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Form Approved OMB
No. 0938-0391

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	03/12/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49654 Based on interview and document review, the facility failed to ensure a level II pre-admission screen and resident review (PASSAR) was completed prior to admission for 1 of 1 residents (R54) reviewed who required a level II PASSAR screening for mental illness. Findings include: R54 quarterly minimum data set (MDS) dated [DATE], indicated R54 was cognitively intact, and had experienced feeling down, hopeless or depressed, had trouble falling asleep or staying asleep, felt tired or had little energy, and had difficulty concentrating on things at least half or more days in the two weeks prior to the assessment. R54's face sheet printed 3/12/25, indicated an admitted [DATE], identified R54 as a veteran and listed diagnoses to include major depressive disorder, anxiety disorder, post-traumatic stress disorder, attention deficit hyperactivity disorder and opioid dependency. R54's Minnesota Senior linkage Line preadmission screening results dated 11/25/24, indicated R54 met the requirements for a mental illness OBRA Level II assessment. The screening identified a lead agency and provided contact information. R54's medical record was reviewed on 3/10/25 and lacked documentation of results of a Level II assessment. During interview on 3/11/25 at 1:46 p.m., social services designee (SS)-A confirmed R54's chart lacked any documentation of a Level II assessment being completed. SS-A stated R54's admission PASSAR identified suicidal ideations in the six months prior to his admission PASSAR assessment and a Level II PASSAR was required to offer additional resources to R54. SS-A stated it was important to have the Level II PASSAR completed to ensure residents received all available mental health services. Facility policy was requested but not 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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035 Based on observation, interview and document review the facility failed to ensure a thorough smoking assessment was completed on residents who wished to smoke for 5 of 5 residents (R54, R16, R34, R52 and R19) reviewed for smoking. Findings include: An undated facility document titled Mission Nursing Home Resident leveling and Smoking program identified R54, R16, R34, R52 and R19 as current smokers. R54's admission minimum data set (MDS) dated [DATE], indicated R54 admitted to the facility on [DATE] and had the following diagnoses: Stroke, Non-traumatic brain dysfunction, traumatic brain dysfunction, progressive neurological conditions, and traumatic spinal cord dysfunction. The MDS further indicated R54 was cognitively intact and identified R54 as a current tobacco user. R54's face sheet printed 3/12/25, identified R54 as a current daily smoker. R54's care plan with a last review/revision date of 3/10/25, indicated R54 was an independent smoker, had a goal of remaining safe while smoking and would be reassessed for smoking safety annually, with significant change and reviewed quarterly. R54's comprehensive smoking assessment, dated 11/27/24, indicated an in progress status and revealed entire sections of the assessment blank and unfinished. No further smoking assessments were completed or provided. R54's medical record contained a document titled MNH Smoking Policy which reviewed facility policies for smokers. R54's signature was on the bottom of the form next to the date of 12/27/24. A facility representative signature identified as social services (SS)-A was below R54's signature. R16's admission MDS dated [DATE], indicated R16 admitted to the facility on [DATE] and had the following diagnoses: stroke, high blood pressure, hemiplegia (paralyzed on one side of the body) anxiety and depression. The MDS further indicated R16 was cognitively intact and identified R16 as a current tobacco user. R16's face sheet printed 3/12/25, identified R16 as a current daily smoker. R16's care plan with a last review/revision date of 1/21/25, indicated R16 was an independent smoker, had a goal of remaining safe while smoking and would be reassessed for smoking safety annually, with significant change and reviewed quarterly. R16 had a completed comprehensive smoking assessment completed on 6/27/23, four months after his admission. No further smoking assessments were completed or provided. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16's medical record contained a document titled MNH Smoking Policy which reviewed facility policies for smokers. R16's signature was on the bottom of the form next to the date of 12/27/24. A facility representative signature identified as SS-A was below R16's signature. R34's admission MDS dated [DATE], indicated R34 admitted to the facility on [DATE], and had the following diagnoses: progressive neurological disorders, dementia, vascular dementia and personal history of trans ischemic attack (temporary blockage of blood flow to the brain). The MDS further indicated R34 was not cognitively intact. R34's face sheet printed 3/12/25, identified R34 as a former smoker. R34's care plan with a last review/revision date of 3/3/25, indicated R34 was an independent smoker, who had previously quit but had restarted smoking, had a goal of remaining safe while smoking and would be reassessed for smoking safety annually, with significant change and reviewed quarterly. R34's comprehensive smoking assessment dated [DATE], indicated an in progress status and revealed entire sections of the assessment blank and unfinished. No further smoking assessments were completed or provided. R34's medical record contained a document titled MNH Smoking Policy which reviewed facility policies for smokers. R34's signature was on the bottom of the form next to the date of 9/3/24. A facility representative signature identified as SS-A was below R34's signature R52's admission MDS dated [DATE], indicated R52 admitted to the facility on [DATE], and had the following diagnoses: anemia, high blood pressure, traumatic subdural hemorrhage, anxiety and depression. The MDS further indicated R52 was cognitively intact and identified R52 as a current tobacco user. R52's care plan with a last review/revision date of 2/4/25, indicated R52 was a dependent smoker and would need assistance to smoke as he was unable to hold a cigarette, had a goal of remaining safe while smoking and would be reassessed for smoking safety annually, with significant change and reviewed quarterly. R52's comprehensive smoking assessment, dated 12/26/24, (two months after admission) indicated an in progress status and revealed entire sections of the assessment blank and unfinished. No further smoking assessments were completed or provided. R52's medial record contained a document titled MNH Smoking Policy which reviewed facility policies for smokers. R52's signature was absent on the bottom of the. A facility representative signature identified as SS-A was below R52's printed name and was dated 1/15/25. R19's admission minimum data set (MDS) dated [DATE], included an admitted [DATE]. R19's diagnoses included hemiplegia (weakness on one side of the body), diabetes, and chronic obstructive pulmonary disease (COPD). R19's care plan reviewed 2/6/25, included R19 was an independent smoker. Care plan included resident would be reassessed for smoking annually and with significant change. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress note dated 1/16/25, included R19 went downstairs for smoking as scheduled. R19's comprehensive smoking assessment dated [DATE], was incomplete with no data entered. During an interview on 3/11/25 at 1:48 p.m., SS-A stated no one person was solely responsible for completing the smoking assessment but it was the responsibility of multiple staff including nursing, social service and therapy services. SS-A stated nursing staff completed the first portion of the assessment which included watching the resident smoke to determine safety. SS-A went on to say a smoking assessment must be completed upon admission before a resident was allowed to smoke independently and then annually and with any significant change of condition. SS-A stated certain behaviors such as smoking outside of the designated smoking areas like in a resident room, or a resident who was noted to have burn marks on their clothing would indicate a necessity to be reassessed for safe smoking. During an interview on 3/12/25 at 10:01 a.m., director of nursing (DON) stated if an assessment was listed as in progress it indicated the assessment was still open and had not been completed. DON stated the initial smoking assessment should be done as part of the admission process and needed to be completed before a resident was allowed to smoke independently. DON went on to say after nursing completed the initial assessment, social services and if necessary, therapy would complete their portion of the smoking assessment and make recommendations for independent smoking, dependent or supervised smoking or needed adaptive equipment for smoking. Further, the DON stated in addition to being assessed as part of the admission process, a smoking assessment would also be completed annually and with any change of condition. DON stated a resident who had not been assessed for smoking, or whose assessment was not completed should not be allowed to smoke either independently or supervised until the smoking assessment was completed in its entirety by all required staff. Additionally, DON stated he expected staff to complete all necessary assessments on time and to communicate the findings of those assessments with the interdisciplinary team to ensure all team members were made aware of individual needs. DON stated completing, documenting, and communicating the results of the smoking assessment was important for resident safety, and to ensure any necessary precautions were being followed to prevent potential injuries to residents. Furthermore, DON confirmed R54's smoking assessment had not been completed, R16 had been assessed four months after admission in 2023 but had not received an annual assessment in 2024 or 2025, R34's smoking assessment had not been completed, R52's smoking assessment had not been started until two months after admission, but had never been completed, and R19 had never been assessed for smoking. Facility Policy title MNH Smoking Policy with a last revised date of 12/2024 indicated all residents who wished to smoke would be assessed for function, cognition, and financial ability to participate in the smoking program. The policy also indicated residents would be assessed upon admission to determine ability to smoke safely with or without supervision and would be reassessed annually, upon significant change (cognitive or physical) and as determined by staff. 49654

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49035 Based on interview and record review, the facility failed to develop a plan that defined measurable goals and create a system to collect feedback from resident and resident representatives. This had the potential to affect all 56 residents in the facility. Findings Include: During entrance interview on 3/10/25 at 12:54 p.m., a request for a copy of the Quality Assurance and Performance Improvement (QAPI) plan was made to the director of nursing (DON). On 3/13/25 at 1:37 p.m., another request was made for a copy of the QAPI plan. On 3/13/25 at 2:25 p.m., the facility's QAPI program policy was provided. On 3/12/25 at 2:44 p.m., the director of nursing (DON) provided meeting minutes for the last four quarters, but failed to provide an overall plan. QAPI meeting minutes included attendees, agenda, and data related to focuses such as infections, wounds, medication errors, admission/discharges, and weight changes. The document lacked evidence of target goals for sustainability. The document failed to provided evidence that resident and resident representative feedback was obtained to assist in determining quality measures. During interview on 3/13/25 at 2:44 p.m., DON stated they do not have a document that specifically states goals and how the facility will evaluate if the focus was successful or not. The DON was unable to state how feedback was collected from residents and resident representatives. Facility QAPI policy dated March 2020, included it was the QAPI committee's duty to establish benchmarks and goals by which to measure performance improvement.