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	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Nursing Home	3401 East Medicine Lake Boulevard Plymouth, MN 55441

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to perform comprehensive skin assessments (at least weekly) as ordered, which included assessment for new wounds and documenting wound measurements and other wound characteristics for 3 of 3 residents (R1, R2, R3) reviewed for pressure injury. Findings include: R1R1's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition, pressure ulcers (PU) upon admission, and risk to develop PU. The MDS data indicated R1 admitted [DATE], discharged [DATE], re-admitted [DATE], and discharged on 1/14/26. R1's diagnoses included cancer, deep vein thrombosis (a blood clot in a deep vein), bowel and bladder incontinence, and malnutrition. R1 was on chemotherapy upon admission. R1 had mobility limitations that required a wheelchair for mobility. R1's provider orders dated 12/5/25 indicated perform skin check, head to toe, to be completed weekly on Fridays. R1 had ongoing pressure wound care orders for both the right and left ischial tuberosities (large bony projection located at the bottom of the pelvis that serves as the primary weight-bearing structure when sitting) wounds and on 12/17/25, a sacral (large bone at the base of the lumbar spine that acts as a foundation, distributing upper body weight and stabilizes the pelvis for walking, sitting, and standing) wound, which indicated R1 was prone to develop PU. R1's care plan dated 12/18/25, indicated R1 had a non-healing open area on skin, a surgical wound, immobility, nutritional risk, and incontinence as risk factors for alteration in skin. R1's skin assessments indicated R1 had skin audits completed upon admission on [DATE], and 12/5/25. An additional head- to -toe skin assessment was completed 12/26/25. R1's electronic health record (EHR) lacked indication of additional weekly skin assessments during the weeks of 11/9/25, 12/12/25, 12/19/25, 1/2/26, and 1/9/26. R1's progress notes lacked indication the omitted skin assessments were completed, nor that they were refused by R1.R1's progress notes dated 12/5/25 indicated when R1 readmitted on [DATE], he had a left above knee amputation. On 2/10/26 at 2:51 p.m., during an interview licensed practical nurse (LPN)-A acknowledged R1 had only one skin assessment but should have had one each week while a resident. LPN-A stated body audits were completed upon admission to assess the skin initially. Wound care notes assessed known wounds. LPN-A further stated body audits and wound care notes did not replace the requirement of the weekly head-to-toe skin assessments which were utilized weekly to assess for previously unidentified skin changes. LPN-A acknowledged R1 had provider orders to perform weekly skin assessments, but only had one skin assessment on 12/26/25, and R1's EHR lacked documentation indicating why the other assessments were not completed as ordered. On 2/11/26 at 9:54 a.m., during an interview registered nurse (RN)-A stated weekly skin assessments were performed on shower days, and were utilized to assess skin for new redness, skin tears, and any type of open area on the skin. RN-A stated if new areas were found, the areas were measured, reported, and dressed with appropriate dressings for the wound type. RN-A further stated if a resident refused a bath or shower, the nurse was still required to perform the weekly skin assessment, or document why it was not performed. The nurse was required to perform the skin (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245546	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Mission Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 East Medicine Lake Boulevard Plymouth, MN 55441	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment, or they would not know about new skin issues. RN-A acknowledged R1 had one weekly skin assessment on 12/26/25 but should have had one weekly while admitted . R2R2's quarterly MDS dated [DATE], indicated intact cognition, PU upon admission, and risk to develop PU. The MDS indicated diagnoses that included peripheral vascular disease (PVD-a progressive circulation disorder involving narrowing of the blood vessels commonly affecting the legs and feet), kidney disease, a neurogenic bladder (dysfunction of the bladder caused by damage to the nerves that control the bladder commonly caused by spinal cord injuries and diabetes), paraplegia, and diabetes. R2 had mobility limitations that required a wheelchair for mobility. R2's provider orders dated 8/26/25, indicated perform skin check, head to toe, to be completed weekly on Fridays. R2 had pressure wound care orders dated 1/26/26 for a sacral wound, indicating R2 was prone to develop PU. R2's care plan dated 9/17/25, indicated an alteration in skin integrity with a stage IV PU (wound with extensive tissue loss, with directly visible or palpable muscle, tendon, ligament, cartilage, or bone) on the sacrum. R2's skin assessments were completed 1/2/26, 1/9/26, 1/23/26, and 2/6/26. R2's EHR lacked indication of weekly skin assessments during the weeks of 1/16/26, and 1/30/26. R2's progress notes lacked indication the omitted skin assessments were completed, nor that they were refused by R2. R3R3's quarterly MDS dated [DATE], indicated intact cognition, current PU, risk to develop PU, and bowel and bladder incontinence. The MDS indicated diagnosis that included PVD, diabetes, lung disease, and mobility limitation that required a wheelchair for mobility. R3's provider orders dated 9/4/25, indicated perform skin check, head to toe, weekly on Sundays. R3's orders dated 1/28/26, indicated ongoing pressure wound care orders for both the right and left ischial tuberosities, indicating R3 was prone to develop PU. R3's care plan dated 10/29/25, indicated potential skin alteration, a non-healing open area, related to diabetes, PVD, immobility, nutrition risk, incontinence, and impaired cognition. R3's skin assessments were completed 1/11/26, 1/25/26, 2/1/26, and 2/8/26. R3's EHR lacked indication of weekly skin assessment the week of 1/18/26. R3's progress notes lacked indication the omitted skin assessment was completed, nor that it was refused by R3. On 2/11/26 at 10:15 a.m., during an interview RN-B stated R1, R2, and R3 should have had weekly skin assessments. Residents had weekly skin assessments or potentially staff may not have identified new wounds. The policy was to document the skin assessments on the Weekly Skin Check form. RN-B stated body audits upon admission and wound rounds did not replace the weekly skin assessments. RN-B acknowledged: - R1, R2, and R3 had orders for weekly skin assessments. - R1 had only one skin assessment, on 12/26/25. - R2 lacked skin assessments on 1/16/26 and 1/30/26. - R3 lacked a skin assessment on 1/18/26. - R1's, R2's, and R3's EHRs lacked documentation indicating why the skin assessments were not performed as ordered. On 2/11/26 at 11:28 a.m., during an interview the director of nursing (DON) stated it was the expectation each resident would have weekly skin assessments to ensure new skin issues were identified. The skin assessments were to be completed even when residents refused showers or baths. The DON stated the wound rounds did not replace weekly skin assessments, and acknowledged R1, R2, and R3 each missed weekly skin assessments. The facility was working on the skin assessments/ wound assessments process and would continue the work. The Prevention of Pressure Injuries policy dated 4/2020, indicated evaluate, report, and document potential changes in skin. The Skin Integrity and Wound Care policy dated 8/2025, indicated follow preventative interventions per the care plan. Conduct thorough skin assessments upon admission, weekly, and with a change in condition. Residents at risk included those with cognitive impairment, limited or no mobility, incontinence, acute illness or rapid decline, poor nutrition, or those with fragile skin from medications such as anticoagulants, steroids, or chemotherapy.