Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 16, 2026

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

RE: CCN: 245546
Cycle Start Date: February 11, 2026

Dear Administrator:

On April 1, 2026, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 16, 2026

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

Re: Reinspection Results
Event ID: 1E3777-H2

Dear Administrator:

On March 18, 2026, 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 February 11, 2026. 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
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 12, 2026

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

RE: CCN: 245546
Cycle Start Date: February 11, 2026

Dear Administrator:

On February 11, 2026, a survey was completed at your facility by the Minnesota Departments of Health, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

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, 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 May 11, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 11, 2026 (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Freeman Building | HRD-OLF 3B
625 Robert St. N.
P.O. Box 64975
St. Paul, MN 55164-0899
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Electronically delivered

February 12, 2026

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

Re: Event ID: 1E3777-H1

Dear Administrator:

The above facility survey was completed on February 11, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Freeman Building | HRD-OLF 3B
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/11/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS From 2/9/26 to 2/11/26, 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 complaint was reviewed: H55465581C (2736800) with a deficiency issued at F686. 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.	F0000		03/04/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F0686	Plan of Correction – F686 (Treatment/Services to Prevent/Heal Pressure Ulcer Deficiency Addressed (F686): Failure to ensure residents received appropriate treatment and services to prevent the development of pressure injuries and to ensure comprehensive skin assessments were completed and documented in accordance with facility policy and federal regulations. Immediate Corrective Action: • Education was provided immediately to all nursing staff regarding pressure injury prevention, proper completion of comprehensive skin assessments, and associated risks including infection, sepsis, decline in condition, and death. • A mandatory nurses' meeting was held with education on F686 requirements, documentation standards, and timely escalation of identified skin concerns. • An in-house full skin audit was initiated for all identified high-risk residents and will remain ongoing for two (2)	03/04/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/11/2026

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F0686 SS = D	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to perform comprehensive skin assessments (at least weekly) as ordered, which included assessment for new wounds and documenting wound measurements and other wound characteristics for 3 of 3 residents (R1, R2, R3) reviewed for pressure injury. Findings include: R1 R1's Admission Minimum Data Set (MDS) dated 11/12/25, indicated intact cognition, pressure ulcers (PU) upon admission, and risk to develop PU. The MDS data indicated R1 admitted 11/12/25, discharged 11/21/25, re-admitted 12/5/25, and discharged on 1/14/26. R1's diagnoses included cancer, deep vein thrombosis (a blood clot in a deep vein), bowel and bladder incontinence, and malnutrition. R1 was on chemotherapy upon admission. R1 had mobility limitations that required a wheelchair for mobility. R1's provider orders dated 12/5/25 indicated perform skin check, head to toe, to be completed weekly on Fridays. R1 had ongoing pressure wound care orders for both the right and left ischial tuberosities (large bony projection located at the bottom of the pelvis that serves as the primary weight-bearing structure when sitting) wounds and on 12/17/25, a sacral (large bone at the base of the lumbar spine that acts as a foundation, distributing upper body weight and stabilizes the pelvis for walking, sitting, and standing) wound, which indicated R1 was prone to develop PU. R1's care plan dated 12/18/25, indicated R1 had a non-healing open area on skin, a surgical wound, immobility, nutritional risk, and incontinence as risk factors for alteration in skin. R1's skin assessments indicated R1 had skin audits completed upon admission on 11/19/25, and 12/5/25. An additional head- to -toe skin assessment was completed 12/26/25. R1's electronic health record (EHR) lacked indication of additional weekly skin assessments during the weeks of 11/9/25, 12/12/25, 12/19/25, 1/2/26, and 1/9/26.	F0686	Continued from page 1 weeks. • Resident R1 has been discharged. • Residents R2 and R3 received full-body skin audits completed during wound rounds. Systemic Changes to Prevent Recurrence: • The facility will complete daily audits of skin assessments for all residents for four (4) consecutive weeks. • Following completion of daily audits, weekly audits will be conducted for an additional four (4) weeks. • Upon successful completion of weekly audits, the facility will transition to monthly audits for two (2) months. • Audit results will be reviewed by nursing leadership to identify trends and ensure ongoing compliance with F686 requirements. Monitoring and Ongoing Compliance: • The Director of Nursing or designee will monitor audit completion and compliance. • Any missed or incomplete skin assessments will be addressed immediately with corrective action and re-education as appropriate. • Audit findings will be reviewed in the facility's Quality Assurance and Performance Improvement (QAPI) meetings to ensure sustained compliance. Date of Compliance: The facility expects to achieve substantial compliance upon implementation of the corrective actions outlined above and will sustain compliance through continued monitoring and QAPI oversight.	

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

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F0686 SS = D	Continued from page 2 R1's progress notes lacked indication the omitted skin assessments were completed, nor that they were refused by R1. R1's progress notes dated 12/5/25 indicated when R1 readmitted on 12/5/25, he had a left above knee amputation. On 2/10/26 at 2:51 p.m., during an interview licensed practical nurse (LPN)-A acknowledged R1 had only one skin assessment but should have had one each week while a resident. LPN-A stated body audits were completed upon admission to assess the skin initially. Wound care notes assessed known wounds. LPN-A further stated body audits and wound care notes did not replace the requirement of the weekly head-to-toe skin assessments which were utilized weekly to assess for previously unidentified skin changes. LPN-A acknowledged R1 had provider orders to perform weekly skin assessments, but only had one skin assessment on 12/26/25, and R1's EHR lacked documentation indicating why the other assessments were not completed as ordered. On 2/11/26 at 9:54 a.m., during an interview registered nurse (RN)-A stated weekly skin assessments were performed on shower days, and were utilized to assess skin for new redness, skin tears, and any type of open area on the skin. RN-A stated if new areas were found, the areas were measured, reported, and dressed with appropriate dressings for the wound type. RN-A further stated if a resident refused a bath or shower, the nurse was still required to perform the weekly skin assessment, or document why it was not performed. The nurse was required to perform the skin assessment, or they would not know about new skin issues. RN-A acknowledged R1 had one weekly skin assessment on 12/26/25 but should have had one weekly while admitted. R2 R2's quarterly MDS dated 11/24/25, indicated intact cognition, PU upon admission, and risk to develop PU. The MDS indicated diagnoses that included peripheral vascular disease (PVD-a progressive circulation disorder involving narrowing of the blood vessels commonly affecting the legs and feet), kidney disease, a neurogenic bladder (dysfunction of the bladder caused by damage to the nerves that control the bladder commonly caused by spinal cord injuries and diabetes), paraplegia, and diabetes. R2 had mobility limitations	F0686		

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Mission Nursing Home	3401 EAST MEDICINE LAKE BOULEVARD , PLYMOUTH, Minnesota, 55441

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F0686 SS = D	Continued from page 3 that required a wheelchair for mobility. R2's provider orders dated 8/26/25, indicated perform skin check, head to toe, to be completed weekly on Fridays. R2 had pressure wound care orders dated 1/26/26 for a sacral wound, indicating R2 was prone to develop PU. R2's care plan dated 9/17/25, indicated an alteration in skin integrity with a stage IV PU (wound with extensive tissue loss, with directly visible or palpable muscle, tendon, ligament, cartilage, or bone) on the sacrum. R2's skin assessments were completed 1/2/26, 1/9/26, 1/23/26, and 2/6/26. R2's EHR lacked indication of weekly skin assessments during the weeks of 1/16/26, and 1/30/26. R2's progress notes lacked indication the omitted skin assessments were completed, nor that they were refused by R2. R3 R3's quarterly MDS dated 12/9/25, indicated intact cognition, current PU, risk to develop PU, and bowel and bladder incontinence. The MDS indicated diagnosis that included PVD, diabetes, lung disease, and mobility limitation that required a wheelchair for mobility. R3's provider orders dated 9/4/25, indicated perform skin check, head to toe, weekly on Sundays. R3's orders dated 1/28/26, indicated ongoing pressure wound care orders for both the right and left ischial tuberosities, indicating R3 was prone to develop PU. R3's care plan dated 10/29/25, indicated potential skin alteration, a non-healing open area, related to diabetes, PVD, immobility, nutrition risk, incontinence, and impaired cognition. R3's skin assessments were completed 1/11/26, 1/25/26, 2/1/26, and 2/8/26. R3's EHR lacked indication of weekly skin assessment the week of 1/18/26.	F0686		

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F0686 SS = D	Continued from page 4	F0686		

R3's progress notes lacked indication the omitted skin assessment was completed, nor that it was refused by R3.

On 2/11/26 at 10:15 a.m., during an interview RN-B stated R1, R2, and R3 should have had weekly skin assessments. Residents had weekly skin assessments or potentially staff may not have identified new wounds. The policy was to document the skin assessments on the Weekly Skin Check form. RN-B stated body audits upon admission and wound rounds did not replace the weekly skin assessments.

RN-B acknowledged:

- R1, R2, and R3 had orders for weekly skin assessments.

- R1 had only one skin assessment, on 12/26/25.

- R2 lacked skin assessments on 1/16/26 and 1/30/26.

- R3 lacked a skin assessment on 1/18/26.

- R1's, R2's, and R3's EHRs lacked documentation indicating why the skin assessments were not performed as ordered.

On 2/11/26 at 11:28 a.m., during an interview the director of nursing (DON) stated it was the expectation each resident would have weekly skin assessments to ensure new skin issues were identified. The skin assessments were to be completed even when residents refused showers or baths. The DON stated the wound rounds did not replace weekly skin assessments, and acknowledged R1, R2, and R3 each missed weekly skin assessments. The facility was working on the skin assessments/ wound assessments process and would continue the work.

The Prevention of Pressure Injuries policy dated 4/2020, indicated evaluate, report, and document potential changes in skin.

The Skin Integrity and Wound Care policy dated 8/2025, indicated follow preventative interventions per the care plan. Conduct thorough skin assessments upon admission, weekly, and with a change in condition. Residents at risk included those with cognitive

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F0686 SS = D	Continued from page 5 impairment, limited or no mobility, incontinence, acute illness or rapid decline, poor nutrition, or those with fragile skin from medications such as anticoagulants, steroids, or chemotherapy.	F0686		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/11/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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20000	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: From 2/9/26 to 2/11/26, 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 order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		03/04/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/11/2026**

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Mission Nursing Home	**3401 EAST MEDICINE LAKE BOULEVARD , PLYMOUTH, Minnesota, 55441**

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20000	Continued from page 1 The following complaints were reviewed: H55465581C (2736800) with a licensing order issued at 0900. 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 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.	20000		
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	20900	Plan of Correction – F686 (Treatment/Services to Prevent/Heal Pressure Ulcer Deficiency Addressed (F686): Failure to ensure residents received appropriate treatment and services to prevent the development of pressure injuries and to ensure comprehensive skin assessments were completed and documented in accordance with facility policy and federal regulations.	03/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/11/2026**

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20900	Continued from page 2 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to perform comprehensive skin assessments as ordered, which included an assessment for new wounds, documenting wound measurements and other wound characteristics for 3 of 3 residents (R1, R2, R3) who were at risk of developing new pressure ulcers (PU). Findings include: R1's Admission Minimum Data Set (MDS) dated 11/12/25, indicated intact cognition, pressure ulcers (PU) upon admission, and risk to develop PU. The MDS data indicated R1 admitted 11/12/25, discharged 11/21/25, re-admitted 12/5/25, and discharged on 1/14/26. R1's diagnoses included cancer, deep vein thrombosis (a blood clot in a deep vein), bowel and bladder incontinence, and malnutrition. R1 was on chemotherapy upon admission. R1 had mobility limitations that required a wheelchair for mobility. R1's provider orders dated 12/5/25 indicated perform skin check, head to toe, to be completed weekly on Fridays. R1 had ongoing pressure wound care orders for both the right and left ischial tuberosities (large bony projection located at the bottom of the pelvis that serves as the primary weight-bearing structure when sitting) wounds and on 12/17/25, a sacral (large bone at the base of the lumbar spine that acts as a foundation, distributing upper body weight and stabilizes the pelvis for walking, sitting, and standing) wound, which indicated R1 was prone to develop PU. R1's care plan dated 12/18/25, indicated R1 had a non-healing open area on skin, a surgical wound, immobility, nutritional risk, and incontinence as risk factors for alteration in skin.	20900	Continued from page 2 Immediate Corrective Action: • Education was provided immediately to all nursing staff regarding pressure injury prevention, proper completion of comprehensive skin assessments, and associated risks including infection, sepsis, decline in condition, and death. • A mandatory nurses' meeting was held with education on F686 requirements, documentation standards, and timely escalation of identified skin concerns. • An in-house full skin audit was initiated for all identified high-risk residents and will remain ongoing for two (2) weeks. • Resident R1 has been discharged. • Residents R2 and R3 received full-body skin audits completed during wound rounds. Systemic Changes to Prevent Recurrence: • The facility will complete daily audits of skin assessments for all residents for four (4) consecutive weeks. • Following completion of daily audits, weekly audits will be conducted for an additional four (4) weeks. • Upon successful completion of weekly audits, the facility will transition to monthly audits for two (2) months. • Audit results will be reviewed by nursing leadership to identify trends and ensure ongoing compliance with F686 requirements. Monitoring and Ongoing Compliance: • The Director of Nursing or designee will monitor audit completion and compliance. • Any missed or incomplete skin assessments will be addressed immediately with corrective action and re-education as appropriate. • Audit findings will be reviewed in the facility's Quality Assurance and Performance Improvement (QAPI) meetings to ensure sustained compliance. Date of Compliance: The facility expects to achieve substantial compliance upon implementation of the corrective actions outlined above and will sustain compliance through continued monitoring and QAPI oversight.	

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20900	Continued from page 3 R1's skin assessments indicated R1 had skin audits completed upon admission on 11/12/25, and 12/5/25. An additional head- to -toe skin assessment was completed 12/26/25. R1's electronic health record (EHR) lacked indication of additional weekly skin assessments during the weeks of 11/19/25, 12/12/25, 12/19/25, 1/2/26, and 1/9/26. R1's progress notes lacked indication the omitted skin assessments were completed, nor that they were refused by R1. R1's progress notes dated 12/5/25 indicated when R1 readmitted on 12/5/25, he had a left above knee amputation. On 2/10/26 at 2:51 p.m., during an interview licensed practical nurse (LPN)-A acknowledged R1 had only one skin assessment but should have had one each week. LPN-A stated body audits were completed upon admission to assess the skin initially, and wound care notes assessed known wounds. LPN-A further stated body audits and wound care notes did not replace the requirement of the weekly head-to-toe skin assessments which were utilized weekly to assess for previously unidentified skin changes. LPN-A acknowledged R1 had provider orders to perform weekly skin assessments, but only had one skin assessment on 12/26/25, and R1's EHR lacked documentation indicating why the other assessments were not completed as ordered. On 2/11/26 at 9:54 a.m., during an interview registered nurse (RN)-A stated weekly skin assessments were performed on shower days, and were utilized to assess skin for new redness, skin tears, and any type of open area on the skin. RN-A stated if new areas were found, the areas were measured, reported, and dressed with appropriate dressings for the wound type. RN-A further stated if a resident refused a bath or shower, the nurse was still required to perform the weekly skin assessment, or document why it was not performed. The nurse was required to perform the skin assessment, or they would not know about new skin issues. RN-A acknowledged R1 had one weekly skin assessment on 12/26/25 but should have had one weekly while admitted. R2's quarterly MDS dated 11/24/25, indicated intact cognition, PU upon admission, and risk to develop PU.	20900		

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20900	Continued from page 4 The MDS indicated diagnoses that included peripheral vascular disease (PVD-a progressive circulation disorder involving narrowing of the blood vessels commonly affecting the legs and feet), kidney disease, a neurogenic bladder (dysfunction of the bladder caused by damage to the nerves that control the bladder commonly caused by spinal cord injuries and diabetes), paraplegia, and diabetes. R2 had mobility limitations that required a wheelchair for mobility. R2's provider orders dated 8/26/25, indicated perform skin check, head to toe, to be completed weekly on Fridays. R2 had pressure wound care orders dated 1/26/26 for a sacral wound, indicating R2 was prone to develop PU. R2's care plan dated 9/17/25, indicated an alteration in skin integrity with a stage IV PU (wound with extensive tissue loss, with directly visible or palpable muscle, tendon, ligament, cartilage, or bone) on the sacrum. R2's skin assessments were completed 1/2/26, 1/9/26, 1/23/26, and 2/6/26. R2's EHR lacked indication of weekly skin assessments during the weeks of 1/16/26, and 1/30/26. R2's progress notes lacked indication the omitted skin assessments were completed, nor that they were refused by R2. R3's quarterly MDS dated 12/9/25, indicated intact cognition, current PU, risk to develop PU, and bowel and bladder incontinence. The MDS indicated diagnosis that included PVD, diabetes, lung disease, and mobility limitation that required a wheelchair for mobility. R3's provider orders dated 9/4/25, indicated perform skin check, head to toe, weekly on Sundays. R3's orders dated 1/28/26, indicated ongoing pressure wound care orders for both the right and left ischial tuberosities, indicating R3 was prone to develop PU. R3's care plan dated 10/29/25, indicated potential skin alteration, a non-healing open area, related to diabetes, PVD, immobility, nutrition risk, incontinence, and impaired cognition.	20900		

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20900	Continued from page 5 R3's skin assessments were completed 1/11/26, 1/25/26, 2/1/26, and 2/8/26. R3's EHR lacked indication of weekly skin assessment the week of 1/18/26. R3's progress notes lacked indication the omitted skin assessment was completed, nor that it was refused by R3. On 2/11/26 at 10:15 a.m., during an interview RN-B stated R1, R2, and R3 should have had weekly skin assessments. Residents had weekly skin assessments or potentially staff may not have identified new wounds. The policy was to document the skin assessments on the Weekly Skin Check form. RN-B stated body audits upon admission and wound rounds did not replace the weekly skin assessments. RN-B acknowledged: - R1, R2, and R3 had orders for weekly skin assessments. - R1 had only one skin assessment, on 12/26/25. - R2 lacked skin assessments on 1/16/26 and 1/30/26. - R3 lacked a skin assessment on 1/18/26. - R1's, R2's, and R3's EHRs lacked documentation indicating why the skin assessments were not performed as ordered. On 2/11/26 at 11:28 a.m., during an interview the director of nursing (DON) stated it was the expectation each resident would have weekly skin assessments to ensure new skin issues were identified. The skin assessments were to be completed even when residents refused showers or baths. The DON stated the wound rounds did not replace weekly skin assessments, and acknowledged R1, R2, and R3 each missed weekly skin assessments. The facility was working on the skin assessments/ wound assessments process and would continue the work.	20900		

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20900	Continued from page 6 The Prevention of Pressure Injuries policy dated 4/2020, indicated evaluate, report, and document potential changes in skin. The Skin Integrity and Wound Care policy dated 8/2025, indicated follow preventative interventions per the care plan. Conduct thorough skin assessments upon admission, weekly, and with a change in condition. Residents at risk included those with cognitive impairment, limited or no mobility, incontinence, acute illness or rapid decline, poor nutrition, or those with fragile skin from medications such as anticoagulants, steroids, or chemotherapy. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to ensure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		