| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245546 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mission Nursing Home | 3401 East Medicine Lake Boulevard<br>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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083<br><br>Based on observation, interview, and document review, the facility failed to ensure call lights were within reach and accessible for 1 of 3 residents (R2) who was dependent on staff for care.<br><br>Findings include:<br><br>R2's admission Minimal Data Set (MDS) dated [DATE], indicated R2 had diagnoses which included hemiplegia and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (or stroke, a condition where a part of the brain is damaged or dies due to a lack of blood supply) affecting left non-dominant side, chronic pain syndrome, depression and anxiety disorder. R2's cognition was intact and R2 required substantial assistance by staff for toileting, dressing, and bed mobility.<br><br>On 4/9/25 at 12:16 p.m., R2 was observed in his room sitting in his standard manual wheelchair. R2's call light was wrapped around the grab bar of his bed on the left side along the window and wall side of his room. R2 was in front of the television and call light was not within reach. R2 stated he would utilize the call light to get staff's attention however its on the side of the bed stating, I tell them not to put it there but that is where it's at. R2 added sometimes he had to call his sister using his personal cell phone to have her call the facility to let the staff know he needed assistance because his call light was not accessible. Further, R2 stated he also had to self-propel himself in his wheelchair to the nurses' station to get staff to assist him, we have had problems with that. In addition, R2 stated he was not able to stand up from his wheelchair without assistance and reach across his bed to get to his call light especially since the left side of his body was immobile following a stroke.<br><br>On 4/9/25 at 12:24 p.m., registered nurse (RN)-A enters R2's room to offer R2 his lunch options. When asked about the call light, RN-A unwrapped R2's call light from the grab bar and clipped the call light to edge of the bed. RN-A stated staff were expected to ensure R2's call light was within reach if he was not in bed.<br><br>On 4/9/25 at 12:33 p.m., RN-A approached surveyor and stated she spoke with RN-B and R2's call light was supposed to be tied to the handrail so he can reach over and press it I guess.<br><br>(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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245546 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mission Nursing Home | 3401 East Medicine Lake Boulevard<br>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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/9/25 at 3:01 p.m., RN-B stated R2 required staff assistance with all activities of daily living (ADLs) and stated staff would be expected to remove R2's call light from the grab bar and drape it across his bed so R2 could easily grab it. RN-B stated R2 would not be able to stand up from his wheelchair independently as he required assist of two staff with a mechanical lift for transfers.<br><br>On 4/10/25 at 9:30 a.m., director of nursing (DON) stated staff were expected to ensure call lights were within reach and accessible to all residents.<br><br>Review of facility policy titled Resident Care-Call Light dated 11/24, indicated residents were provided with a means to call staff for assistance through a communication system that directly calls a staff member or centralized workstation. Further, each resident would be provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245546 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mission Nursing Home | 3401 East Medicine Lake Boulevard<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083<br><br>Based on observation, interview and document review, the facility failed to ensure adaptive equipment was provided for 1 of 2 residents (R3) reviewed for safety while smoking.<br><br>Findings include:<br><br>R3's significant change Minimal Data Set (MDS) dated [DATE], indicated R3 had diagnoses which included chronic obstructive pulmonary disease, schizophrenia, and R3 was cognitively intact.<br><br>R3's Smoking assessment dated [DATE], indicated R3 used 6-10 cigarettes a day and did not have a preference on time of day he liked to smoke. R3 was assessed to need a smoking apron for adaptive equipment while smoking. Further, interdisciplinary team reviewed and determined R3 had a modified smoking plan, wears an apron for safety and had not been observed falling asleep with current assessment.<br><br>Review of facility document titled Mission Nursing Home Resident Leveling and Smoke Program, undated, identified R3 as a smoker, on a modified smoking program, and required a smoking apron.<br><br>On 4/8/25 at approximately 10:00 a.m., R3 was observed to self-propel in his wheelchair to the smoking-room door, where door monitor (DM)-A removed R3's oxygen concentrator and assisted R3 inside the smoking room. R3 was then observed to independently smoke a cigarette. DM-A did not assist R3 with a smoking apron.<br><br>On 4/8/25 at 11:24 a.m., DM-A stated he was responsible for unlocking the smoking room for the residents and assist with any adaptive equipment that the resident required for smoking safety such as apron. DM-A stated he had a list of residents who smoked and what adaptive equipment they required and referred to the facility document titled Mission Nursing Home Resident Leveling and Smoke Program. Further, DM-A confirmed he did not assist R3 with a smoking apron and stated R3 required an apron for smoking outside but did not require an apron if R3 was smoking in the smoking room. DM-A stated he did not have any safety concerns related to R3 smoking and there had been no incidents he was aware of that resulted in R3 sustaining any burns from smoking.<br><br>On 4/9/25 at 12:28 p.m., R3 confirmed he did not wear an apron while smoking yesterday and stated some staff put an apron on him and some don't. R3 stated he had not sustained any burns or injuries while smoking.<br><br>On 4/9/25 at 2:37 p.m., assistant director of nursing (ADON) stated upon admission and as needed staff complete a smoking assessment with a resident who was wanting to smoke, after the assessment was completed the interdisciplinary team (IDT) would then review the assessment and discuss if the adaptive equipment identified in the assessment was appropriate. ADON stated each DM had a list of all residents who smoke and what adaptive equipment was required, and the DM would be responsible to implement those interventions and assist with the adaptive equipment to ensure the resident was safe while smoking.<br><br>(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<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mission Nursing Home | 3401 East Medicine Lake Boulevard<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/9/25 at 3:01 p.m., registered nurse (RN)-B stated R3 was alert and orientated and required staff assistance with activities of daily living (ADLs). RN-B stated R3 was identified as a smoker and required an apron while smoking inside or outside to prevent any burns. RN-B stated there had been no incidents or burns for R3 that she was aware of. Further RN-B stated a smoking assessment would be completed with the resident and brought to the IDT meeting to review and determine interventions and adaptive equipment needs. RN-B stated the DMs would then be given a list that would identify interventions and adaptive equipment each resident required, and the DMs would be responsible to implement.<br><br>On 4/10/25 at 9:30 a.m., director of nursing (DON) stated upon admission a smoking assessment would be completed to determine any adaptive equipment needs and the assessment would then be reviewed at the IDT meeting. DON stated a list, which DON identified as the facility document titled Mission Nursing Home Resident Leveling and Smoke Program, would be provided to the DMs and on the list adaptive equipment required would be identified and DMs would be expected to implement and assist the resident.<br><br>Review of facility policy titled Mission Nursing Home (MNH) Smoking Policy implemented 2024, indicated any resident with adaptive equipment to safely smoke would be set up by staff, monitoring shall occur by a staff or family member, visitor or volunteer as needed. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245546 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mission Nursing Home | 3401 East Medicine Lake Boulevard<br>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 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083<br><br>Based on interview and document review, the facility failed to ensure pain medications were re-ordered and available for administration per physician orders for 1 of 3 residents (R2), who had chronic pain and utilized pain medication. This resulted in actual harm when R2 was not administered the physicians ordered pain medication before a pre-scheduled surgery prior to leaving the facility for surgery, and arrived at the surgery center tearful and in severe pain. The facility implemented immediate corrective action prior to the survey and was therefore issued at past non-compliance.<br><br>Findings include:<br><br>R2's admission Minimal Data Set (MDS) dated [DATE], indicated R2 had diagnoses which included hemiplegia and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (or stroke, a condition where a part of the brain is damaged or dies due to a lack of blood supply) affecting left non-dominant side, chronic pain syndrome, depression and anxiety disorder. R2's cognition was intact. Further, MDS assessment revealed almost constant pain 8/10.<br><br>R2's Medication Administration Record (MAR) dated 4/9/25, indicated R2 had a physician order for Acetaminophen 325 mg every 6 hours as needed, and Hydrocodone-acetaminophen 10-325 mg four times daily as well as an order for two additional doses as needed (PRN) per day for pain. Further, R1's MAR revealed an order directing staff to administer the following on the morning of surgery date 4/3/25: Acetaminophen 650 milligrams (mg) and Hydrocodone-acetaminophen 10-325 mg PRN 10-325 mg. Registered nurse (RN)-C signed off on the order indicating the medications were administered, however neither medication was administered (no evidence of supply), and no rationale was identified in the resident's record. After review of R2's orders, R2 could receive up to 6 tabs of Hydrocodone-acetaminophen 10-325 mg a day depending on pain level.<br><br>Review of facility document titled 2nd Floor 24 Hour Report dated 4/1/25, revealed R2 needed a new Norco script.<br><br>Review of facility document titled 2nd Floor 24 Hour Report dated 4/2/25, revealed R2 had a doctor appointment on 4/3/35 and leaving the facility at 5:00 a.m. Document lacked evidence of staff following up related to obtaining Norco script.<br><br>R2's Provider On- call Encounter dated 4/2/25, indicated at 9:11 p.m. floor nurse requested new script for oxycodone-acetaminophen script be sent to pharmacy. The order was reviewed and confirmed to be accurate by floor nurse and new script was sent. Nurse Practitioner signed the document on 4/3/25 at 1:15 p. m.<br><br>R2's Individual Narcotic Record revealed on 3/27/25, 30 tabs of Hydrocodone 10-325 mg were received and on 4/2/25, the last one was administered to R2 at 11:39 p.m. Review of R2's Narcotic Record, on 4/1/25 when staff first identified R1 needed a new script there were 10 tabs of Hydrocodone-acetaminophen remaining which would cover at minimum 2.5 days if R2 did not require an as needed dose.<br><br>(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<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mission Nursing Home | 3401 East Medicine Lake Boulevard<br>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 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 4/9/25 at 1:18 p.m., combined interview with anonymous complainant (AC)-A, AC-B, and AC-C indicated R2 had a pre-scheduled surgery and upon arrival to hospital R2 was sobbing with pain, and R2 reported the facility staff did not administer his pain medications. Further, complainants reported R2 was in severe pain and appeared to be cognitively intact and R2 expressed due to staff not administering his pain medication, R2 did not want to return to the facility following surgery. Complainants reported they were able to administer R2 Tylenol upon arrival to assist with pain and R2 received other pain medications related to surgery later. Complainants reached out to facility regarding R2's concerns and facility staff reported pharmacy did not deliver R2's medications.<br><br>On 4/9/25 at 3:01 p.m., registered nurse (RN)-B stated R2 had a pre-scheduled surgery and she had entered an order into R2's chart regarding specific medications that were to be administered before surgery which included Hydrocodone-acetaminophen. RN-B stated after reviewing R2's MAR the Hydrocodone-acetaminophen was not administered prior to R2's surgery and there was no evidence in R2's record regarding administration or reason for not administering. RN-B stated the importance of R2 receiving the Hydrocodone-acetaminophen and Tylenol prior to surgery would be for pain management, as R2 was traveling a longer distance for the surgery. RN-B reviewed R2's narcotic record and recalled there was an issue with the pharmacy not delivering the Hydrocodone-acetaminophen prior to R2 leaving the facility the morning of 4/3/35 for his surgery. RN-B confirmed there were zero tabs left. R2 had received the last dose the night before surgery and pharmacy delivered 30 tabs on 4/3/25, after R2 had already left the facility. RN-B stated she had retrained all licensed nursing staff on that day, 4/3/25, regarding ordering medications timely from the pharmacy to avoid running out of a medication.<br><br>On 4/9/25 at 6:43 p.m., registered nurse (RN)-C stated she was R2's nurse during the overnight shift leading into the day of his surgery on 4/3/25. RN-C stated R2 had an order to administer specific medications and his pain medication prior to leaving the facility for his surgery. RN-C stated R2 had received a Hydrocodone-acetaminophen at approximately 1:00 a.m. on 4/3/24, and that was the last one available so RN-C called the pharmacy twice and was told they would be delivered. However, the medication was not delivered to the facility prior to R2 leaving at 4:00 a.m., Further, RN-C stated R2 was upset and R2 did not want to go to the surgery because, he said he had pain and was afraid for the 45-minute ride and sitting that long. RN-C stated R2 then left the facility without pain medication being administered and R2 had refused Tylenol, but RN-C did not document the refusal. RN-C stated staff were expected to notify pharmacy when there are no less than 8 pills remaining and if a new script would be needed ordering would need to be done sooner, especially if the resident was taking the medication more than once daily. RN-C stated she was not sure what happened, and staff should have ordered the medication sooner. RN-C confirmed she did not reach out to R2's provider for direction or the director of nursing (DON). In addition, RN-C stated RN-B had re-educated staff on 4/3/25, regarding ordering medications timely to avoid running out of the medication.<br><br>On 4/10/25 at 9:30 a.m., DON indicated medications were refilled weekly on Wednesday or 7 days prior to the medication completion. DON stated there was an emergency medication kit at the facility if needed, however Hydrocodone-acetaminophen was not included in the kit. Further, DON stated the pharmacy delivered to the facility up to four times a day and if there were an urgent situation staff were expected to notify the DON. DON stated he was aware of the incident regarding R2 not receiving the medication and DON stated staff did notify pharmacy on multiple occasions however, the pharmacy did not deliver but was unsure why there was a delay.<br><br>(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<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mission Nursing Home | 3401 East Medicine Lake Boulevard<br>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 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 4/10/24 at 11:27 a.m., assistant director of nursing (ADON) stated on 4/1/25, staff passed on in report R2 needed a new script for Hydrocodone-acetaminophen and that was what staff were directed to do when a medication was running low, and the following day on 4/2/25, the nurse on day shift called to obtain the script. ADON stated R2 received 4 doses of Hydrocodone-acetaminophen at minimum a day and then two additional doses as needed for pain, so R2 could run out faster if he needed the PRN medication. ADON stated if staff identified the end of the medication with no refills or needing a new script, they would be expected to call 7 days prior. ADON indicated they educated all licensed staff on 4/3/25, following the incident with R2 regarding ordering medications timely.<br><br>Review of facility policy titled Mission Nursing Home 14-Day Easypak Inservice, undated, indicated medication that much be reordered by nursing include all controlled medication these would be dispensed on 30-day punch cards. Further, it was recommended that medications are reordered when there is a 3-5-day supply left to allow for any clarifications or needed prescription renewals (5-7 days for controlled medications). Refill orders that are faxed, will have a delay of about 24 hours before the information is available for viewing on the Portal. |