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	05/22/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interviews and document review the facility failed to ensure the State Ombudsman for Long Term Care (LTC) was notified of a transfer to the hospital for 1 of 3 residents (R6) when transferred to the hospital for medical treatment. Findings include: R6's Continuity of Care document undated, indicated diagnosis of schizophrenia, diabetes, and epilepsy. A progress note dated 9/4/25 at 9:16 p.m., indicated R6 went to the hospital for seizure activity. The facility notified the provider and family of the hospitalization. R6's medical record lacked evidence the State Ombudsman for LTC was notified of the transfer. The facility Bed Hold Policy and Notification of Transfer dated 9/4/25, indicated R6 had been sent to the hospital. However, there was no verification that the LTC Ombudsman was notified of the transfer. An interview on 5/21/26 at 11:21 a.m. the assistant director of nursing (ADON) stated they could not verify if the LTC Ombudsman had been notified unless the nurses wrote they sent it to the LTC Ombudsman the progress notes. ADON stated that sometimes the nurses will send a bed hold notification to the LTC Ombudsman but there is no way to verify that it was done. ADON stated no one was checking if the nurses were sending notification to the LTC Ombudsman. A facility policy was requested however, none was provided.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245546	A. Building B. Wing	05/22/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to monitor and implement interventions per physician orders for 1 of 1 resident (R16) reviewed for heart failure. Findings include: R16's quarterly Minimum Data Set (MDS) dated [DATE], indicated R16 diagnoses included congestive heart failure (CHF), hypertension, and paroxysmal atrial fibrillation (episodes of irregular heart rhythm). R16's Physician Order Report, signed by provider 4/15/26, indicated the following orders:Lasix (furosemide) 20 milligrams (mg) daily as needed (PRN) if weight up over 3 pounds (lbs) in one day or 5 lbs/weekCheck weight daily and update provider if weight is up 5 lbs in one week or 3 lbs in one day R16's weight summary, printed 5/22/26, indicated R16's weight was 208.2 lbs on 4/17/26, and 212.2 lbs on 4/18/26, which indicated a weight gain of 4 lbs in one day. R16's weight continued to be elevated with weights documented as 211.6 lbs on 4/19/26, and 211.6 lbs on 4/20/26. However, R16's record lacked evidence that the provider had been notified of the weight gain. Additionally, Medication Administration Record (MAR) indicated Lasix 20mg PRN was not administered to R16 on 4/18/26, as per provider orders. R16's progress note, dated 4/18/26 at 5:31 a.m., indicated R16 had no signs or symptoms (s/s) of respiratory distress noted. R16's progress note, dated 4/18/26 at 9:29 p.m., indicated R16's lung sounds were diminished in all lobes. R16's progress note, dated 4/19/26 at 9:25 p.m., indicated R16's lung sounds were diminished in all lobes. R16's progress note, dated 4/21/26 at 7:00 a.m., indicated R16 complained of chest pain and left arm pain radiating to his neck since 4-5:00 a.m., and 911 was called. R16's Hospital Cardiology History and Physical, dated 4/21/26, indicated R16 presented with acute-on-chronic systolic heart failure. R16's Hospital Discharge Orders, dated 4/23/26, indicated R16 was hospitalized for heart failure and left shoulder/arm pain likely musculoskeletal in nature, and medication changes included a furosemide (Lasix) dose and frequency increase to furosemide 10mg daily for excess fluid. R16's Provider Hospital Follow-up Visit Progress Note, dated 4/24/26, indicated an order for weight daily; update provider if up 3 pounds in a day 5 pounds in one week for diagnosis of heart failure. R16's Physician Order Report, signed by provider 5/20/26, indicated R16's PRN Lasix was decreased to Lasix (furosemide) 10mg by mouth once a day as needed (PRN) if weight up over 3 lbs in one day or 5 lbs/week, and call to update provider was ordered 4/23/26. R16's progress note, dated 5/15/26 at 10:29 a.m., indicated R16's weight was up 3 lbs in one day, provider was notified, and Lasix 10mg PRN was administered as per orders. R16's weight summary, printed 5/22/26, indicated R16's weight was 210 lbs on 5/16/26, no weight was recorded for 5/17/26, and R16's weight was 217.8 lbs on 5/18/26, which indicated a weight gain of 7.8 lbs in two day. However, R16's record lacked evidence that the provider had been notified of the weight gain. Additionally, Medication Administration Record (MAR) indicated Lasix 10 mg PRN was not administered to R16 on 5/18/26, as per provider orders. R16's Provider Update, dated 5/21/26 at 2:45 p.m., indicated R16 had elevation in weight intermittently with previous hospitalization for acute exacerbation of CHF, chart indicated R16 sent to hospital because of chest pain with pain in left arm and neck, R16 a full code patient with order for Lasix 10mg to be given if weight up 3 lbs., and R16 had known history of ischemic cardiomyopathy (heart's decreased ability to pump blood properly) and reduced ejection fraction of 30% (sign of heart failure). Provider indicated R16 chart revealed staff had not alerted provider of elevated weights. Provider felt R16 would benefit from a scheduled dose of Lasix rather than as needed at this time. R16's Provider Order, dated 5/21/26 at 2:45 p.m., indicated order to give Lasix 20mg currently, and scheduled Lasix 20mg every Monday, Wednesday, Friday, and recheck of basic metabolic profile (BMP) next lab day. Facility staff instructed to continue to monitor for evidence of chest pain or discomfort. During interview on 5/21/26 at 9:43 a.m., registered nurse (RN)-A stated she obtained R16's weight on 5/18/26 before breakfast and verified R16's weight was 217.8 lbs. RN-A verified R16's documented weight on 5/16/26 was 210 lbs, and R16's weight was not documented for 5/17/26. RN-A stated she had not notified the provider of the weight increase on (continued on next page)

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	05/22/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/18/26. RN-A stated she was not aware R16 had a Lasix PRN order and she had not administered the Lasix PRN on 5/18/26 as ordered. RN-A stated the provider should have been notified of the missed weight on 5/17/26, and of the weight increase from 5/16/26 to 5/18/26. RN-A stated it was important to follow provider orders to address before things get worse and avoid potential rehospitalization. During interview on 5/21/26 at 10:18 a.m., licensed practical nurse (LPN)-A acknowledged she obtained and documented R16's weight on 4/18/26 as 212.2 lbs. LPN-A verified R16's weight was 207.4 lbs on 4/17/26. LPN-A stated the provider should have been notified of the weight increase as per orders, but she failed to notify the provider on 4/18/26. LPN-A stated she was not aware R16 had a Lasix 20mg PRN order at that time and had not administered it to R16 as ordered. LPN-A stated the provider should have been notified of the weight gain and the PRN Lasix should have been administered as ordered. During interview on 5/21/26 at 1:37 p.m., assistant director of nursing (ADON) verified R16's weights were 207.4 lbs on 4/17/26 and 212.2 lbs on 4/18/26. ADON stated she would have expected the nurse to have administered the Lasix 20mg PRN and to have notified the provider as ordered. ADON stated R16 could have potentially not been hospitalized had orders been followed. During continued interview with ADON on 5/21/26 at 1:37 p.m., ADON stated it was the nurses' responsibility to know resident PRN orders. ADON verified R16's weight was 210 lbs on 5/16/26, and 217.8 lbs on 5/18/26. ADON acknowledged R16's record lacked evidence a weight was obtained on 5/17/26, as per orders. ADON stated R16's record lacked evidence the nurse notified the provider of the missed weight and of the weight gain. Additionally, ADON stated R16's record lacked evidence the nurse had administered the Lasix 10mg PRN as per orders. ADON stated it was important for nurses to follow these orders to prevent rehospitalization. During interview on 5/21/26 at 2:23 p.m., R16's primary provider (PCP) stated facility staff should have notified the provider for elevated weights as ordered. During interview on 5/22/26 at 1:32 p.m., director of nursing (DON) verified R16's documented weights from 4/17/26 and 4/18/26 indicated a 4.8-lb weight gain. DON stated she 100% expected the nurse to have contacted the provider with the weight increase, expected the Lasix 20mg PRN to have been given as ordered, and would have expected R16's weight to have gone down had the PRN Lasix been administered. DON stated R16's rehospitalization could have absolutely been prevented if orders had been followed. Additionally, DON verified R16 was sent to the hospital due to chest pain, and chest pain is a symptom of CHF exacerbation and anxiety. During continued interview with DON on 5/22/26 at 1:32 p.m., DON verified R16's weight was not obtained on 5/17/26, and R16's documented weights from 5/16/26 and 5/18/26 indicated a 7.8-lb weight gain. DON expected the nurse to have notified the provider when a daily weight was missed, expected the nurse to have notified the provider of the elevated weight on 5/18/26, and expected the nurse to have administered Lasix 10mg PRN on 5/18/26 as ordered. DON stated the errors could have resulted in another rehospitalization. The facility's Administering Medications Policy, revised 4/19, indicated medications are administered in accordance with prescriber orders, and medications are administered in a safe and timely manner.

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	05/22/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure appropriate personal protective equipment (PPE) was used for 2 of 2 residents (R11 and R44) who required enhanced barrier precautions (EBP). In addition, the facility failed to ensure nationally accepted standards of practice for bodily fluid removal from catheter drainage bag were followed for 2 of 2 residents (R11 and R44). Findings include: R11's admission Minimum Data Set, dated [DATE], indicated R11 diagnosis included neurogenic bladder and cancer. R11 was total assist with toilet hygiene. R11 had an indwelling urinary catheter. An observation on 5/19/26 at 4:16 p.m., R11's room had a Centers for Disease Control and Prevention (CDC) sign that indicated EBP was to be worn when staff were doing high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing brief or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, and wound care: any skin opening requiring a dressing. Nursing assistant (NA)-B when in R11's room, put on gloves and told R11 what she was going to do. NA-B did not wear a gown as directed on the sign outside R11's room. NA-B placed paper towels on the ground and put the urinal on them. NA-B opened the catheter drainage bag spout and drained urine from catheter drainage bag into the urinal measuring 750 milliliters (ml). NA-B placed the urinal on the paper towels on the floor. NA-B took soiled gloves off and put on clean gloves. NA-B hooked the catheter drainage bag to the side of the bed. NA-B used a washcloth fresh scent wipe to wipe the spout of the catheter drainage bag and placed the spout in the holder on the catheter drainage bag. NA-B took off soiled gloves and put on clean gloves then emptied the urinal in the toilet and rinsed it out and allowed to air dry. NA-B took the soiled gloves off, washed hands, and put clean gloves on to assist R11 with a brief change. NA-B had assistance from NA-C, she put on clean gloves while assisting R11 to change position. NA-B wiped R11's bottom from a bowel movement with washcloth fresh scent wipes. NA-B took off soiled gloves and put on clean gloves to place brief and secure it in place. Both NA-B and NA-C took off soiled gloves and washed their hands with soap and water. NA-B put new gloves on and took garbage to the soiled bin in the hallway. NA-B took gloves off and used hand sanitizer. An interview on 5/19/26 at 4:40 p.m., NA-B stated she had not worn a gown while assisting R11 and neither had NA-C. C44's Continuity of Care Document, undated, indicted diagnosis of vascular dementia and benign prostatic hyperplasia. An observation on 5/19/26 at 6:14 p.m., R44's room had a Centers for Disease Control and Prevention (CDC) sign that indicated EBP was to be worn when staff were doing high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing brief or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, and wound care: any skin opening requiring a dressing. NA-A was in R44's room with gloves on emptying the urinary catheter drainage bag. NA-A was standing next to R44's wheelchair holding the urinary catheter drainage bag up to her shoulders and holding the urinal in the other hand under the spout of the catheter drainage bag. NA-A stated there (continued on next page)

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	05/22/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was 600ml in the urinal. NA-A placed the catheter drainage bag on R44's wheelchair and put the spout in the holder. NA-A emptied the urinal in the toilet and rinsed it and let air dry. NA-A did not wipe the spout with an alcohol wipe before putting the spout back in the holder. An interview on 5/19/26 at 6:28 p.m., NA-A stated she had emptied the urinary catheter drainage bag while standing up. NA-A stated she did not wear the gown like the EBP sign indicated. An interview on 5/22/26 at 9:04 a.m., with the infection preventionist (IP) stated urinary catheter cares are done during a skills in-service which is mandatory for staff to attend. IP stated staff should wear gowns and gloves when draining urinary catheter drainage bags. IP indicated that staff should keep the urinary catheter drainage bag below the level of the bladder while draining it and when they secure to the bed or wheelchair. IP stated staff should be cleaning the urinary catheter drainage bag spout with alcohol wipe not a washcloth fresh scent wipe. IP stated urinary tract infections were prevalent at the facility. The facility procedure Emptying a Urinary Collection Bag dated 2001, indicated to keep the collection bag below the level of the resident's bladder. Steps in the procedure include: place the clean equipment on the bedside stand or over bed table. Arrange supplies so they can be easily reached. wash and dry hands thoroughly put on disposable gloves. place a paper towel on the floor beneath the drainage bag, position the measuring container under the collection bag. remove the drain tube from its holder. unclamp the valve on the drain spout and let the urine flow into the measuring container. after the drainage bag has emptied, clamp the valve. wipe the drain with an alcohol sponge or swab, discard the sponge swab into the designated container. replace the drain spout back in its holder. measure and record the urinary output, if indicated. pour urine down the commode, flush the commode. rinse the measuring container and return to its designated storage area. discard all disposable items int designated containers. remove gloves, wash and dry hands. (continued on next page)

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	05/22/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clean the bedside stand and/or overbed table, return the overbed table to its proper position. reposition the bed covers, make resident comfortable. place the call light within easy reach of resident. wash and dry your hands.