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	02/25/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to protect 1 of 1 resident (R1) from staff to resident abuse when R1 was physically and verbally abused by nursing aid (NA)-A which resulted in psychosocial harm to R1 who was crying and visibly upset during the abuse incident.? The facility implemented corrective action, and the deficient practice was corrected on 2/19/26, prior to the survey and was issued at past non-compliance. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had diagnoses of stroke and cancer with prognosis less than six months to live.? The MDS indicated severe cognitive impairment, no mood or behaviors, no rejection of care and required staff dependance with activities of daily living, occasionally incontinent of bladder and frequently incontinent of bowel. R1's Care Plan (CP) dated 2/19/25, indicated diagnoses of Hemiplegia (total paralysis) and hemiparesis (weakness) affecting one side of the body caused by stroke, aphasia (impaired speech and understanding), dysphagia (difficulty swallowing), post fracture unspecified part of neck of femur, depressed mood and restlessness with anxiety.? The care plan indicated his ability to perform ADLs has deteriorated related to diagnosis of right sided hemiplegia and is expected to decline due to end of life.? Staff are directed to have consistent approach amongst caregivers, monitor for presence of pain during self-care, provide adequate rest periods between activities, assist of one with incontinent care, Hoyer lift with transfers.? The CP also indicated R1 had difficulty with communication following his stroke and directed staff to face him when speaking, obtain his attention before speaking and provide a quiet, non-hurried environment, free of distractions for conversation.? The CP further revealed R1 had physical behavioral symptoms, rejection of care, refusal to leave his room, avoid over-stimulation, convey an attitude of acceptance towards the resident, maintain a calm environment and approach to the resident offer choices.? He is identified as a vulnerable adult and to be free of abuse, neglect and exploitation, staff to monitor emotional status, monitor for signs and symptoms of abuse, neglect and exploitation.?? A Facility Reported Incident dated 2/18/26, indicated R1 was lying in bed, nursing assistant (NA)-A took unused briefs out from under resident's pillow and threw them on the floor.? NA-A gestured to hit resident with call light cord and began making facial expressions towards the resident who was non-verbal.? NA-A stuck middle finger up at resident and cursed at him. On 2/24/26 at 8:15 p.m. video footage of incident on 2/18/26 at 5:44 p.m., indicated the following: -5:44 p.m., R1 in his room lying in bed with incontinent pad on with no other clothing and a sheet half covering him. NA-A was observed to take a clean incontinent pad from under his pillow and toss it on the floor then with her hip, push his bed towards the wall. R1 was observed in a soft voice saying no, no, no while looking at the floor at his pad that was tossed.? NA-A stated, you already have one on your body you don't need that one. NA-A was then observed grabbing R1's call light and moving to the other side of his bed towards the wall while R1 raised his left hand, NA-A hit his hand with the call light and said stop and plugged the call (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 0600 Level of Harm - Actual harm Residents Affected - Few	light into the wall and stated, I am just trying to help you.? NA then moved back to the other side of the bed, picked a pillow up off the floor and lowered R1's bed to floor with his bed remote and placed it on his bedside dresser top handle. -At 5:45 p.m., NA-A started picking up dirty items and the clean incontinent pad off the floor and placed in a clear plastic bag while R1 began pointing at the floor and was heard saying faintly, here, here, here! NA-A was then observed to be standing at the foot of the bed, dropped the clear bag on the floor raised and lowered her right hand and put out her middle finger at R1 three times, then stuck her tongue out at him.? -5:46 p.m., NA-A walked past R1 mocking him with facial expressions while grabbing another clear bag picking up dirty linen.? R1 then pointed his finger saying no, no, no and NA-A walked out of the room while R1 started crying and placed his left hand over his forehead, his expression was visibly upset.? R1 then began to struggle to reach for his bedside remote that was attached to the top handle of his nightstand and raised his bed so he could see his television. -At 5:47 p.m., NA-A was observed to re-enter the room with a blue bedspread in her hands and grunting sounds (mimicking R1,) threw the comforter over him and lowered his bed back to the floor before she placed the bed remote inside his bedside stand, then walked out, leaving all the lights on in the room. R1 never addressed or spoke to R1 while in the room. R1 was then again observed trying to grab his bedside remote, leaning over struggling to grab the cord and pull it out of the drawer. R1 remained laying on his side looking at the floor with the bed still in lowered position on the floor and never raised his bed back up. During interview on 2/24/26, at 12:40 p.m., director of nursing (DON) stated registered nurse (RN)-A was on call on 2/18/26, and was notified by RN-A via text message of rough staff care by NA-A. The DON stated the family had placed a camera in R1's room per their request. The DON stated NA-A was immediately suspended pending investigation.? R1's family member (FM)-A called the facility informing him she had seen NA-A pointing the middle finger at R1 and told the facility she wanted it to be reported in the morning.?? The DON stated they filed a report to the state immediately and notified the local police department.? In addition, the DON stated re-education was completed to all staff on vulnerable adults, and staff and resident interviews were conducted to see if there were any concerns of abuse in the facility which there were none.?? The DON stated there were no injuries noted on R1 and after the facility investigation and review of the video footage was completed their decision was to terminate NA-A's employment due to abuse and according to facility policy. During interview on 2/24/26 at 7:04 p.m., family member (FM)-A stated she periodically checks the camera she placed in R1's room and on 2/18/26 she noticed his bedding torn apart and that was usually a sign he had a wet brief or needed to be changed.? FM-A stated she called the facility so someone could help him and then turned the camera on and observed the incident in his room.? FM-A stated she then immediately reported the incident to the nurse on duty.? FM-A stated he likes to try to be independent and liked his incontinent pad under his pillow since he will try to change himself and that was why in the video he became so upset when the staff took it away and threw it on the floor. In a follow up interview with FM-A on 2/25/26 at 8:05 a.m., she stated R1 briefly cried because of the way he was being treated by NA-A and not being able to communicate or speak up upset him further. FM-A further stated when the staff member threw his diaper across the floor, he wanted it back and that is why he pointed at it. That is what made him very upset and he felt very defeated. FM-A stated in the beginning she felt he was angry and frustrated, then defeated but ultimately, he was so upset he was crying and tearful, that is when NA-A had flipped him off, he just got really worked up and sad. FM-A stated prior to his strokes he was a very passive man who would have laughed at her and made fun of her.?? FM-A continued to state R1 loved art, painting, and loved to talk.? It is so frustrating for him that he cannot talk, he is a (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	kind man, very gentle. He used to live off the grid, he rode his bike to work, was just a free spirt and would never treat anybody like she treated him.? FM-A added there was also a note on his door to please keep a pad under his bed and she could just not understand why NA-A would do what she did.? During interview on 2/25/26 at 9:15 a.m., FM-B stated the incident that occurred on 2/18/26, made R1 more distrustful of staff, withdrawn and in the moment, it made him cower and cry.? FM-B further stated she was certain he felt disrespected, helpless and in danger physically. The facility corrected the deficient practice on 2/19/26, prior to survey entrance 2/24/26, therefore the deficiency is being issued at Past Non-Compliance. Abuse Prevention and Prohibition reviewed 6/20222, indicated Mission Nursing Home (MNH) will not tolerate the maltreatment of its residents, whether overtly by abuse, through omission by neglect or by financial exploitation of a resident's property or funds. Persons found to be maltreating residents will be dealt with to the limits permitted by law.? All employees of MNH are responsible for assuring that all residents are free of maltreatment, (see definitions). All employees are expected to be knowledgeable of these policies and procedures and for reporting actual or suspected incidents of maltreatment in accordance with these policies and procedures. MNH also expects other providers of service to its residents, as well as volunteers, to abide by these policies and procedures.? MNH will not knowingly employ or contract with individuals who have been convicted of abusing, neglecting or mistreating individuals. MNH will plan for the prevention of abuse of its residents through a Facility Abuse Prohibition and Vulnerable Adults Protection Plan.? Reports of maltreatment are promptly and thoroughly investigated. The Director of Nursing and the Social Services Director are designated as the primary investigators for incidents of maltreatment.? MNH will cooperate completely with law enforcement authorities and the maltreatment. Prior to the start of the survey the facility-initiated education related to Vulnerable Adult Policy and reporting. The education was verified through interview and document review.