Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 31, 2024

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

RE: CCN: 245546
Cycle Start Date: December 13, 2023

Dear Administrator:

On January 11, 2024, 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 31, 2024

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

Re: Reinspection Results
Event ID: NTWL12

Dear Administrator:

On January 11, 2024 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 December 13, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2023

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

RE: CCN: 245546
Cycle Start Date: December 13, 2023

Dear Administrator:

On December 13, 2023, a survey was completed at your facility by the Minnesota Department 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 March 13, 2024 (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 June 13, 2024 (six months after the

identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

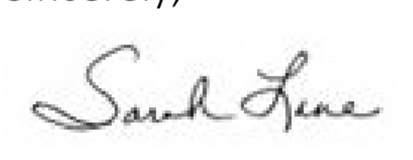
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245546	A. BUILDING _____ B. WING _____	C 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/12/23 through 12/13/23, a standard abbreviated survey and focused infection control survey were 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: H55467923C (MN00099105) with deficiencies issued at F880 and F883. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 880 SS=F	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.	F 880		1/4/24

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

Electronically Signed | 12/27/2023

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

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F 880	Continued From page 1 §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, 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 §483.70(e) 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	F 880		

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F 880	Continued From page 2 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. §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 personal protective equipment (PPE) for source control was worn by all staff, per the Centers for Disease Control (CDC) grid, directing everyone should mask in communal areas of the facility while in COVID-19 outbreak status. This had the opportunity to affect all residents and visitors. Findings include: The CDC PPE grid directs source control is recommended by those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 (COVID-19) or other outbreak of respiratory infection; universal use of source control could be discontinued as mitigation measure once the outbreak is over; no new cases	F 880	F880 Infection Prevention and Control Mission Nursing home has an established infection control program. Mission Nursing Home is following the CDC PPE grid at this time and will continue to do so for all COVID-19 outbreaks or other outbreaks of respiratory infection. All staff scheduled to work any shift since the survey took place on December 12 and December 13 have been spot trained, and a formal house wide training will be completed by January 4, 2024, and signatures will be obtained. Masks will be enforced in all communal and resident care areas, along with frequent hand washing and surface area cleanings per the policy. While caring for	

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F 880	Continued From page 3 of COVID-19 have been identified for 14 days. On 12/12/23 at 9:27 a.m., at the entrance of the facility, a sign indicated the facility had three cases of COVID in the building. On 12/12/23 at 9:27 a.m., a facility document posted on the wall in the entrance of the facility dated 4/17/23 directed masks were no longer required while in the building. On 12/12/23 at 9:27 a.m., the receptionist (R)-A was not wearing a mask while in a communal area on the first floor. On 12/12/23 at 9:28 a.m., social services (SS)-A was not wearing a mask as she walked through the communal area on first floor. On 12/12/23 at 9:28 a.m., the facility administrator walked through the communal areas of first and second floors without a mask. On 12/12/23 at 9:29 a.m., physical therapist (PT)-A was pushing a resident in a wheelchair in the communal area of second floor without a mask. On 12/12/23 at 9:30 a.m., nursing assistant (NA)-A was in the communal area of the second floor without a mask. NA-A stated there were two cases of COVID on the second floor. NA-A stated staff did not wear masks in the hall, but wore them when they entered COVID positive resident rooms. On 12/12/23 at 9:30 a.m., licensed practical nurse (LPN)-A was in the communal area of the second	F 880	residents with respiratory infections and on isolation precautions, proper PPE will be worn including gowns, N95 masks, gloves, and face shields. PPE review will be included in the house wide education for infection control. Employees listed in the identifier list, including the Administrator, R-A, SS-A, PT-A, NA-A, LPN-A, and TMA-A have received repeat training regarding the COVID-19 isolation and infection prevention and control. Ongoing Infection Control and Prevention measures will be monitored during all future outbreaks, and annually as required. The Infection Preventionists have reviewed all Infection Control Policies, and they remain current and in accordance with the CDC requirements.	

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F 880	Continued From page 4 floor without a mask. LPN-A stated there were current cases of COVID in the facility. LPN-A stated staff were not wearing masks in the hall. On 12/12/23 at 9:32 a.m., the administrator stated there were three cases of COVID in the building. The administrator stated COVID had just started 12/11/23. The administrator stated there were also staff out with COVID. On 12/12/23 at 9:35 a.m., trained medication aide (TMA)-A was in the communal area of the second floor without a mask. On 12/12/23 at 10:55 a.m., the director of nursing (DON) stated staff should be wearing masks in communal areas due to the presence of positive COVID cases in the facility. On 12/12/23 at 11:58 a.m., the assistant director of nursing (ADON) stated the current COVID outbreak started on 12/9/23. On 12/12/23 at 3:00 p.m., the medical director (MD)-A stated staff should be wearing masks in the halls and resident areas on the unit where COVID is present. A facility document Employee Health dated 9/20/23 directed all staff to wear an N95 grade mask, and eye protection, goggles or face shield. If you are taking care of a COVID positive resident in their room, you should also wear an isolation gown.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		1/4/24

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F 883	Continued From page 5 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 883		

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F 883	Continued From page 6 already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a timely influenza immunization as recommended by the Centers for Disease Control (CDC) for 1 of 5 residents (R2) residents reviewed for immunizations. Findings include: The CDC recommends before an outbreak occurs the influenza vaccination should be provided routinely to all residents and healthcare personnel of long-term care facilities. If possible, all residents should receive inactivated influenza vaccine (IIV) annually before influenza season. For persons aged =65 years, the following quadrivalent influenza vaccines are recommended: high-dose IIV, adjuvanted IIV, or recombinant influenza vaccine. If not available, standard-dose IIV may be given. R2's admission Minimum Data Set (MDS) dated 10/25/23 indicated he had a medial diagnosis of	F 883	F883 Influenza and Pneumococcal Immunizations R2 has received his Influenza vaccination since the time of the survey. We had a current consent signed by the POA when the resident admitted, but we were waiting on the POA to send his vaccination status since he was from Wisconsin. The Minneapolis VA was able to get us the required information after a few days. His pneumococcal vaccination series is complete, and the Influenza was administered. The Infection Preventionists have reviewed the immunization policies, and they remain current. MNH will review medical records and the MIIC websites upon admission, offer the vaccinations, provide education to all residents/representatives/guardians, and obtain consent or decline signatures for the administration of the vaccines. The vaccinations will be administered within 7	

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F 883	Continued From page 7 Parkinson's Disease. The MDS assessment lacked documentation of influenza immunization. R2's Influenza Consent form signed by R2 on 10/18/23 indicated he wished to receive the influenza immunization. R2's medical record lacked documentation of the influenza immunization for the 2023 influenza season. R2's Minnesota Immunization Information Connection (MIIC) form dated 10/20/23 lacked influenza immunization administration for the 2023 influenza season. On 12/12/23, at 4:03 p.m., the director of nursing (DON) stated R2 was not given the influenza vaccine. On 12/13/23 at 8:52 a.m., the DON stated she and licensed practical nurse (LPN)-B shared the responsibility of tracking and administration of immunizations. On 12/13/23 at 4:08 p.m., licensed practical nurse (LPN)-B stated she was not aware R2 wanted an influenza immunization. On 12/13/23 at 4:10 p.m., the DON stated the facility had not been following their previous process of which residents wanted to get the vaccine. this doesn't really make sense without more info. The DON stated the regulations only stated the immunizations needed to be offered, but did not specify when they were supposed to be administered.	F 883	days of admission. The Preventative Health Status section of the medical record and the MIIC websites will be updated as immunizations are given. All licensed nursing staff will be trained in this new process by January 4, 2024. Audits will be performed on all new admissions by the Infection Preventionists to ensure compliance. The vaccination tracker will be maintained by the Infection Preventionist for all residents house wide to ensure all vaccinations (COVID, Influenza, and Pneumococcal) remain current.	

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F 883	Continued From page 8 The facility Influenza policy dated 1/23 directed between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated or the resident or employee has already been immunized. The policy also directed administration of the influenza vaccine will be made in accordance with current CDC recommendations at the time of the vaccination.	F 883		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: NTWL11

Dear Administrator:

The above facility was surveyed on December 12, 2023 through December 13, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

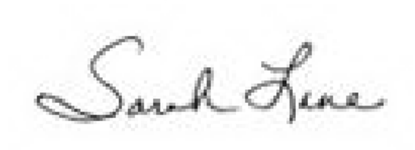
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00235	A. BUILDING: _____ B. WING _____	12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/12/23 through 12/13/23, focused infection control survey and a complaint survey were conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN	2 000		

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2 000	Continued From page 1 State Licensure. The following complaint was reviewed: H55467923C (MN00099105). A licensing order was issued at 4658.0800 Subp 1. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate personal protective equipment (PPE) for source control was worn by all staff, per the Centers for Disease Control (CDC) grid, directing everyone should mask in communal areas of the facility while in COVID-19 outbreak status. This had the opportunity to affect all residents and visitors. Findings include:	21375	F880 Infection Prevention and Control Mission Nursing home has an established infection control program. Mission Nursing Home is following the CDC PPE grid at this time and will continue to do so for all COVID-19 outbreaks or other outbreaks of respiratory infection. All staff scheduled to work any shift since the survey took place on December 12 and	1/4/24

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21375	Continued From page 2 The CDC PPE grid directs source control is recommended by those residing or working on a unit or area of the facility experiencing a SARS-CoV-2 (COVID-19) or other outbreak of respiratory infection; universal use of source control could be discontinued as mitigation measure once the outbreak is over; no new cases of COVID-19 have been identified for 14 days. On 12/12/23 at 9:27 a.m., at the entrance of the facility, a sign indicated the facility had three cases of COVID in the building. On 12/12/23 at 9:27 a.m., a facility document posted on the wall in the entrance of the facility dated 4/17/23 directed masks were no longer required while in the building. On 12/12/23 at 9:27 a.m., the receptionist (R)-A was not wearing a mask while in a communal area on the first floor. On 12/12/23 at 9:28 a.m., social services (SS)-A was not wearing a mask as she walked through the communal area on first floor. On 12/12/23 at 9:28 a.m., the facility administrator walked through the communal areas of first and second floors without a mask. On 12/12/23 at 9:29 a.m., physical therapist (PT)-A was pushing a resident in a wheelchair in the communal area of second floor without a mask. On 12/12/23 at 9:30 a.m., nursing assistant (NA)-A was in the communal area of the second	21375	December 13 have been spot trained, and a formal house wide training will be completed by January 4, 2024, and signatures will be obtained. Masks will be enforced in all communal and resident care areas, along with frequent hand washing and surface area cleanings per the policy. While caring for residents with respiratory infections and on isolation precautions, proper PPE will be worn including gowns, N95 masks, gloves, and face shields. PPE review will be included in the house wide education for infection control. Employees listed in the identifier list, including the Administrator, R-A, SS-A, PT-A, NA-A, LPN-A, and TMA-A have received repeat training regarding the COVID-19 isolation and infection prevention and control. Ongoing Infection Control and Prevention measures will be monitored during all future outbreaks, and annually as required. The Infection Preventionists have reviewed all Infection Control Policies, and they remain current and in accordance with the CDC requirements. F883 Influenza and Pneumococcal Immunizations R2 has received his Influenza vaccination since the time of the survey. We had a current consent signed by the POA when the resident admitted, but we were waiting on the POA to send his vaccination status since he was from Wisconsin. The Minneapolis VA was able to get us the required information after a few days. His pneumococcal vaccination series is complete, and the Influenza was	

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21375	Continued From page 3 floor without a mask. NA-A stated there were two cases of COVID on the second floor. NA-A stated staff did not wear masks in the hall, but wore them when they entered COVID positive resident rooms. On 12/12/23 at 9:30 a.m., licensed practical nurse (LPN)-A was in the communal area of the second floor without a mask. LPN-A stated there were current cases of COVID in the facility. LPN-A stated staff were not wearing masks in the hall. On 12/12/23 at 9:32 a.m., the administrator stated there were three cases of COVID in the building. The administrator stated COVID had just started 12/11/23. The administrator stated there were also staff out with COVID. On 12/12/23 at 9:35 a.m., trained medication aide (TMA)-A was in the communal area of the second floor without a mask. On 12/12/23 at 10:55 a.m., the director of nursing (DON) stated staff should be wearing masks in communal areas due to the presence of positive COVID cases in the facility. On 12/12/23 at 11:58 a.m., the assistant director of nursing (ADON) stated the current COVID outbreak started on 12/9/23. On 12/12/23 at 3:00 p.m., the medical director (MD)-A stated staff should be wearing masks in the halls and resident areas on the unit where COVID is present. A facility document Employee Health dated 9/20/23 directed all staff to wear an N95 grade mask, and eye protection, goggles or face shield.	21375	administered. The Infection Preventionists have reviewed the immunization policies, and they remain current. MNH will review medical records and the MIIC websites upon admission, offer the vaccinations, provide education to all residents/representatives/guardians, and obtain consent or decline signatures for the administration of the vaccines. The vaccinations will be administered within 7 days of admission. The Preventative Health Status section of the medical record and the MIIC websites will be updated as immunizations are given. All licensed nursing staff will be trained in this new process by January 4, 2024. Audits will be performed on all new admissions by the Infection Preventionists to ensure compliance. The vaccination tracker will be maintained by the Infection Preventionists for all residents house wide to ensure all vaccinations (COVID, Influenza, and Pneumococcal) remain current.	

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21375	Continued From page 4 If you are taking care of a COVID positive resident in their room, you should also wear an isolation gown. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could establish a system to track PPE use. The facility could conduct periodic audits of staff utilization of PPE. The Quality Assurance Performance Improvement (QAPI) committee could monitor ongoing compliance. TIME FOR CORRECTION: Twenty-one (21) days.	21375		