be able to stand up from his wheelchair independently as he required assist of two staff with a mechanical lift for transfers. On 4/10/25 at 9:30 a.m., director of nursing (DON) stated staff were expected to ensure call lights were within reach and accessible to all residents. Review of facility policy titled Resident Care-Call Light dated 11/24, indicated residents were provided with a means to call staff for assistance through a communication system that directly calls a staff member or centralized workstation. Further, each resident would be provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		