Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 9, 2025

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

RE: CCN: 245546

Cycle Start Date: July 3,2025

Dear Administrator:

On August 18, 2025, 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.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 9, 2025

Administrator

Mission Nursing Home

3401 East Medicine Lake Boulevard
Plymouth, MN 55441

Re: Reinspection Results
Event ID: DQIN11

Dear Administrator:

On August 18, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 3, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 25, 2025

Administrator
Mission Nursing Home

3401 EAST MEDICINE LAKE BOULEVARD
PLYMOUTH, MN 55441

RE: CCN:245546
Cycle Start Date: July 23, 2025

Dear Administrator:

On July 23, 2025, 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 October 3, 2025, (three months after the identification of noncompliance) the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 3, 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
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
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 **07/03/2025**

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 On 7/1/25 through 7/3/25, 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: H55467307C (MN00113838) H55468311C (MN00114219) with deficiencies issued at F550 and F760. As a result of the investigation, an additional deficiency was issued at F880. 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		08/15/2025
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F0550	F0550 Resident Rights/ Exercise of Rights How corrective action will be accomplished for those residents found to have been affected by the deficient practice The Social Worker interviewed R3 and R4 to confirm there was no harm from the reported observations. Both care plans were reviewed and are up to date.	08/15/2025

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 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 **07/03/2025**

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F0550 SS = D	Continued from page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure call lights were answered in a timely manner for 2 of 3 residents (R3, R4) reviewed for dignity. Findings include: Resident council meeting minutes dated January 2025 identified call light times were long, March 2025 meeting notes identified call light times were still long. R3's admission MDS dated 4/22/25, identified intact cognition and no behaviors. He required	F0550	Continued from page 1 How the facility will identify other residents having the potential to be affected by the same deficient practice. The Resident Council meeting minutes were reviewed with the IDT to confirm all grievances are addressed. An upcoming meeting will update residents on call light issue follow-up. Social services will audit or interview 10 residents weekly about call light response and satisfaction and address any concerns. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. The Call Light policy and procedure have been updated. A comprehensive staff meeting was conducted to review the revised policy and clarify expectations regarding response times to call lights. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Weekly audits of call light responsiveness and satisfaction will be conducted for 30 days. Subsequently, 10 audits per month will be completed over the next quarter, followed by 10 audits per quarter. Resident council minutes, grievances, and audit results will be reported to the QAPI Committee, which will evaluate the data to determine when compliance has been achieved. The date that each deficiency will be corrected. 8/14/25	

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F0550 SS = D	Continued from page 2 substantial/maximal assistant with personal hygiene and upper body dressing, dependent upon staff to provide toileting hygiene, lower body dressing, and chair/bed to chair transfers. He had an indwelling urinary catheter and frequently incontinent of bowel. Medical diagnoses included neurogenic bladder (bladder dysfunction caused by neurologic damage due to brain, spinal cord, or nerve problems), urinary tract infection (UTI), paraplegia (paralysis that affects the lower half of the body on both sides), and seizure disorder. R3's care plan dated 4/22/25, identified self-care deficit with ADLs and directed staff to aid with all personal cares, toileting, and transfers. R4's quarterly Minimum Data Set (MDS) dated 5/26/25, identified intact cognition, and no behaviors. He had impairment of functional range of motion (ROM) on one side and required substantial/maximal assistance with toileting hygiene, upper body dressing, personal hygiene, roll left and right, dependent for lower body dressing, all transfers, and used a manual wheelchair for mobility. He was frequently incontinent of bowel and bladder. Medical diagnoses include stroke, hemiplegia/hemiparalysis (paralysis or severe weakness on one side of the body), and depression. R4's care plan dated 6/9/25, identified self-care deficit with activities of daily living (ADLS) and directed staff to provide extensive assistance of one to two staff with all ADLS, bed mobility toileting, dressing, grooming, and wheelchair mobility, transfer with assistance of two staff and Hoyer lift, and care always provided in pairs of two caregivers. During an observation and interview on 7/2/25 at 11:50 a.m., R3 laid on his back, on his bed fully dressed, call light located outside, above his room door was on and activated before entry to room. R3 stated it had taken a long time for them to answer his call light, placed it on 10 minutes ago. R3 stated, they help him get up into his wheelchair, he wears a brief and was able to make staff aware when he required assistance, adding he was in an accident when his legs became paralyzed so he was unable to walk or self -transfer and wished he could do more for himself. He also indicated call light wait times were up to 15 to 20 minutes or longer and he was not ok with that. He was told by staff they do not want him to self-transfer and	F0550		

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F0550 SS = D	Continued from page 3 fall because they would get into trouble, then do not answer his call light for a long time. The long call light wait times happened all the time, not a certain time of the day/night. He stated it bothered him to have to wait a long time for assistance, made him mad, and felt like staff do not care. At 12:05 p.m. R3's call light remained on (over 15 observed minutes). He wanted to get up for lunch and use the telephone. At 12:12 p.m. nursing assistance NA-A carried two plates of food into his room (not acknowledging the call light) She asked him which one he wanted for lunch, R3 chose, she then turned around to exit the room and he stated "can I get up in my chair please?" NA-A stopped, turned around an stated, "oh yea", and continued to walk down the hallway while she carried the plates of food. He stated the call light was turned on at least 10 minutes prior to the surveyor entering my room and would really like to get up for lunch, and off his back as he had been laying down for quite a while now. At 12:15 p.m. no staff were seen in the hallway. R3's call light remained on and continued to beep approximately every 9 seconds. At 12:18 p.m. (over 28 observed minutes) NA-A was seen walking in hallway towards his room, opened the door and entered a room located right before R3's room. In less than one minute NA-A exited the room and walked towards his room, and stated, "this man needs to get up" and entered R3's room. She informed him he was not forgotten and she had planned on helping him get out of bed. She left the call light on at 12:20 p.m., exited his room, and walked down the hallway. At 12:25 p.m. (over 40 observed minutes and 50 minutes per resident interview) NA-A and NA-B entered his room with a EZ lift machine, closed the door, and turned call light off. During an interview on 7/2/25 at 2:44 p.m., NA-B stated staff were expected to answer a resident's call light within 15 minutes, adding it would be important to respond to call lights right away in case the resident may have fallen, required assistance to be cleaned up or get up, and their needs/expectations are expected to be met. During an interview on 7/2/25 at 4:23 p.m., NA-A stated staff were expected to answer call lights within 15 minutes. We do not know what they are calling for and may be in need of medications, water, or are on the floor. We should not assume why they requested help. We are expected to respond to the call lights in a timely manner to meet the resident's needs.	F0550		

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F0550 SS = D	Continued from page 4 During an interview on 7/3/25 at 2:00 p.m., family member (FM) stated R4 had an episode in June 2025, when staff did not answer his call light for over almost an hour and he was sick and needed assistance. He continued to have concerns about long call light wait times after meals when he was in his wheelchair and requested to go back to bed so that he could use his urinal. Call light response time was anywhere from twenty minutes up to over one hour. There were times when staff came into his room, turned off call light off, indicated they would have to find another staff to assist and had taken up to one hour to return to his room. FM had received phone calls from R4 and he was incontinent of urine and unable to get assistance. He used a urinal to prevent incontinence but required staff to place the urinal for him while in bed. Prior to his stroke he was a very clean and well-groomed person, it really bothered him, and felt embarrassed to have had urine accidents. During an interview on 7/3/25 at 1:44 p.m. director of nursing (DON) stated staff were expected to respond to call lights in less than 15 minutes. The residents relied on staff for care and it could have been an emergent thing they need assistance with. Facility policy Answering the Call light dated 9/2022, identified staff were expected to response to resident call lights in a timely manner to meet their requests and needs. Calls lights were expected to be answered immediately. If resident required assistance indicate the approximate time it will take for you to respond. If the resident request was something you can fulfill, complete the task within five minutes if possible. Facility policy Combined Federal and Minnesota State Bill of Rights dated 6/8/19, identified resident rights was defined as a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The resident had the right to be treated with respect and dignity including the right to reside and receive services in the facility with reasonable accommodations of resident needs.	F0550		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F0760	F0760 Residents are Free of Significant Med Errors How corrective action will be accomplished for those residents found to have been affected by the deficient practice	08/15/2025

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F0760 SS = D	Continued from page 5 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure 1 of 3 resident (R2) was free of significant medication errors when physician's orders for Darbepoetin (causes the bone marrow to produce red blood cells and used to treat anemia in people with chronic kidney failure) was not administered as prescribed, resulting in seven missed doses of Darbepoetin. Findings include: R2's admission Minimum Data Set (MDS) dated 3/11/25, identified moderately impaired cognition and no behaviors. R2's quarterly MDS date 5/30/25, identified medical diagnoses of anemia (low red blood cell count), coronary disease (CAD), high blood pressure (HTN), renal failure, neurogenic bladder, diabetes mellitus (DM), anxiety, and depression. Currently taking a diuretic (reduces fluid buildup in body) and daily insulin. R2's emergency department (ED) record dated 8/23/24, identified . . . labs notable for hemoglobin of 6.8 which is baseline between 8 and 9. Creatinine is 3.2 with prior values between 2.5 and 3.3. Emails exchanged with provider and facility assistant director of nursing (ADON) prior to R2's admission to facility on 3/4/25, revealed the following: -on 2/27/25, from ADON to provider - received all correct documentation, diagnoses, length of time it will be prescribed and a note from a specialty it should be covered, would also need to get from a specialty clinic through our pharmacy so that if "you guys" are able to do a hemoglobin (hgb) this weekend and administer as needed so that we have time to get the medication, we can do Monday at 10:30 a.m. -on 2/28/25, from provider to ADON: the provider will continue monitoring the injections. We can arrange for	F0760	Continued from page 5 R2 discharged from the facility on 7/1/2025. How the facility will identify other residents having the potential to be affected by the same deficient practice. Comprehensive audits of physician orders were conducted for all residents, encompassing both the scheduling and completion of external provider appointments. Medication error reports from the past three months have been reviewed by the Director of Nursing with no adverse effects noted. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. A meeting was conducted with the designated pharmacy to review medication procedures. The protocols for appointment scheduling and order transcription have been updated, and all pertinent staff have undergone the necessary training. Additionally, a new system will be introduced for managing and monitoring external appointments to facilitate prompt receipt of follow-up information. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Five resident audits focusing on order transcription and appointment scheduling will be conducted weekly for 30 days. Subsequently, five audits per month will be carried out for one quarter, followed by five audits per quarter thereafter. The results of these audits will be reported to the QAPI Committee, which will assess compliance and determine when established standards have been met. The date that each deficiency will be corrected 8/15/25	

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F0760 SS = D	Continued from page 6 continued transportation to and from renal clinic. -on 3/4/25, from ADON to provider: just need the layout of his rides and appointment times . . . main thing is the injections and make sure labs and rides are set-up, our lab days are Mondays. R2's hospital discharge summary dated 3/4/25, identified acute kidney injury/chronic kidney disease (commonly caused by HTN and diabetes) vs end stage chronic kidney disease (CKD), stage four (very poor kidney function, kidneys were severely damaged and close to not working), right lower below the knee amputation. Has had progressively worsening renal function, admitted with encephalopathy (brain damage due to lack of oxygen), anemia likely due to CKD stage four and iron deficiency. No indications for dialysis . . . patient did not want dialysis . . . Hemoglobin (hgb) (a protein in the red blood cells that carries oxygen and carbon dioxide) dropped less than 7.0 to 6.7, on 2/2/25, transfused with one unit, 2/3/25 hgb 8.2 , and 2/10/25 hgb 8.4. Plan: will continue monitoring hgb intermittently and transfuse for hgb below 7, iron sucrose 200 milligrams (mg) intravenously (IV) times three days (1/28/25 through 1/30/25), started Darbepoetin 1/30/25, currently at 80 micrograms (mcg) every two weeks, next dose 3/13/25, complete blood count (CBC) should be drawn on 3/12/25 prior to dose and a four week follow up appointment. R2's hospital discharge medication orders dated 3/4/25, identified: -Darbepoetin Alfa, Recombinant injection solution 80 mcg/0.8 millimeters (ml) subcutaneously (SQ) every two weeks. Increase dose for next dose 3/13/25 (last dose 2/27/25), renal following indication: anemia. -Needs renal clinic follow up in one month with CBC and comprehensive metabolic panel (CMP) at Veteran's clinic, provider was arranging. Review of R2's electronic medication record (EMAR) for March 2025, April 2025, May 2025, June 2025, and July 2025, lacked evidence the order written on 3/4/25, for Darbepoetin Alfa, Recombinant injection solution 80 mcg/0.8 millimeters (ml) subcutaneously (SQ) every two weeks. Increase dose for next dose 3/13/25 (last dose 2/27/25), renal following, was not located or signed off as administered while R2 resided at the facility	F0760		

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 07/03/2025

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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F0760 SS = D	Continued from page 7 from 3/4/35, through 6/19/25, seven missed doses. R2's labs from 3/4/25 through 6/16/25, identified: - on 3/12/25 the R2's record lacked evidence a lab draw was completed as ordered. -on 3/24/25, Albumin (a protein in the blood plasma, keeps fluid from leaking out of the blood stream) 3.3 grams/deciliter (g/dL) low, carbon dioxide (CO2) (helps maintain acid/base balance in your body) 18 millimoles per liter (mmol/L) low, urea nitrogen (waste product the body removes from the blood) 50.6 mg/dl high, creatinine (waste product from muscle metabolism and excreted in urine) 3.6 mg/dL high, glomerular filtration rate (GFR) (checks to see how well the kidneys can filter the blood) estimate 21 mL/min low, hgb 9.1 g/dL low, and hematocrit (HCT) 28.8 %. -on 4/14/25, CO2 21 mmol/L low, urea nitrogen 49.1 mg/dl high, creatinine 3.90 mg/dL high, GFR estimate 17 mL/min low, hgb 9.2 g/dL low, HCT 29% low. -on 6/16/25, hgb 7.6 g/dL low. Handwritten note: results called to provider office and triage will update nurse practitioner (NP) on 6/16/25. Nurse practitioner (NP) visits dated 3/20/25, 4/10/25, 4/29/25, 5/14/25, and 6/10/25, identified list of current medications included Darbepoetin alfa recombinant injection solution 80 mcg/O ml SQ every two weeks. Increased dose for next dose 3/13/25 (last dose 2/7/25), renal following. Indication: for anemia. R2's provider order's dated 4/1/25 through 4/30/35, 5/1/25 through 5/31/25, 6/1/25 through 6/30/25, signed by provider each month, identified: Start dated 3/4/35 end date: open ended: Darbepoetin alfa recombinant injection solution mcg/0.8 ml solution; 0.8 ml; amt: 0.8 ml; subcutaneous. Special instructions: renal following, anemia. R2's renal consult dated 4/3/25, identified kidney function improved today creatinine 3.1, GFR 22 (best in months). Still would not want dialysis. Hgb at 10, continue same dose of Darbepoetin. Next renal appointment 7/2/25, 2:00 p.m. and labs at 1:00 p.m. R2's progress notes from 6/19/25, through 6/23/25,	F0760		

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F0760 SS = D	Continued from page 8 identified: -on 6/19/25 at 11:20 a.m., writer called NP regarding hgb 7.9 resident complained of extreme fatigue and he was not feeling well. Per provider okay to send to emergency room (ER) for evaluation. Resident was agreeable to go to hospital. -on 6/19/25 at 1:25 p.m., resident sent to hospital for low hgb 7.9 with extreme fatigue. Writer contacted power of attorney (POA), spoke with her and notified her of resident status. -on 6/19/15 at 8:19 p.m., writer called hospital . . . admitted. . . and unsure when he would be discharged. -on 6/21/25 at 1:04 a.m., writer called hospital . . . resident was being followed by renal related to high potassium and creatinine and low hgb . . . no discharge date at this time. During an interview on 7/2/25 at 1:40 p.m., pharmacist (P) stated the facility sent discharge orders dated 3/4/25, from the hospital and included an order for Darbepoetin. The pharmacy would have been able to fill the order and they could have administered it. This medication was ordered due to the diagnoses of severe anemia. The medication helps make red blood cells in order to keep the hgb up and prevent anemia. This medication was a specialty drug and required clarification/preauthorized of the LTC facility. We contacted the facility for clarification, no response back, and Darbepoetin was not ordered, requested, or provided from our pharmacy. This medication was ordered to be administered every two weeks. During an interview on 7/2/25 at 2:20 p.m., PharmD (PD) stated there was an order for Darbepoetin. On 3/4/25, the medication was entered by health unit coordinator (HUC), verified by licensed practical nurse (LPN)-A, and discontinued on 7/2/25. The Darbepoetin was usually administered for anemia and if received would have helped keep up R2's hgb. He ran and reviewed the resident medications every month, searched order history, Darbepoetin did not show up on his reports (EMAR/TAR/notes), and most likely was missed. He was unable to identify when or if the medication was administered while he was a resident at the facility. During an interview on 7/2/25 at 4:15 p.m., HUC stated she was responsible to enter the orders for a new	F0760		

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F0760 SS = D	Continued from page 9 admission into the EMAR from the orders received. The floor nurse or ADON would be the second staff to verify all ordered entered. On 3/4/25, she entered R2's orders into the EMAR and LPN-A came down from 2nd floor and verified them. She recalled the order for the Darbepoetin and was unsure what happened when it was not located on the EMAR. HUC stated she was unaware of this error until it was brought to her attention today. When an order was placed in the general orders, staff were unable to view it on the EMAR to administer the medication and would have only been seen on the order sheets in the electronic medical records. She did not recall a fax or call from pharmacy for clarification regarding that specific medication. During an interview on 7/3/25 at 9:47 a.m., LPN-A stated the HUC uploads the medication orders into the EMAR and then notifies the nurse to verify them. Two staff were required to verify the orders entered and one of them must be a nurse. LPN-A stated he systematically reviewed each medication with the printed discharge orders from the hospital with the EMAR and had not remembered verification of R2's medications on 3/4/25. He was unaware of a medication error (Darbepoetin) and how that could have happened. During an interview on 7/3/25 at 10:15 a.m., ADON stated the HUC was responsible to enter orders into the EMAR and a staff nurse should have verified them. The Darbepoetin was placed in the general order which meant we were not intending to administer it in house. R2 received a dose of Darbepoetin SQ prior to his discharge from the hospital on 3/4/25 and admitted to our facility. He was to continue to receive the injections at the renal clinic. Labs (CBC) were ordered to be completed on 3/12/25 prior to the next injection on 3/13/25 and were not completed until 3/24/25. The HUC would have been responsible to schedule the follow-up appointment with renal provider, who would then administer the injection. R2 was seen by renal on 3/21/25, order was to continue Darbepoetin injections and was signed off by the facility staff nurse. R2 resided in our facility, he was our responsibility, and we failed to follow through and he had not received the Darbepoetin as ordered. The medication should have been given for his chronic kidney disease. This was considered a medication error and the provider should have been notified. Call placed on 7/3/25 at 1:22 p.m., renal provider, voicemail left, but no return call received.	F0760		

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F0760 SS = D	Continued from page 10 During an interview on 7/2/25 at 4:05 p.m., director of nursing (DON) stated the order for the Darbepoetin was entered correctly by the HUC but it may have defaulted and went into the general flow sheet section instead of the medication flow sheet and therefore did not show up on the EMAR. The nurse verified R2's admission orders were entered into the computer system but was unaware this medication was placed in the general section and not on the EMAR, and so it got missed. R2 had not received the Darbepoetin as ordered. Facility policy Administering Medications dated 4/2019, identified medications are to be administered in a safe and timely manner, and as prescribed. Facility policy Adverse Consequences and Medication Errors dated 2/2023, identified the definition of a medication error as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. An example of medication error include omission of a drug ordered but not administered. A significant medication-related error was defined as requiring hospitalization, or extending a hospitalization, requiring medication discontinuation or dose modification, and requiring treatment with a prescription medication.	F0760		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F0880	F0880 Infection Prevention & Control How corrective action will be accomplished for those residents found to have been affected by the deficient practice R4 exhibited no adverse effects following the observation. The care plan for R4 has been reviewed and remains up to date. How the facility will identify other residents having the potential to be affected by the same deficient practice. The Infection Preventionist reviewed the Infection Control program, and audits for standards are ongoing.	08/15/2025

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F0880 SS = D	Continued from page 11 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880	Continued from page 11 What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. The Handwashing Policy underwent a comprehensive review. Infection and antibiotic records are examined weekly to monitor emerging trends and determine necessary follow-up actions. Additionally, all staff members have completed training on infection control protocols, with an emphasis on proper hand hygiene. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Five staff audits focused on infection control standards will be conducted weekly for 30 days. After this period, five audits per month will be performed for one quarter, followed by five audits per quarter. Audit results will be reported to the QAPI Committee, which will review compliance and decide when the standards are met. The date that each deficiency will be corrected: 8/15/25	

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F0880 SS = D	Continued from page 12 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate hand hygiene was performed during personal cares for 1 of 1 resident (R4) reviewed for infection prevention and control. Findings include: R4's quarterly Minimum Data Set (MDS) dated 5/26/25, identified intact cognition, impairment of functional range of motion (ROM) on one side and required substantial/maximal assistance with toileting hygiene, upper body dressing, personal hygiene, roll left and right, dependent for lower body dressing, all transfers, and used a manual wheelchair for mobility. He was frequently incontinent of bowel and bladder. Medical diagnoses include stroke, hemiplegia/hemiparalysis (paralysis or severe weakness on one side of the body), and depression. R4's care plan dated 9/26/25, identified self-care deficit with activities of daily living (ADL) and directed staff to provide extensive assistance of one to two staff with all ADL, bed mobility toileting, dressing, grooming, and wheelchair mobility, transfer with assistance of two staff and Hoyer lift, and care always provided in pairs of two. During an observation on 7/2/25 at 12:27 p.m., R4's room call light was noted to be on. He laid in bed on his back covered up with a sheet, and head of bed up approximately 20 degrees. At 12:37 p.m. two nursing assistants (NA)-A and NA-B entered the room with an EZ way smart lift machine. NA-B opened drawers and was unable to find wipes. NA-B exited the room without sanitizing hands and returned shortly thereafter with wipes. NA-A and NA-B applied gloves, and together pulled down his pants and the front of his brief. NA-A wiped the front peri area from front to back. He was turned onto his left side, brief was pulled away from his buttocks, NA-A wiped his rectal area from front to back and stool was visible on the wipe and brief. NA-A was not observed removing her gloves, sanitizing her hands and donning new gloves before she placed a clean	F0880		

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F0880 SS = D	Continued from page 13 brief and the lift sling underneath him. R4 was turned onto his right side, while NA-A placed her gloved hands on his left shoulder and right leg, pulled him over, pulled up brief and pants. NA-A and NA-B each placed a shoe on one foot. NA-A grabbed the EZ lift machine by the handles and pushed it over to the resident while he laid in bed. NA-A hooked up the lift sling loops to the EZ lift machine, raised him off the bed, lowered him down into his wheelchair and removed the lift sheet loops from the EZ lift machine. NA-A straightened the bed sheets, placed dirty linen in two clear bags, removed her gloves, and did not sanitize her hands. She held the dirty gloves in her hand along with the two bags of dirty linen, exited the room, walked down the hallway, entered a dirty utility room, disposed of the two bags and the dirty gloves, all without observation of sanitizing her hands. She then walked back down the hallway, opened the door, entered the nurse's station, and washed her hands at the sink with soap and water, and dried them with a paper towel. During an interview on 7/2/25 at 2:44 p.m., NA-B stated staff were expected to complete hand hygiene prior to the start of and after cares with a resident, prior to when the resident goes to dining room, before they eat, and when gloves were changed. Hand hygiene was important to help prevent the spread of germs from one area to another. During an interview on 7/2/225 at 4:23 p.m., NA-A stated staff were expected to complete hand hygiene before and after resident cares and after removal of gloves. She preferred to use soap and water to make sure hands were thoroughly clean. Hand hygiene was important for resident and staff safety to help prevent the spread of sickness, disease, and infection around by touching something dirty then touching clothing or the resident. NA-A stated she had changed her gloves after she completed R4's peri cares (though this was not in the observation)but did not sanitize her hands prior to the application of a new pair of gloves or exiting the resident's room and should have. She usually had hand sanitizer in her pocket but had forgot it. During an interview on 7/3/25 at 10:15 a.m., assistant director of nursing (ADON) stated staff were expected to complete hand hygiene prior to taking care of a resident, prior to entering their room, exiting their room, in between cares, before and after glove use. Hand hygiene was important to prevent infection.	F0880		

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F0880 SS = D	Continued from page 14 During an interview on 7/3/25 at 1:44 p.m., director of nursing (DON) stated staff were expected to complete hand hygiene prior to resident cares, after cares as they leave the room, after removal of gloves, before clean gloves were applied to prevent infection. The staff should have completed hand hygiene multiple times during the observation with R4's cares and transfer. Facility policy Handwashing/Hand Hygiene dated 10/2023, identified hand hygiene is the primary means to prevent the spread of healthcare associated infections. Hand hygiene was indicated: immediately before touching a resident, before performing an aseptic task, after contact with blood, body fluids, or contaminated surfaces, after touching the resident's environment, before moving from work on a soiled body site to a clean body site on the same resident, and immediately after glove removal. Wash hands with soap and water when hands are visibly soiled and after contact with a resident with infectious diarrhea. Single-use disposable gloves should be used before aseptic procedures, when anticipating contact with blood or body fluids, and when in contact with resident, equipment or environment of a resident who is on contact precautions. The use of gloves does not replace hand washing/hygiene. Perform hand hygiene before and after application of gloves.	F0880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 25, 2025

Administrator

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

Re: State Nursing Home Licensing Orders
Event ID: DQIN11

Dear Administrator:

The above facility was surveyed on July 3, 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.

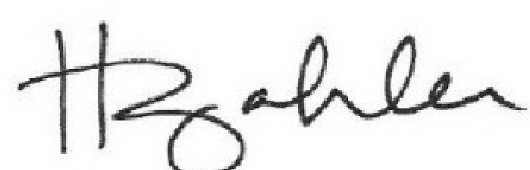
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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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
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: On 7/1/25 through 7/3/25, 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 and identify the date when they will be completed.	20000		08/15/2025

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 07/03/2025

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20000	Continued from page 1	20000		

The following complaints were reviewed:

H55467307C (MN00113838). No licensing orders were issued.

H55468311C (MN00114219) with licensing orders issued at 1545 and 1805.

Additionally, as a result of the investigation, a licensing order was issued at 1390.

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

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20000	Continued from page 2 PAGE	20000		
21390	Infection Control CFR(s): MN Rule 4658.0800 Subp. 4 A-I Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate hand hygiene was performed during personal cares for 1 of 1 resident (R4) reviewed for infection prevention and control. Findings include: R4's quarterly Minimum Data Set (MDS) dated 5/26/25, identified intact cognition, impairment of functional	21390	Corrected.	08/15/2025

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21390	Continued from page 3 range of motion (ROM) on one side and required substantial/maximal assistance with toileting hygiene, upper body dressing, personal hygiene, roll left and right, dependent for lower body dressing, all transfers, and used a manual wheelchair for mobility. He was frequently incontinent of bowel and bladder. Medical diagnoses include stroke, hemiplegia/hemiparalysis (paralysis or severe weakness on one side of the body), and depression. R4's care plan dated 9/26/25, identified self-care deficit with activities of daily living (ADL) and directed staff to provide extensive assistance of one to two staff with all ADL, bed mobility toileting, dressing, grooming, and wheelchair mobility, transfer with assistance of two staff and Hoyer lift, and care always provided in pairs of two. During an observation on 7/2/25 at 12:27 p.m., R4's room call light was noted to be on. He laid in bed on his back covered up with a sheet, and head of bed up approximately 20 degrees. At 12:37 p.m. two nursing assistants (NA)-A and NA-B entered the room with an EZ way smart lift machine. NA-B opened drawers and was unable to find wipes. NA-B exited the room without sanitizing hands and returned shortly thereafter with wipes. NA-A and NA-B applied gloves, and together pulled down his pants and the front of his brief. NA-A wiped the front peri area from front to back. He was turned onto his left side, brief was pulled away from his buttocks, NA-A wiped his rectal area from front to back and stool was visible on the wipe and brief. NA-A was not observed removing her gloves, sanitizing her hands and donning new gloves before she placed a clean brief and the lift sling underneath him. R4 was turned onto his right side, while NA-A placed her gloved hands on his left shoulder and right leg, pulled him over, pulled up brief and pants. NA-A and NA-B each placed a shoe on one foot. NA-A grabbed the EZ lift machine by the handles and pushed it over to the resident while he laid in bed. NA-A hooked up the lift sling loops to the EZ lift machine, raised him off the bed, lowered him down into his wheelchair and removed the lift sheet loops from the EZ lift machine. NA-A straightened the bed sheets, placed dirty linen in two clear bags, removed her gloves, and did not sanitize her hands. She held the dirty gloves in her hand along with the two bags of dirty linen, exited the room, walked down the hallway, entered a dirty utility room, disposed of the two bags and the dirty gloves, all without observation of sanitizing her hands. She then walked back down the hallway, opened the door, entered the nurse's station,	21390		

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21390	Continued from page 4 and washed her hands at the sink with soap and water, and dried them with a paper towel. During an interview on 7/2/25 at 2:44 p.m., NA-B stated staff were expected to complete hand hygiene prior to the start of and after cares with a resident, prior to when the resident goes to dining room, before they eat, and when gloves were changed. Hand hygiene was important to help prevent the spread of germs from one area to another. During an interview on 7/2/225 at 4:23 p.m., NA-A stated staff were expected to complete hand hygiene before and after resident cares and after removal of gloves. She preferred to use soap and water to make sure hands were thoroughly clean. Hand hygiene was important for resident and staff safety to help prevent the spread of sickness, disease, and infection around by touching something dirty then touching clothing or the resident. NA-A stated she had changed her gloves after she completed R4's peri cares (though this was not in the observation)but did not sanitize her hands prior to the application of a new pair of gloves or exiting the resident's room and should have. She usually had hand sanitizer in her pocket but had forgot it. During an interview on 7/3/25 at 10:15 a.m., assistant director of nursing (ADON) stated staff were expected to complete hand hygiene prior to taking care of a resident, prior to entering their room, exiting their room, in between cares, before and after glove use. Hand hygiene was important to prevent infection. During an interview on 7/3/25 at 1:44 p.m., director of nursing (DON) stated staff were expected to complete hand hygiene prior to resident cares, after cares as they leave the room, after removal of gloves, before clean gloves were applied to prevent infection. The staff should have completed hand hygiene multiple times during the observation with R4's cares and transfer. Facility policy Handwashing/Hand Hygiene dated 10/2023, identified hand hygiene is the primary means to prevent the spread of healthcare associated infections. Hand hygiene was indicated: immediately before touching a resident, before performing an aseptic task, after contact with blood, body fluids, or contaminated surfaces, after touching the resident's environment,	21390		

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21390	Continued from page 5 before moving from work on a soiled body site to a clean body site on the same resident, and immediately after glove removal. Wash hands with soap and water when hands are visibly soiled and after contact with a resident with infectious diarrhea. Single-use disposable gloves should be used before aseptic procedures, when anticipating contact with blood or body fluids, and when in contact with resident, equipment or environment of a resident who is on contact precautions. The use of gloves does not replace hand washing/hygiene. Perform hand hygiene before and after application of gloves. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review and revise policies and procedures related to ensuring staff were following proper hand hygiene process. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are following guidance with hand hygiene. TIME PERIOD FOR CORRECTION: Twenty-one- (21) days	21390		
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error	21545	Corrected.	08/15/2025

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21545	Continued from page 6 could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure 1 of 3 resident (R2) was free of significant medication errors when physician's orders for Darbepoetin (causes the bone marrow to produce red blood cells and used to treat anemia in people with chronic kidney failure) was not administered as prescribed, resulting in seven missed doses of Darbepoetin. Findings include: R2's admission Minimum Data Set (MDS) dated 3/11/25, identified moderately impaired cognition and no behaviors. R2's quarterly MDS date 5/30/25, identified medical diagnoses of anemia (low red blood cell count), coronary disease (CAD), high blood pressure (HTN), renal failure, neurogenic bladder, diabetes mellitus (DM), anxiety, and depression. Currently taking a diuretic (reduces fluid buildup in body) and daily insulin. R2's emergency department (ED) record dated 8/23/24, identified . . . labs notable for hemoglobin of 6.8 which is baseline between 8 and 9. Creatinine is 3.2 with prior values between 2.5 and 3.3.	21545		

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Emails exchanged with provider and facility assistant director of nursing (ADON) prior to R2's admission to facility on 3/4/25, revealed the following:

-on 2/27/25, from ADON to provider - received all correct documentation, diagnoses, length of time it will be prescribed and a note from a specialty it should be covered, would also need to get from a specialty clinic through our pharmacy so that if "you guys" are able to do a hemoglobin (hgb) this weekend and administer as needed so that we have time to get the medication, we can do Monday at 10:30 a.m.

-on 2/28/25, from provider to ADON: the provider will continue monitoring the injections. We can arrange for continued transportation to and from renal clinic.

-on 3/4/25, from ADON to provider: just need the layout of his rides and appointment times . . . main thing is the injections and make sure labs and rides are set-up, our lab days are Mondays.

R2's hospital discharge summary dated 3/4/25, identified acute kidney injury/chronic kidney disease (commonly caused by HTN and diabetes) vs end stage chronic kidney disease (CKD), stage four (very poor kidney function, kidneys were severely damaged and close to not working), right lower below the knee amputation. Has had progressively worsening renal function, admitted with encephalopathy (brain damage due to lack of oxygen), anemia likely due to CKD stage four and iron deficiency. No indications for dialysis . . . patient did not want dialysis . . . Hemoglobin (hgb) (a protein in the red blood cells that carries oxygen and carbon dioxide) dropped less than 7.0 to 6.7, on 2/2/25, transfused with one unit, 2/3/25 hgb 8.2 , and 2/10/25 hgb 8.4. Plan: will continue monitoring hgb intermittently and transfuse for hgb below 7, iron sucrose 200 milligrams (mg) intravenously (IV) times three days (1/28/25 through 1/30/25), started Darbepoetin 1/30/25, currently at 80 micrograms (mcg) every two weeks, next dose 3/13/25, complete blood count (CBC) should be drawn on 3/12/25 prior to dose and a four week follow up appointment.

R2's hospital discharge medication orders dated 3/4/25, identified:

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21545	Continued from page 8 -Darbepoetin Alfa, Recombinant injection solution 80 mcg/0.8 millimeters (ml) subcutaneously (SQ) every two weeks. Increase dose for next dose 3/13/25 (last dose 2/27/25), renal following indication: anemia. -Needs renal clinic follow up in one month with CBC and comprehensive metabolic panel (CMP) at Veteran's clinic, provider was arranging. Review of R2's electronic medication record (EMAR) for March 2025, April 2025, May 2025, June 2025, and July 2025, lacked evidence the order written on 3/4/25, for Darbepoetin Alfa, Recombinant injection solution 80 mcg/0.8 millimeters (ml) subcutaneously (SQ) every two weeks. Increase dose for next dose 3/13/25 (last dose 2/27/25), renal following, was not located or signed off as administered while R2 resided at the facility from 3/4/35, through 6/19/25, seven missed doses. R2's labs from 3/4/25 through 6/16/25, identified: - on 3/12/25 the R2's record lacked evidence a lab draw was completed as ordered. -on 3/24/25, Albumin (a protein in the blood plasma, keeps fluid from leaking out of the blood stream) 3.3 grams/deciliter (g/dL) low, carbon dioxide (CO_2) (helps maintain acid/base balance in your body) 18 millimoles per liter (mmol/L) low, urea nitrogen (waste product the body removes from the blood) 50.6 mg/dl high, creatinine (waste product from muscle metabolism and excreted in urine) 3.6 mg/dL high, glomerular filtration rate (GFR) (checks to see how well the kidneys can filter the blood) estimate 21 mL/min low, hgb 9.1 g/dL low, and hematocrit (HCT) 28.8 %. -on 4/14/25, CO_2 21 mmol/L low, urea nitrogen 49.1 mg/dl high, creatinine 3.90 mg/dL high, GFR estimate 17 mL/min low, hgb 9.2 g/dL low, HCT 29% low. -on 6/16/25, hgb 7.6 g/dL low. Handwritten note: results called to provider office and triage will update nurse practitioner (NP) on 6/16/25. Nurse practitioner (NP) visits dated 3/20/25, 4/10/25, 4/29/25, 5/14/25, and 6/10/25, identified list of current medications included Darbepoetin alfa recombinant injection solution 80 mcg/O ml SQ every two weeks. Increased dose for next dose 3/13/25 (last dose 2/7/25), renal following. Indication: for anemia.	21545		

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21545	Continued from page 9 R2's provider order's dated 4/1/25 through 4/30/35, 5/1/25 through 5/31/25, 6/1/25 through 6/30/25, signed by provider each month, identified: Start dated 3/4/35 end date: open ended: Darbepoetin alfa recombinant injection solution mcg/0.8 ml solution; 0.8 ml; amt: 0.8 ml; subcutaneous. Special instructions: renal following, anemia. R2's renal consult dated 4/3/25, identified kidney function improved today creatinine 3.1, GFR 22 (best in months). Still would not want dialysis. Hgb at 10, continue same dose of Darbepoetin. Next renal appointment 7/2/25, 2:00 p.m. and labs at 1:00 p.m. R2's progress notes from 6/19/25, through 6/23/25, identified: -on 6/19/25 at 11:20 a.m., writer called NP regarding hgb 7.9 resident complained of extreme fatigue and he was not feeling well. Per provider okay to send to emergency room (ER) for evaluation. Resident was agreeable to go to hospital. -on 6/19/25 at 1:25 p.m., resident sent to hospital for low hgb 7.9 with extreme fatigue. Writer contacted power of attorney (POA), spoke with her and notified her of resident status. -on 6/19/15 at 8:19 p.m., writer called hospital . . . admitted. . . and unsure when he would be discharged. -on 6/21/25 at 1:04 a.m., writer called hospital . . . resident was being followed by renal related to high potassium and creatinine and low hgb . . . no discharge date at this time. During an interview on 7/2/25 at 1:40 p.m., pharmacist (P) stated the facility sent discharge orders dated 3/4/25, from the hospital and included an order for Darbepoetin. The pharmacy would have been able to fill the order and they could have administered it. This medication was ordered due to the diagnoses of severe anemia. The medication helps make red blood cells in order to keep the hgb up and prevent anemia. This medication was a specialty drug and required clarification/preauthorized of the LTC facility. We contacted the facility for clarification, no response back, and Darbepoetin was not ordered, requested, or provided from our pharmacy. This medication was ordered to be administered every two weeks.	21545		

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During an interview on 7/2/25 at 2:20 p.m., PharmD (PD) stated there was an order for Darbepoetin. On 3/4/25, the medication was entered by health unit coordinator (HUC), verified by licensed practical nurse (LPN)-A, and discontinued on 7/2/25. The Darbepoetin was usually administered for anemia and if received would have helped keep up R2's hgb. He ran and reviewed the resident medications every month, searched order history, Darbepoetin did not show up on his reports (EMAR/TAR/notes), and most likely was missed. He was unable to identify when or if the medication was administered while he was a resident at the facility.

During an interview on 7/2/25 at 4:15 p.m., HUC stated she was responsible to enter the orders for a new admission into the EMAR from the orders received. The floor nurse or ADON would be the second staff to verify all ordered entered. On 3/4/25, she entered R2's orders into the EMAR and LPN-A came down from 2nd floor and verified them. She recalled the order for the Darbepoetin and was unsure what happened when it was not located on the EMAR. HUC stated she was unaware of this error until it was brought to her attention today. When an order was placed in the general orders, staff were unable to view it on the EMAR to administer the medication and would have only been seen on the order sheets in the electronic medical records. She did not recall a fax or call from pharmacy for clarification regarding that specific medication.

During an interview on 7/3/25 at 9:47 a.m., LPN-A stated the HUC uploads the medication orders into the EMAR and then notifies the nurse to verify them. Two staff were required to verify the orders entered and one of them must be a nurse. LPN-A stated he systematically reviewed each medication with the printed discharge orders from the hospital with the EMAR and had not remembered verification of R2's medications on 3/4/25. He was unaware of a medication error (Darbepoetin) and how that could have happened.

During an interview on 7/3/25 at 10:15 a.m., ADON stated the HUC was responsible to enter orders into the EMAR and a staff nurse should have verified them. The Darbepoetin was placed in the general order which meant we were not intending to administer it in house. R2 received a dose of Darbepoetin SQ prior to his discharge from the hospital on 3/4/25 and admitted to our facility. He was to continue to receive the

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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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21545	Continued from page 11 injections at the renal clinic. Labs (CBC) were ordered to be completed on 3/12/25 prior to the next injection on 3/13/25 and were not completed until 3/24/25. The HUC would have been responsible to schedule the follow-up appointment with renal provider, who would then administer the injection. R2 was seen by renal on 3/21/25, order was to continue Darbepoetin injections and was signed off by the facility staff nurse. R2 resided in our facility, he was our responsibility, and we failed to follow through and he had not received the Darbepoetin as ordered. The medication should have been given for his chronic kidney disease. This was considered a medication error and the provider should have been notified. Call placed on 7/3/25 at 1:22 p.m., renal provider, voicemail left, but no return call received. During an interview on 7/2/25 at 4:05 p.m., director of nursing (DON) stated the order for the Darbepoetin was entered correctly by the HUC but it may have defaulted and went into the general flow sheet section instead of the medication flow sheet and therefore did not show up on the EMAR. The nurse verified R2's admission orders were entered into the computer system but was unaware this medication was placed in the general section and not on the EMAR, and so it got missed. R2 had not received the Darbepoetin as ordered. Facility policy Administering Medications dated 4/2019, identified medications are to be administered in a safe and timely manner, and as prescribed. Facility policy Adverse Consequences and Medication Errors dated 2/2023, identified the definition of a medication error as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. An example of medication error include omission of a drug ordered but not administered. A significant medication-related error was defined as requiring hospitalization, or extending a hospitalization, requiring medication discontinuation or dose modification, and requiring treatment with a prescription medication. SUGGESTED METHOD OF CORRECTION: (DON) or designee could review facility policies and procedures, educate staff	21545		

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21545	Continued from page 12 and implement an ongoing monitoring system to ensure all resident orders are correctly transcribed and implemented as directed by physician orders. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21805	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 5 Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure call lights were answered in a timely manner for 2 of 3 residents (R3, R4) reviewed for dignity. Findings include: Resident council meeting minutes dated January 2025 identified call light times were long, March 2025 meeting notes identified call light times were still long. R3's admission MDS dated 4/22/25, identified intact cognition and no behaviors. He required substantial/maximal assistant with personal hygiene and upper body dressing, dependent upon staff to provide toileting hygiene, lower body dressing, and chair/bed to chair transfers. He had an indwelling urinary catheter and frequently incontinent of bowel. Medical diagnoses included neurogenic bladder (bladder dysfunction caused by neurologic damage due to brain, spinal cord, or nerve problems), urinary tract infection (UTI), paraplegia (paralysis that affects the lower half of the body on both sides), and seizure disorder. R3's care plan dated 4/22/25, identified self-care deficit with ADLs and directed staff to aid with all personal cares, toileting, and transfers. R4's quarterly Minimum Data Set (MDS) dated 5/26/25, identified intact cognition, and no behaviors. He had	21805	Corrected.	08/15/2025

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21805	Continued from page 13 impairment of functional range of motion (ROM) on one side and required substantial/maximal assistance with toileting hygiene, upper body dressing, personal hygiene, roll left and right, dependent for lower body dressing, all transfers, and used a manual wheelchair for mobility. He was frequently incontinent of bowel and bladder. Medical diagnoses include stroke, hemiplegia/hemiparalysis (paralysis or severe weakness on one side of the body), and depression. R4's care plan dated 6/9/25, identified self-care deficit with activities of daily living (ADLS) and directed staff to provide extensive assistance of one to two staff with all ADLS, bed mobility toileting, dressing, grooming, and wheelchair mobility, transfer with assistance of two staff and Hoyer lift, and care always provided in pairs of two caregivers. During an observation and interview on 7/2/25 at 11:50 a.m., R3 laid on his back, on his bed fully dressed, call light located outside, above his room door was on and activated before entry to room. R3 stated it had taken a long time for them to answer his call light, placed it on 10 minutes ago. R3 stated, they help him get up into his wheelchair, he wears a brief and was able to make staff aware when he required assistance, adding he was in an accident when his legs became paralyzed so he was unable to walk or self -transfer and wished he could do more for himself. He also indicated call light wait times were up to 15 to 20 minutes or longer and he was not ok with that. He was told by staff they do not want him to self-transfer and fall because they would get into trouble, then do not answer his call light for a long time. The long call light wait times happened all the time, not a certain time of the day/night. He stated it bothered him to have to wait a long time for assistance, made him mad, and felt like staff do not care. At 12:05 p.m. R3's call light remained on (over 15 observed minutes). He wanted to get up for lunch and use the telephone. At 12:12 p.m. nursing assistance NA-A carried two plates of food into his room (not acknowledging the call light) She asked him which one he wanted for lunch, R3 chose, she then turned around to exit the room and he stated "can I get up in my chair please?" NA-A stopped, turned around an stated, "oh yea", and continued to walk down the hallway while she carried the plates of food. He stated the call light was turned on at least 10 minutes prior to the surveyor entering my room and would really like to get up for lunch, and off his back as he had been laying down for quite a while now. At 12:15 p.m. no staff were seen in the hallway. R3's call	21805		

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21805	Continued from page 14	21805		

light remained on and continued to beep approximately every 9 seconds. At 12:18 p.m. (over 28 observed minutes) NA-A was seen walking in hallway towards his room, opened the door and entered a room located right before R3's room. In less than one minute NA-A exited the room and walked towards his room, and stated, "this man needs to get up" and entered R3's room. She informed him he was not forgotten and she had planned on helping him get out of bed. She left the call light on at 12:20 p.m., exited his room, and walked down the hallway. At 12:25 p.m. (over 40 observed minutes and 50 minutes per resident interview) NA-A and NA-B entered his room with a EZ lift machine, closed the door, and turned call light off.

During an interview on 7/2/25 at 2:44 p.m., NA-B stated staff were expected to answer a resident's call light within 15 minutes, adding it would be important to respond to call lights right away in case the resident may have fallen, required assistance to be cleaned up or get up, and their needs/expectations are expected to be met.

During an interview on 7/2/25 at 4:23 p.m., NA-A stated staff were expected to answer call lights within 15 minutes. We do not know what they are calling for and may be in need of medications, water, or are on the floor. We should not assume why they requested help. We are expected to respond to the call lights in a timely manner to meet the resident's needs.

During an interview on 7/3/25 at 2:00 p.m., family member (FM) stated R4 had an episode in June 2025, when staff did not answer his call light for over almost an hour and he was sick and needed assistance. He continued to have concerns about long call light wait times after meals when he was in his wheelchair and requested to go back to bed so that he could use his urinal. Call light response time was anywhere from twenty minutes up to over one hour. There were times when staff came into his room, turned off call light off, indicated they would have to find another staff to assist and had taken up to one hour to return to his room. FM had received phone calls from R4 and he was incontinent of urine and unable to get assistance. He used a urinal to prevent incontinence but required staff to place the urinal for him while in bed. Prior to his stroke he was a very clean and well-groomed person, it really bothered him, and felt embarrassed to have had urine accidents.

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21805	Continued from page 15 During an interview on 7/3/25 at 1:44 p.m. director of nursing (DON) stated staff were expected to respond to call lights in less than 15 minutes. The residents relied on staff for care and it could have been an emergent thing they need assistance with. Facility policy Answering the Call light dated 9/2022, identified staff were expected to response to resident call lights in a timely manner to meet their requests and needs. Calls lights were expected to be answered immediately. If resident required assistance indicate the approximate time it will take for you to respond. If the resident request was something you can fulfill, complete the task within five minutes if possible. Facility policy Combined Federal and Minnesota State Bill of Rights dated 6/8/19, identified resident rights was defined as a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The resident had the right to be treated with respect and dignity including the right to reside and receive services in the facility with reasonable accommodations of resident needs. SUGGESTED METHOD OF CORRECTION: The facility could review their education and training in providing dignified care of vulnerable adults and review/implement policies and procedures for ensuring dignified care. The facility could assure all staff are trained on call light expectations, importance of answering timely, and call light management techniques. Call light audits can be conducted to ensure ongoing compliance as well as resident satisfaction surveys. The facility could provide ongoing education and training and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		