| 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 | 07/03/2025 |

| 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.

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|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<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 |
|---|---|---|
| | | |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure call lights were answered in a timely manner for 2 of 3 residents (R3, R4) reviewed for dignity. Findings include: Resident council meeting minutes dated January 2025 identified call light times were long, March 2025 meeting notes identified call light times were still long. R3's admission MDS dated [DATE], identified intact cognition and no behaviors. He required substantial/maximal assistant with personal hygiene and upper body dressing, dependent upon staff to provide toileting hygiene, lower body dressing, and chair/bed to chair transfers. He had an indwelling urinary catheter and frequently incontinent of bowel. Medical diagnoses included neurogenic bladder (bladder dysfunction caused by neurologic damage due to brain, spinal cord, or nerve problems), urinary tract infection (UTI), paraplegia (paralysis that affects the lower half of the body on both sides), and seizure disorder. R3's care plan dated 4/22/25, identified self-care deficit with ADLs and directed staff to aid with all personal cares, toileting, and transfers. R4's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition, and no behaviors. He had impairment of functional range of motion (ROM) on one side and required substantial/maximal assistance with toileting hygiene, upper body dressing, personal hygiene, roll left and right, dependent for lower body dressing, all transfers, and used a manual wheelchair for mobility. He was frequently incontinent of bowel and bladder. Medical diagnoses include stroke, hemiplegia/hemiparalysis (paralysis or severe weakness on one side of the body), and depression. R4's care plan dated 6/9/25, identified self-care deficit with activities of daily living (ADLS) and directed staff to provide extensive assistance of one to two staff with all ADLS, bed mobility toileting, dressing, grooming, and wheelchair mobility, transfer with assistance of two staff and Hoyer lift, and care always provided in pairs of two caregivers. During an observation and interview on 7/2/25 at 11:50 a.m., R3 laid on his back, on his bed fully dressed, call light located outside, above his room door was on and activated before entry to room. R3 stated it had taken a long time for them to answer his call light, placed it on 10 minutes ago. R3 stated, they help him get up into his wheelchair, he wears a brief and was able to make staff aware when he required assistance, adding he was in an accident when his legs became paralyzed so he was unable to walk or self -transfer and wished he could do more for himself. He also indicated call light wait times were up to 15 to 20 minutes or longer and he was not ok with that. He was told by staff they do not want him to self-transfer and fall because they would get into trouble, then do not answer his call light for a long time. The long call light wait times happened all the time, not a certain time of the day/night. He stated it bothered him to have to wait a long time for assistance, made him mad, and felt like staff do not care. At 12:05 p.m. R3's call light remained on (over 15 observed minutes). He wanted to get up for lunch and use the telephone. At 12:12 p. m. nursing assistance NA-A carried two plates of food into his room (not acknowledging the call light) She asked him which one he wanted for lunch, R3 chose, she then turned around to exit the room and he stated can I get up in my chair please? NA-A stopped, turned around an stated, oh yea, and continued to walk down the hallway while she carried the plates of food. He stated the call light was turned on at least 10 minutes prior to the surveyor entering my room and would really like to get up for lunch, and off his back as he had been laying down for quite a while now. At 12:15 p.m. no staff were seen in the hallway. R3's call light remained on and continued to beep approximately every 9 seconds. At 12:18 p.m. (over 28 observed minutes) NA-A was seen walking in hallway towards his room, opened the door and entered a room located right before R3's room. In less than one minute NA-A exited the room and walked towards his room, and stated, this man needs to get up and entered R3's room. She informed him he was not forgotten and she had planned on helping him get out of bed. She left the call light on at 12:20 p.m., exited his room, and walked down the hallway. At 12:25 p.m. (over 40 observed minutes and 50 minutes per resident interview) NA-A and NA-B entered his room with a EZ lift machine, closed the door, and turned call light off. During an interview on 7/2/25 at 2:44 p.m., NA-B stated staff were expected to answer a resident's call light within 15 minutes, adding it would be important to respond to call lights right away in case the resident may have fallen, required assistance to be cleaned up or get up, and their needs/expectations are expected to be met. During an interview on 7/2/25 at 4:23 p.m., NA-A stated staff were expected to answer call lights within 15 minutes. We do not know what they are calling for and may be in need of medications, water, or are on the floor. We should not assume why they requested help. We are expected to respond to the call lights in a timely manner to meet the resident's needs. During an interview on 7/3/25 at 2:00 p.m., family member (FM) stated |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure 1 of 3 resident (R2) was free of significant medication errors when physician's orders for Darbepoetin (causes the bone marrow to produce red blood cells and used to treat anemia in people with chronic kidney failure) was not administered as prescribed, resulting in seven missed doses of Darbepoetin.Findings include: R2's admission Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition and no behaviors. R2's quarterly MDS date 5/30/25, identified medical diagnoses of anemia (low red blood cell count), coronary disease (CAD), high blood pressure (HTN), renal failure, neurogenic bladder, diabetes mellitus (DM), anxiety, and depression. Currently taking a diuretic (reduces fluid buildup in body) and daily insulin. R2's emergency department (ED) record dated 8/23/24, identified . labs notable for hemoglobin of 6.8 which is baseline between 8 and 9. Creatinine is 3.2 with prior values between 2.5 and 3.3. Emails exchanged with provider and facility assistant director of nursing (ADON) prior to R2's admission to facility on 3/4/25, revealed the following: -on 2/27/25, from ADON to provider - received all correct documentation, diagnoses, length of time it will be prescribed and a note from a specialty it should be covered, would also need to get from a specialty clinic through our pharmacy so that if you guys are able to do a hemoglobin (hgb) this weekend and administer as needed so that we have time to get the medication, we can do Monday at 10:30 a.m. -on 2/28/25, from provider to ADON: the provider will continue monitoring the injections. We can arrange for continued transportation to and from renal clinic. -on 3/4/25, from ADON to provider: just need the layout of his rides and appointment times . main thing is the injections and make sure labs and rides are set-up, our lab days are Mondays. R2's hospital Discharge summary dated [DATE], identified acute kidney injury/chronic kidney disease (commonly caused by HTN and diabetes) vs end stage chronic kidney disease (CKD), stage four (very poor kidney function, kidneys were severely damaged and close to not working), right lower below the knee amputation. Has had progressively worsening renal function, admitted with encephalopathy (brain damage due to lack of oxygen), anemia likely due to CKD stage four and iron deficiency. No indications for dialysis . patient did not want dialysis . Hemoglobin (hgb) (a protein in the red blood cells that carries oxygen and carbon dioxide) dropped less than 7.0 to 6.7, on 2/2/25, transfused with one unit, 2/3/25 hgb 8.2 , and 2/10/25 hgb 8.4. Plan: will continue monitoring hgb intermittently and transfuse for hgb below 7, iron sucrose 200 milligrams (mg) intravenously (IV) times three days (1/28/25 through 1/30/25), started Darbepoetin 1/30/25, currently at 80 micrograms (mcg) every two weeks, next dose 3/13/25, complete blood count (CBC) should be drawn on 3/12/25 prior to dose and a four week follow up appointment. R2's hospital discharge medication orders dated 3/4/25, identified: -Darbepoetin Alfa, Recombinant injection solution 80 mcg/0.8 millimeters (ml) subcutaneously (SQ) every two weeks. Increase dose for next dose 3/13/25 (last dose 2/27/25), renal following indication: anemia. -Needs renal clinic follow up in one month with CBC and comprehensive metabolic panel (CMP) at Veteran's clinic, provider was arranging. Review of R2's electronic medication record (EMAR) for March 2025, April 2025, May 2025, June 2025, and July 2025, lacked evidence the order written on 3/4/25, for Darbepoetin Alfa, Recombinant injection solution 80 mcg/0.8 millimeters (ml) subcutaneously (SQ) every two weeks. Increase dose for next dose 3/13/25 (last dose 2/27/25), renal following, was not located or signed off as administered while R2 resided at the facility from 3/4/35, through 6/19/25, seven missed doses. R2's labs from 3/4/25 through 6/16/25, identified: - on 3/12/25 the R2's record lacked evidence a lab draw was completed as ordered.-on 3/24/25, Albumin (a protein in the blood plasma, keeps fluid from leaking out of the blood stream) 3.3 grams/deciliter (g/dL) low, carbon dioxide (CO2) (helps maintain acid/base balance in your body) 18 millimoles per liter (mmol/L) low, urea nitrogen (waste product the body removes from the blood) 50.6 mg/dl high, creatinine (waste product from muscle metabolism and excreted in urine) 3.6 mg/dL high, glomerular filtration rate (GFR) (checks to see how well the kidneys can filter the blood) estimate 21 mL/min low, hgb 9.1 g/dL low, and hematocrit (HCT) 28.8 %. -on 4/14/25, CO2 21 mmol/L low, urea nitrogen 49.1 mg/dl high, creatinine 3.90 mg/dL high, GFR estimate 17 mL/min low, hgb 9.2 g/dL low, HCT 29% low. -on 6/16/25, hgb 7.6 g/dL low. Handwritten note: results called to provider office and triage will update nurse practitioner (NP) on 6/16/25. Nurse practitioner (NP) visits dated 3/20/25, 4/10/25, 4/29/25, 5/14/25, and 6/10/25, identified list of current medications included Darbepoetin alfa recombinant injection solution 80 mcg/O ml SQ every two weeks. Increased dose for next dose 3/13/25 (last dose 2/7/25), renal following. Indication: for anemia. R2's provider order's dated 4/1/25 through 4/30/35 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure appropriate hand hygiene was performed during personal cares for 1 of 1 resident (R4) reviewed for infection prevention and control. Findings include: R4's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition, impairment of functional range of motion (ROM) on one side and required substantial/maximal assistance with toileting hygiene, upper body dressing, personal hygiene, roll left and right, dependent for lower body dressing, all transfers, and used a manual wheelchair for mobility. He was frequently incontinent of bowel and bladder. Medical diagnoses include stroke, hemiplegia/hemiparalysis (paralysis or severe weakness on one side of the body), and depression. R4's care plan dated 9/26/25, identified self-care deficit with activities of daily living (ADL) and directed staff to provide extensive assistance of one to two staff with all ADL, bed mobility toileting, dressing, grooming, and wheelchair mobility, transfer with assistance of two staff and Hoyer lift, and care always provided in pairs of two. During an observation on 7/2/25 at 12:27 p.m., R4's room call light was noted to be on. He laid in bed on his back covered up with a sheet, and head of bed up approximately 20 degrees. At 12:37 p.m. two nursing assistants (NA)-A and NA-B entered the room with an EZ way smart lift machine. NA-B opened drawers and was unable to find wipes. NA-B exited the room without sanitizing hands and returned shortly thereafter with wipes. NA-A and NA-B applied gloves, and together pulled down his pants and the front of his brief. NA-A wiped the front peri area from front to back. He was turned onto his left side, brief was pulled away from his buttocks, NA-A wiped his rectal area from front to back and stool was visible on the wipe and brief. NA-A was not observed removing her gloves, sanitizing her hands and donning new gloves before she placed a clean brief and the lift sling underneath him. R4 was turned onto his right side, while NA-A placed her gloved hands on his left shoulder and right leg, pulled him over, pulled up brief and pants. NA-A and NA-B each placed a shoe on one foot. NA-A grabbed the EZ lift machine by the handles and pushed it over to the resident while he laid in bed. NA-A hooked up the lift sling loops to the EZ lift machine, raised him off the bed, lowered him down into his wheelchair and removed the lift sheet loops from the EZ lift machine. NA-A straightened the bed sheets, placed dirty linen in two clear bags, removed her gloves, and did not sanitize her hands. She held the dirty gloves in her hand along with the two bags of dirty linen, exited the room, walked down the hallway, entered a dirty utility room, disposed of the two bags and the dirty gloves, all without observation of sanitizing her hands. She then walked back down the hallway, opened the door, entered the nurse's station, and washed her hands at the sink with soap and water, and dried them with a paper towel. During an interview on 7/2/25 at 2:44 p.m., NA-B stated staff were expected to complete hand hygiene prior to the start of and after cares with a resident, prior to when the resident goes to dining room, before they eat, and when gloves were changed. Hand hygiene was important to help prevent the spread of germs from one area to another. During an interview on 7/2/225 at 4:23 p.m., NA-A stated staff were expected to complete hand hygiene before and after resident cares and after removal of gloves. She preferred to use soap and water to make sure hands were thoroughly clean. Hand hygiene was important for resident and staff safety to help prevent the spread of sickness, disease, and infection around by touching something dirty then touching clothing or the resident. NA-A stated she had changed her gloves after she completed R4's peri cares (though this was not in the observation)but did not sanitize her hands prior to the application of a new pair of gloves or exiting the resident's room and should have. She usually had hand sanitizer in her pocket but had forgot it. During an interview on 7/3/25 at 10:15 a.m., assistant director of nursing (ADON) stated staff were expected to complete hand hygiene prior to taking care of a resident, prior to entering their room, exiting their room, in between cares, before and after glove use. Hand hygiene was important to prevent infection. During an interview on 7/3/25 at 1:44 p.m., director of nursing (DON) stated staff were expected to complete hand hygiene prior to resident cares, after cares as they leave the room, after removal of gloves, before clean gloves were applied to prevent infection. The staff should have completed hand hygiene multiple times during the observation with R4's cares and transfer. Facility policy Handwashing/Hand Hygiene dated 10/2023, identified hand hygiene is the primary means to prevent the spread of healthcare associated infections. Hand hygiene was indicated: immediately before touching a resident, before performing an aseptic task, after contact with blood, body fluids, or contaminated surfaces, after touching the resident's environment, before moving from work on a soiled body site to a clean body site on the same resident, and |