



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 8, 2026

Administrator
MARTIN LUTHER CARE CENTER
1401 EAST 100TH STREET
BLOOMINGTON, MN 55425

RE: CCN: 245272

Cycle Start Date: September 2, 2026

Dear Administrator:

On September 2, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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August 11, 2026

Administrator
MARTIN LUTHER CARE CENTER
1401 EAST 100TH STREET
BLOOMINGTON, MN 55425

RE: CCN:245272

Cycle Start Date: July 30, 2026

Dear Administrator:

On July 30, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 30, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 30, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Melissa Poepping". The signature is fluid and cursive, with the first name "Melissa" and last name "Poepping" clearly distinguishable.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245272		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2026	
NAME OF PROVIDER OR SUPPLIER MARTIN LUTHER CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1401 EAST 100TH STREET , BLOOMINGTON, Minnesota, 55425			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E0000	Initial Comments On 7/27/26 to 7/30/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			08/19/2026
F0000	INITIAL COMMENTS On 7/27/26 to 7/30/26, a standard recertification survey (S5272043) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52722769C (3014225), H52723357C (3094299), H52723484C (2563524), H52723483C (2705341), H52723482C (2732032), H52723500C (3063711), H52723481C (3075072). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000			

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 reverse for further 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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F0570 SS = E	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident personal fund accounts were insured with adequate surety bond coverage (a contract or promise by a surety or guarantor to pay a certain amount if a second party fails to meet the obligation) to cover the total account balance. This had the potential to affect 33 residents identified with a positive account balance. Findings include: A Bond Execution Report dated 5/10/19, indicated the facility had a surety bond in place for up to \$25,000.00. The facility resident fund account record dated 7/29/26, identified 33 residents who had current fund accounts with a positive balance. The total amount of these accounts was recorded as \$38,563.85. During an interview on 7/30/26 at 8:26 a.m., the administrator acknowledged the surety bond would not fully cover the resident's personal fund. The administrator stated that "corporate" oversaw the surety bond. The administrator stated that when she reached out to corporate about the surety bond, they stated the bank for the resident funds was FDIC (Federal Deposit Insurance Corporation, protects the depositor if the bank fails) insured. When a facility surety bond policy was requested, policies titled Trust Fund Accounting & Records dated 11/2017 and Trust Fund Authorization dated 9/2019 were received. Neither policy included information regarding a surety bond.			F0570	The Administrator, in coordination with the corporate finance office, immediately obtained a current accounting of all resident personal fund accounts, which totaled \$38,563.85 across 33 residents as of 7/29/26. The facility's existing surety bond (\$25,000.00 limit) has been submitted for an increase rider to raise coverage to an amount that exceeds the highest resident trust fund balance on record, with an additional cushion to accommodate normal fluctuation, effective no later than the completion date below. The facility's Trust Fund Accounting & Records and Trust Fund Authorization policies are being revised to explicitly reference the surety bond requirement, the method for verifying adequate coverage, and the frequency of review. Because the surety bond covers the pooled resident trust fund account rather than an individual resident, the corrective action of increasing bond coverage applies to and protects all residents with funds on deposit with the facility, not only the 33 identified with a positive balance on 7/29/26. Date of completion: August 28, 2026 The Business Office Manager or designee will run a resident trust fund balance report monthly and compare the total to the current surety bond coverage amount, documenting the comparison on a standardized monitoring log. If the total trust fund liability approaches 80% of current bond coverage, the Business Office Manager will immediately notify the Administrator and corporate finance to initiate a bond increase before the threshold is exceeded. The Administrator will review the trust fund/surety bond monitoring log monthly for a minimum of 3 months, then quarterly thereafter, as part of the facility's QAPI process, with results reported to the QAPI committee throughout the audit period.		08/28/2026

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F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to honor resident rights to make choices about food preferences at meals for 1 of 1 resident (R12) reviewed for food choices. Findings include: R12's quarterly Minimum Data Set (MDS) dated 7/24/26, indicated R12 had moderate cognitive impairment, required substantial/maximal assistance with personal and oral hygiene and set up/clean up assistance with eating. R12's diagnoses include type 2 diabetes, acute cystitis (bladder infection), muscle weakness, history of transient ischemic attack and cerebral infarction, dysphasia (difficulty swallowing) and protein-calorie malnutrition.			F0561	R12 started on hospice on 8/3/2026 and passed away on 8/4/2026. Individual corrective action specific to R12 is therefore no longer applicable; however, the systemic corrective actions below have been implemented to prevent recurrence for all residents with similar needs. Kitchen and nursing assistant staff were re-educated on the facility's Food and Nutrition Services/Nursing policy requiring verification of each meal against the meal ticket, including texture, consistency, and stated preferences, prior to tray delivery. The Registered Dietitian is conducting a whole house audit of care plans and nutrition assessments for all current residents with documented food preferences or dislikes to identify and correct any inconsistencies between the nutrition assessment, care plan, Kardex, and meal ticket. All dietary and nursing assistant staff received re-education on honoring resident food preferences and verifying tray accuracy against the meal ticket before service, with sign-in sheets maintained as evidence of training. Date of completion: August 28, 2026 The facility's Registered Dietitian(s) will review and reconcile nutrition-related preferences across the nutrition assessment, care plan, Kardex, and meal ticket at each quarterly and significant-change MDS assessment. Kitchen staff will perform a tray-to-ticket verification prior to tray assembly, and the delivering nursing assistant will perform a second verification prior to serving, with both steps documented on a tray-accuracy checklist. The Registered Dietician or designee will conduct random twice weekly tray-accuracy audits for 8 weeks, then monthly for 3 months, with results reviewed through the facility's QAPI committee, and corrective re-education provided for any variance identified throughout the audit period.		08/28/2026

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F0561 SS = D	Continued from page 3 R12’s care plan dated 7/9/26, indicated potential alteration in nutrition and instructed staff to “Cater to food preference as much as possible: Likes: EGGS [pureed].” R12’s nutrition assessment dated 7/8/26, indicated, “Cater to food preference as much as possible: NO EGGS” During observation on 7/29/26 at 8:27 a.m., unidentified staff delivered R12’s breakfast tray. The breakfast tray included a plate of scrambled eggs, milk and water. R12’s meal ticket indicated, “Cheese Omelet > Minced and Moist...Add-On Salsa...Water...Milk.” In addition, the meal ticket indicated a preference for “PUREED EGGS OK.” During observation and interview on 7/29/26 at 12:09 p.m., R12’s lunch tray was delivered and breakfast tray removed by nursing assistant (NA)-B. NA-B verified and R12’s breakfast included scrambled eggs and it appeared she had only eaten a bite or two. NA-B further verified R12’s breakfast meal ticket indicated cheese omelet and stated the provided meal did not match the ticket. During interview on 7/29/26 at 12:10 p.m., resident friend (RF)-A stated she visited R12 at least three times a week and assisted with meals when she at times. RF-A stated R12 did not really like eggs, but if she did get them, they had to be mashed up pretty well in order for R12 to swallow them. RF-A stated scrambled eggs were not mashed enough. During observation and interview on 7/30/26 at 8:28 a.m., R12 sitting up in bed with a breakfast tray in front of her. The breakfast consisted of scrambled eggs, cream of wheat, water and apple juice. R12 stated she did not really like eggs and had previously requested not to have them. R12 stated lately, all she seemed to get for breakfast was scrambled eggs. R12’s breakfast meal ticket indicated, “Water...Sausage Breakfast Casserole > Minced and Moist ...Pureed Bread...Oatmeal >Add-On Brown Sugar...Apple Juice.” During observation and interview on 7/30/26 at 8:28 a.m., nursing assistant (NA)-A in to assist R12 with breakfast NA-A placed a clothing protector on R12			F0561			08/28/2026

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F0561 SS = D	Continued from page 4 and proceeded to provide spoonful after spoonful of cereal to R12 without offering sips of beverage in between. After about one quarter of the cream of wheat, NA-A provided a spoonful of scrambled egg. R12 chewed the one bite of eggs for approximately five minutes with several attempts at swallowing. NA-A attempted to offer additional bites of egg but R12 declined stating she was done with breakfast. When directed to the meal ticket, NA-A confirmed R12’s breakfast meal did not match the meal indicated on the ticket and could not explain why. NA-A stated it was the kitchen staff responsibility to assemble the meal as indicated on the ticket. During interview on 7/30/26 at 8:57 a.m., registered nurse (RN)-E stated would expect meals provided to residents would match what was ordered and listed on the meal ticket. During interview on 7/30/26 at 9:09 a.m., registered dietician (RD) stated the food services process recently changed and now the NAs rounded on residents approximately two hours prior to each meal would offered food choices for the upcoming meal. The NA would then enter the order into the iPad, which went into the system and print the meal ticket. RD stated resident choices should be honored and that when R12 was provided eggs, they should be pureed. During interview on 7/30/26 at 12:18 p.m., director of nursing (DON) stated that resident preferences should be honored. DON further stated would expect the meals provided would match the meal ticket and kitchen staff should be checking for accuracy while NAs provided a second check as well. During interview on 7/30/26 at 1:06 p.m., corporate culinary director (CCD) stated kitchen staff should set up trays according to the meal ticket. Facility policy Food and Nutrition Services/Nursing dated 5/24, indicated, “Staff will check individual name and diet on each meal ticket/card to verify the meal is served to the appropriate person, check items on the plate/tray to assure accuracy for therapeutic diets, texture, adaptive equipment and consistency modifications as needed.” The policy further indicated, “Staff will offer alternative choices for refused food/meals or any resident dislikes.”			F0561			08/28/2026

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F0561 SS = D	Continued from page 5			F0561			08/28/2026
F0656 SS = D	Facility policy Resident Rights dated 6/25, indicated the facility was "committed to honoring and protecting each resident's individuality, preferences, autonomy, and equal access to care." In addition, the facility indicated the resident had "The right to make choices and exercise self-determination." Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements			F0656	R12 started on hospice on 8/3/2026 and passed away on 8/4/2026. Individual corrective action specific to R12 is therefore no longer applicable; however, the systemic corrective actions below have been implemented to prevent recurrence for all residents with similar needs. Facility leadership reinforced with the Registered Dietitian and Corporate Culinary Director that meal tray content and equipment must be assembled to match the meal ticket, and that any discrepancy identified by staff must be corrected before the tray is served. The DON and designees are auditing current care plans, Kardex's, and meal tickets for all residents requiring feeding assistance or adaptive equipment to confirm consistency across documentation. All nursing assistants and dietary staff received facility-wide re-education on the requirement to review and follow each resident's individualized Kardex and care plan, including adaptive equipment and positioning needs, feeding assistance, prior to and during meal service. Date of completion: August 28, 2026 New and updated care plan interventions related to meal assistance, adaptive equipment, and positioning will be communicated to nursing assistants through the Kardex. The DON or designee will conduct meal observation audits for a sample of residents requiring feeding assistance twice weekly for 8 weeks, then monthly for 3 months, verifying that care provided matches the care plan and Kardex. Audit findings will be reviewed through the facility's QAPI committee, with immediate individual re-education provided for any staff member found		08/28/2026

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F0656 SS = D	Continued from page 6 set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff was familiar with and provided care according to the residents plan of care for 1 of 1 residents (R12) reviewed for meal assistance. Findings include: R12's quarterly Minimum Data Set (MDS) dated 7/24/26, indicated R12 had moderate cognitive impairment, required substantial/maximal assistance with personal and oral hygiene and set up/clean up assistance with eating. R12's diagnoses include type 2 diabetes, acute cystitis (bladder infection), muscle weakness, history of transient ischemic attack and cerebral infarction, dysphasia (difficulty swallowing) and protein-calorie malnutrition. R12's care plan dated 7/9/26, indicated activities of daily living (ADL) self-care deficit and potential alteration in nutrition. The care plan indicated R12 required adaptive feeding equipment to include weighted utensils and two handled cups and to instructed staff to encourage R12 to work on self-feeding at all meals. The care plan further indicated R12 had potential for alteration in nutrition and instructed staff, "upright at 90 degrees for all intake, upright for 30 minutes after meals, reflux precautions, use of safe swallowing strategies during intake, feeding assistance." R12's Nutritional Assessment dated 7/8/26, indicated, R12 was admitted from hospital after "possible aspiration pneumonia" and had "complaints of difficulty or pain when swallowing." The care plan further indicated, "adaptive equipment required." R12's Kardex printed 7/29/26, indicated, "EATING: Partial/moderate assistance. Encourage [R12] to work on self-feeding at all meals...Requires adaptive feeding equipment: weighted utensils and 2-handled cups w/lids at each meal...Upright 90 degrees during intake/meals. Stay upright 30 minutes following meals. Use safe swallowing strategies during meals."			F0656	Continued from page 6 not following a resident's plan of care throughout the audit period.		08/28/2026

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F0656 SS = D	Continued from page 7 R12’s Rehab Communication dated 3/24/26, indicated, “Please provide pt w-handled cup w/lid and weighted utensils for all meals. Assist pt in cutting up food PRN [as needed].” R12’s breakfast meal ticket dated 7/29/26, indicated, “Feeding assist during meals but encourage self-feeding as able...Equipment: Weighted Utensils [Grey], Two Handled Cups with Lid.” R12’s lunch meal ticket dated 7/29/26, indicated, “Feeding assist during meals but encourage self-feeding as able...Equipment: Weighted Utensils [Grey], Two Handled Cups with Lid.” R12’s breakfast meal ticket dated 7/30/26, indicated, “Feeding assist during meals but encourage self-feeding as able...Equipment: Weighted Utensils [Grey], Two Handled Cups with Lid.” During interview on 7/27/26 at 12:30 p.m., resident friend (RF)-A stated she visited R12 frequently and did not think R12 was getting enough to eat. RF-A stated R12 required assistance with meals and did not think anyone ever helped her since she often found her meals untouched. During observation on 7/29/26 at 8:27 a.m., unidentified staff delivered R12’s breakfast tray, set on bedside table and did not provide any set up or attempt to wake R12. The breakfast tray included a plate of scrambled eggs, milk and water-both in regular cups. The tray had regular utensils and did not include any weighted utensils. R12’s bed was flat and staff did not provide any set up assistance with the meal tray. During observation and interview on 7/29/26 at 12:09 p.m., R12’s lunch tray was delivered and her breakfast tray was removed. R12’s lunch tray included minced meatloaf, mashed potatoes, minced broccoli, milk and water in regular cups and no weighted utensils. RF-A stated she had arrived at 11:10 a.m., and that R12’s breakfast tray was untouched. RF-A further stated that she visited R12 at least three times a week and felt that staff did not provide the assistance R12 required. Staff “should not just drop it [the tray] off and wake her up and encourage her to eat.” RF-A further stated that the head of bed was supposed to be fully up during meals to prevent choking. During observation and interview on 7/30/26 at 8:28 a.m., nursing assistant (NA)-A in to assist R12 with breakfast. R12’s breakfast tray contained scrambled			F0656			08/28/2026

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F0656 SS = D	Continued from page 8 eggs, cream of wheat, water and apple juice. The beverages were in regular cups and no weighted utensils on tray. NA-A placed a clothing protector on R12 and proceeded to provide spoonful after spoonful of cereal to R12 without offering sips of beverage in between. After about one quarter of the cream of wheat, NA-A provided a spoonful of scrambled egg. R12 chewed the one bite of eggs for approximately five minutes with several attempts at swallowing. NA-A attempted to offer additional bites of egg before R12 had finished the first one. NA-A did not offer R12 to hold the utensils or the cups and did not encourage R12 to self-feed. After approximately a quarter of the breakfast was consumed, R12 stated she was done. NA-A picked up the tray and started to lower R12's head of bed to a flat position. R12 started yelling for him to stop and stated she had to stay up after meals and did not want to choke. NA-A confirmed that R12 was not provided with adaptive equipment and stated was not aware she was supposed to be receiving them. NA-A further stated was not aware staff were supposed to be encouraging self-feeding or that R12 required to remain upright for 30 minutes after every meal. When NA-A was directed to the meal ticket, he confirmed the meal ticket indicated weighted utensils, two-handled cups, and to encourage self-feeding. NA-A stated did not know those items were part of R12's plan of care. NA-A could not define safe swallowing strategies. During interview on 7/30/26 at 8:57 a.m., registered nurse (RN)- E stated R12 required assistance with meals but staff should encourage self-feeding. RN-E stated would expect staff to know and follow the plan of care and Kardex and confirmed R12 should receive adaptive equipment with meals to promote independence and should remain upright after meals. RN-E stated safe swallowing strategies meant upright during meals, slow small bites, and be supervised. During interview on 7/30/26 at 9:09 a.m., registered dietician (RD) stated trays should be set up according to the meal ticket. RD stated R12 should be supplied with weighted utensils and two-handled cups. During interview on 7/30/26 at 10:20 a.m., speech therapist (ST) stated R12 was currently maximum assistance with meals but could self-feed at times and that staff should be encouraging self-feeding. ST further stated that R12's goal was to eat independently and therefore, should have adaptive equipment to assist in reaching that goal. ST stated R12 should have someone with her during all meals			F0656			08/28/2026

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F0656 SS = D	Continued from page 9 and would expect her to remain upright for 30 minutes after each meal. During interview on 7/30/26 at 12:18 p.m., director of nursing (DON) stated would expect staff to know and follow the residents care plan and Kardex. DON stated would expect residents would receive adaptive equipment as recommended and as indicated on the meal ticket and staff to follow safe swallowing strategies as indicated in their plan of care. Facility policy Food and Nutrition Services/Nursing dated 5/24, indicated, "Resident's ordered or recommended type and consistency by IDT [interdisciplinary team] team members will determine and care planed for supervision, assistive devices and monitoring of intake will be care planned for the appropriate interventions."			F0656			08/28/2026
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure pain medication was administered timely for 1 of 1 resident (R12) reviewed for pain management. Findings include: R12's quarterly Minimum Data Set (MDS) dated 7/24/26, indicated R12 had moderate cognitive impairment, had lower extremity impairment on both sides, was fully dependent or required substantial/maximal assistance with many activities of daily living (ADLs), and was fully dependent with transfers and bed mobility. R12's MDS further identified R12 had almost constant pain and received scheduled and as needed pain (PRN) medication. R12's diagnoses included muscle weakness, history of transient ischemic attack and cerebral infarction, and dysphasia (difficulty swallowing).			F0697	R12 started on hospice on 8/3/2026 and passed away on 8/4/2026. Individual corrective action specific to R12 is therefore no longer applicable; however, the systemic corrective actions below have been implemented to prevent recurrence for all residents with similar needs. RN-D and RN-E were counseled on the facility's expectation that scheduled and PRN pain medications be administered within the facility's window of one hour before to one hour after the scheduled time, and on the importance of coordinating care tasks so pain medication is not delayed by competing assignments. The DON is auditing the July 2026 MAR for all residents with scheduled pain medications to identify any additional instances of late administration and to follow up with the resident's physician as clinically indicated. All licensed nursing staff received re-education on timely administration of scheduled and PRN pain medications, prioritization of medication passes, and the process for notifying the charge nurse or supervisor when an assignment conflict threatens timely administration. Date of completion: August 28, 2026 The electronic MAR administration-color alert will continue to flag medications approaching the outer		08/28/2026

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F0697 SS = D	Continued from page 10 R12’s care plan dated 4/8/26, indicated R12 was on opioid/pain medication due to chronic pain and instructed staff to, “Administer ANALGESIC medications as ordered by physician.” R12’s care plan further identified R12 had pain related to ankle fracture repair and neuropathy and instructed staff to “Give pain medications per schedule to maintain therapeutic levels.” R12’s Pain Interview and Evaluation dated 7/9/26, identified R12 had a condition or diagnosis that usually cased pain or had potential to cause pain and that pain was typically worse in the morning. R12’s medication administration record (MAR) July 2026, reviewed on 7/29/26 at 8:58 a.m., identified the following scheduled and PRN pain medications had not been administered yet: -Acetaminophen ER (extended release) 650mg, give two times a day at 8:00 a.m. and 2:00 p.m. -Gabapentin 40mg, give two times a day at 8:00 a.m. and 2:00 p.m. -Hydromorphone 2mg, give as needed for severe pain, last administration 7/25/26 at 3:51 p.m. -Hydromorphone 2mg, give four times a day for chronic pain at 7:00 a.m., 12:00 p.m., 6:00 p.m., and 10:00 p.m. -Lidocaine External patch 4%, apply to bilateral shoulders one time a day at 8:00 a.m. for pain (apply two patches) During observation and interview on 7/29/26 at 8:48 a.m. physical therapist (PT) in to initiate a PT session. R12 declined and stated that she was in too much pain for a therapy session and had not received any pain medication yet this morning. During observation on 7/29/26 at 9:17 a.m., registered nurse (RN)-D in to assess R12’s pain and administer pain medications. R12 stated she was in a lot of pain and yelled, “please help, please help!” R12 stated she had pain in her stomach, arms and legs and stated again, “Oh God, please help.” RN-D attempted to administer each pill one at a time with a spoon, and R12 had a very hard time swallowing them. RN-D left the room to get some applesauce to assist R12 in swallowing the pills. R12 continued to			F0697	Continued from page 10 limit of the administration window, and the charge nurse, house supervisor or Nurse Manager will reassign tasks in real time to prevent late administration. The DON or designee will audit MAR administration times for scheduled pain medications on a sample of residents weekly for 8 weeks, then monthly for 3 months, tracking late administrations by cause. Results will be reported to the QAPI committee, and additional staff education will be implemented throughout the audit period.		08/28/2026

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F0697 SS = D	Continued from page 11 yell, "Oh please God help!" At 9:31 a.m., RN-D returned and continued to administer the pain medications. At 9:41 a.m., all the scheduled oral pain medications were administered. During observation on 7/29/26 at 9:43 a.m., RN-E in to assist RN-D to reposition and perform incontinent care. R12 was assisted from side to side and verbalized increased pain with every turn. During observation on 7/29/26 at 10:05 a.m., RN-D back in R12's room and applied one lidocaine patch on each of R12's shoulders. R12 stated, "just make the pain go away!" During interview on 7/29/26 at 10:11 a.m., RN-D stated he was tied up with wound care on two other residents this morning and confirmed R12's morning medications, including her pain medication was given very late. RN-D further stated that had R12 received her pain medications timely, she may not have been in as much pain during morning cares and may have been able to participate in her PT session. During interview on 7/29/26 at 1:28 p.m., RN-E stated she can verbalize her pain and displayed quite a bit of non-verbal pain cues during repositioning. RN-E stated R12 did have scheduled and PRN pain medications ordered. RN-E further stated if R12 had received her pain medication on time this morning, she may have participated in PT and may have experienced a lot less pain during morning cares. RN-E stated medications should be administered on time as scheduled. During interview on 7/30/26 at 10:36 a.m., PT stated they try to coordinate PT sessions so they were approximately 30 minutes or so after pain medication administration so the resident would not be in pain and more successful with therapy. PT stated if R12 had received her morning pain medication as scheduled, she would have been more likely to participate in the PT session. During interview on 7/30/26 at 12:18 p.m., director of nursing (DON) expectation was that residents received pain medications per physician order and on time with a maximum of one hour before and one hour after they were scheduled. DON further stated			F0697			08/28/2026

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F0757 SS = D	Continued from page 13 orders were prevented with the potential for excessive medication use and correlating adverse effects for 1 of 5 residents (R3) reviewed for unnecessary medication use. Findings include: Antihypertensive Medications R15's annual Minimum Data Set (MDS) dated 7/6/26, indicated R15 had intact cognition and was diagnosed with heart failure and diabetes. R15's Medication Administration Record (MAR) dated 7/1/26 to 7/30/26 at 10:33 a.m., indicated R15 had an order dated 6/11/26 for 50 milligrams (mg) of metoprolol (antihypertensive medication) to be given twice a day for high blood pressure. The order had provider-set parameters to hold the metoprolol if R15's systolic blood pressure (SBP) was lower than 120 or the heart rate was lower than 60. In the a.m. on 7/13/26, R15's SBP was 116, and the medication was documented as given. In the a.m. on 7/16/26, R15's SBP was 115, and the medication was documented as given. In the a.m. on 7/20/26, R15's SBP was 112, and the medication was documented as given. In the a.m. on 7/30/26, R15's SBP was 106, and the medication was documented as given. R15's care plan dated 7/20/26, indicated R15 had hypertension and received antihypertensive medications. The care plan indicated R15 was to receive blood pressure checks per the provider order and staff were to monitor for side effects such as orthostatic hypotension and increased heart rate. R15's medical record was reviewed, and consent from the provider to give the metoprolol against the written ordered parameters was not found. During an interview on 7/30/26 at 12 p.m., registered nurse (RN)-A stated she was the nurse overseeing R15's care for the shift. RN-A stated staff administering medications should review the pulse and blood pressure before administering antihypertensive medications to ensure they were not below the parameters. RN-A confirmed she had reviewed R15's medication and stated that R15's metoprolol should have been held today because the blood pressure was lower than ordered parameters, but it was not. RN-A stated she would worry about potential adverse effects to R15 as the metoprolol was administered when R15's SBP was lower than 120.			F0757	Continued from page 13 antihypertensive medications, and on the two-step verification process required before a newly transcribed order is confirmed active in the EHR. Date of completion: August 28, 2026 The DON or designee will audit a sample of MARs twice weekly for 8 weeks, then monthly for 3 months, to verify hold parameters were checked and honored and that no duplicate orders are active for hospice residents. Findings will be reported to the QAPI committee, and the two-nurse order-verification process will continue to be monitored for compliance, with individual re-education provided for any identified lapse throughout the audit period.		08/28/2026

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F0757 SS = D	Continued from page 14 During an interview on 7/30/26 at 12:12 p.m., RN-C, the nurse manager for the unit, confirmed she had reviewed R15's medical record and stated that R15's metoprolol should not be given if R15's SBP is lower than 120. RN-C confirmed the metoprolol had been administered on multiple occasions, including today (7/30/26) when it was outside of the parameters. RN-C stated this was a "medication error" and she would need to follow up with the staff who administered the medication and notify the provider. The facility's Medication Administration policy dated 2/2026, indicated nursing staff should obtain and record any vital signs or other monitoring parameters ordered, and if a dose is held, the staff member administering the medication would document this in the space provided in the EHR. Duplicate Medication Order R3's quarterly MDS dated 4/17/26, indicated R3 had intact cognition and was diagnosed with kidney disease, diabetes, and dementia. The MDS indicated R3 did not have vomiting during the look back period. R3's MAR dated 7/1/26 to 7/29 at 12:14 p.m., indicated R3 had an active order dated 4/8/26 for four mg of ondansetron (anti-nausea medication) every eight hours as needed for nausea and vomiting. Ondansetron was given to R3 under this order twice during the period (7/11/26 and 7/16/26). The MAR had an additional order dated 7/10/26 for four mg of ondansetron every six hours as needed. Ondansetron was given to R3 under this order three times during the period (7/22/26, 7/25/26, and 7/26/26). R3's progress note dated 7/10/26, indicated R3 signed onto hospice on this date. R3's Certification and Plan of Care dated 7/10/26, included an order summary with one Ondansetron order (four mg of ondansetron every six hours as needed). During an interview on 7/30/26 at 12:07 p.m., RN-B confirmed he was the nurse overseeing R3's care for the day. After RN-B confirmed he had reviewed R3's record, he stated R3 had two as-needed orders for ondansetron, and both were available to be administered through the facility's electronic administration software. RN-B stated that the health unit coordinator entered orders in the electronic health record (EHR), and then nursing staff was			F0757			08/28/2026

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F0757 SS = D	Continued from page 15 responsible for reviewing and confirming the resident's orders, so the order became active in the EHR. RN-B stated he would have to call the provider to see which ondansetron order should be kept as active. During an interview on 7/30/26 at 12:19 p.m., RN-C, the nurse manager for the unit, stated R3 had recently signed on to hospice, and it was possible that hospice had ordered a duplicate of the ondansetron. RN-C stated that the health unit coordinator transcribed the order into the EHR and then the nurse reviewed all medications currently ordered to ensure the medication was not a duplicate before confirming the medication. During interview on 7/30/26 at 9:19 p.m., consulting pharmacy manager (PM) stated blood pressure and heart rate should be taken before each dose and held based upon prescribed parameters and if staff gave metoprolol to the resident when their blood pressure was below prescribed parameters it could further lower their blood pressure and increase the potential for lightheadedness, dizziness, lethargy, and falls. Regarding duplicate orders, PM stated it was important to ensure there were no duplicate orders to prevent a resident from receiving more medication than was ordered. During an interview on 7/30/26 at 12:27 p.m., the director of nursing (DON) stated she expected her nursing staff to follow provider orders regarding antihypertensive medication parameters. The DON stated she would have expected nursing staff to review all medications when the medications were entered into the EHR to ensure R3's Zofran was not a duplicate prior to confirming the medication. The facility's Order Transcription policy dated 10/2024, indicated the health unit coordinator/nurse should review the "chart" after the provider visit to check for any new orders, and the orders should then be transcribed into the EHR. The policy indicated a second licensed staff member must confirm the order placed in the EHR.			F0757			08/28/2026
F0810 SS = D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming			F0810	R12 started on hospice on 8/3/2026 and passed away on 8/5/2026. Individual corrective action specific to R12 is therefore no longer applicable; however, the systemic corrective actions below have been implemented to prevent recurrence for all residents with similar needs. The nursing assistants and dietary staff involved in R12's meal service were re-educated that adaptive		08/28/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0810 SS = D	Continued from page 16 meals and snacks. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adaptive equipment was provided for 1 of 1 resident (R12) who required weighted utensils and two-handled cups to encourage and promote self-feeding. Findings include: R12's quarterly Minimum Data Set (MDS) dated 7/24/26, indicated R12 had moderate cognitive impairment, required substantial/maximal assistance with personal and oral hygiene and set up/clean up assistance with eating. R12's diagnoses include type 2 diabetes, acute cystitis (bladder infection), muscle weakness, history of transient ischemic attack and cerebral infarction, dysphasia (difficulty swallowing) and protein-calorie malnutrition. R12's care plan dated 7/9/26, indicated activities of daily living (ADL) self-care deficit and potential alteration in nutrition. The care plan indicated R12 required adaptive feeding equipment to include weighted utensils and two handled cups and to instructed staff to encourage R12 to work on self-feeding at all meals. R12's Nutritional Assessment dated 7/8/26, indicated, "Adaptive equipment required." R12's Kardex printed 7/29/26, indicated, "EATING: Partial/moderate assistance. Encourage [R12] to work on self-feeding at all meals...Requires adaptive feeding equipment: weighted utensils and 2-handled cups w/lids at each meal." R12's Rehab Communication dated 3/24/26, indicated, "Please provide pt w-handled cup w/lid and weighted utensils for all meals. Assist pt in cutting up food PRN [as needed]." R12's breakfast meal ticket dated 7/29/26, indicated, "Equipment: Weighted Utensils [Grey], Two Handled Cups with Lid." R12's lunch meal ticket dated 7/29/26, indicated,	F0810	Continued from page 16 equipment listed on the meal ticket must be included on the tray at assembly and verified again by the delivering staff member before service. The DON reinforced with unit staff that responsibility for tray accuracy, including adaptive equipment, is shared between dietary staff at assembly and the nursing assistant at delivery, and is not the sole responsibility of either department. The Registered Dietitian and Culinary Director are auditing meal tickets and trays for all current residents identified as requiring adaptive eating equipment to confirm the equipment specified on the meal ticket is consistently provided. All dietary and nursing assistant staff received facility-wide re-education on verifying and providing adaptive equipment as indicated on the meal ticket for every meal and snack. Date of completion: August 28, 2026 Dietary staff will verify adaptive equipment against the meal ticket at tray assembly, and the delivering nursing assistant will perform a second verification at the bedside before the resident begins eating. The Culinary Director or designee will conduct random twice weekly audits of tray adaptive-equipment accuracy for residents with this need for 8 weeks, then monthly for 3 months. Audit results will be reviewed by the QAPI committee, with additional staff re-education provided for any resident found without required adaptive equipment throughout the audit period.	08/28/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245272		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2026	
NAME OF PROVIDER OR SUPPLIER MARTIN LUTHER CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1401 EAST 100TH STREET , BLOOMINGTON, Minnesota, 55425			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0810 SS = D	Continued from page 17 “Equipment: Weighted Utensils [Grey], Two Handled Cups with Lid.” R12’s breakfast meal ticket dated 7/30/26, indicated, “Equipment: Weighted Utensils [Grey], Two Handled Cups with Lid.” During interview on 7/27/26 at 12:30 p.m., resident friend (RF)-A stated she visited R12 frequently and did not think R12 was getting enough to eat. RF-A stated R12 required assistance with meals and did not think anyone ever helped her since she often found her meals untouched. During observation on 7/29/26 at 8:27 a.m., unidentified staff delivered R12’s breakfast tray, set on bedside table and did not provide any set up or attempt to wake R12. The breakfast tray included a plate of scrambled eggs, milk and water-both in regular cups. The tray had regular utensils and did not include any weighted utensils. During observation on 7/29/26 at 12:09 p.m., R12’s lunch tray was delivered and her breakfast tray was removed. R12’s lunch tray included minced meatloaf, mashed potatoes, minced broccoli, milk and water in regular cups and no weighted utensils. During interview on 7/29/26 at 12:28 p.m., R12 stated she used to receive weighted utensils and two-handled cups with her meals, but had not received them for quite some time. R12 stated adaptive equipment made it much easier for her to eat independently since she had a difficult time grasping and handling the regular utensils and cups. During observation and interview on 7/30/26 at 8:28 a.m., nursing assistant (NA)-A in to assist R12 with breakfast. R12’s breakfast tray contained scrambled eggs, cream of wheat, water and apple juice. The beverages were in regular cups and no weighted utensils on tray. NA-A confirmed that R12 was not provided with adaptive equipment and stated was not aware she was supposed to be receiving them. When NA-A was directed to the meal ticket, he confirmed the meal ticket indicated weighted utensils and two-handled cups. NA-A stated it was the kitchen’s responsibility to ensure the trays were set up correctly.			F0810			08/28/2026

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F0810 SS = D	Continued from page 18 During interview on 7/30/26 at 8:57 a.m., registered nurse (RN)-E stated R12 should be assisted with meals but also should be encouraged to self-feed as much as she could. RN-E stated R12 was supposed to get weighted utensils and two-handled cups to help promote independence during meals. During interview on 7/30/26 at 9:09 a.m., registered dietician (RD) stated trays should be set up according to the meal ticket. RD stated R12 should be supplied with weighted utensils and two-handled cups. During interview on 7/30/26 at 10:20 a.m., speech therapist (ST) stated R12 was currently maximum assistance with meals but could self-feed at times and that staff should be encouraging self-feeding. ST further stated that R12’s goal was to eat independently and therefore, should have adaptive equipment to assist in reaching that goal. During interview on 7/30/26 at 12:18 p.m., director of nursing (DON) stated would expect residents to receive adaptive equipment as recommended and as indicated on the meal ticket. DON stated that weighted utensils and 2-handled cups would help promote independence for R12 during meals. DON further stated the kitchen staff were responsible for tray set up, but the NAs who deliver the tray, should also check the tray for accuracy. During interview on 7/30/26 at 1:06 p.m., corporate culinary director (CCD) stated kitchen staff should set up trays according to the meal ticket and if adaptive equipment was listed on the meal ticket, they should be included on the tray. Facility policy Food and Nutrition Services/Nursing dated 5/24, indicated, “Staff will check individual name and diet on each meal ticket/card to verify the meal is served to the appropriate person, check items on the plate/tray to assure accuracy for therapeutic diets, texture, adaptive equipment and consistency modifications as needed.”			F0810			08/28/2026

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NAME OF PROVIDER OR SUPPLIER MARTIN LUTHER CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1401 EAST 100TH STREET , BLOOMINGTON, Minnesota, 55425			
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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 07/28/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Martin Luther Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			08/20/2026

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 reverse for further 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245272		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/28/2026	
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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Martin Luther Care Center is a 2-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1984 which was determined to be of Type II (000) construction. An addition, a 1-story, Type V (111) building was completed in 2010 and a 1-story, Type II (000) building was completed in 2011. The buildings will be surveyed as one building. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 137 beds and had a census of 131 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			08/20/2026

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K0363 SS = F Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/28/2026, at 11:23 AM, it was revealed by observation that the smoke control doors near the elevator lobby failed to properly close.			K0363	The smoke control doors near the elevator lobby were fixed. Specifically, the Director of EVS lubricated and adjusted the linkage and adjusted the smoke gasket, which allowed the doors to properly close. The date certain is 8/28/26. Audits will be completed 2 times a week for 4 weeks to ensure smoke control doors per NFPA and Life Safety Code are properly closing. Audits will be monitored by the safety committee during the audit period.		08/28/2026

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K0363 SS = F Bldg. 01	Continued from page 3			K0363			08/28/2026
K0321 SS = D Bldg. 01	An interview with the Director of Environmental Serves and Administration Interns verified this deficient finding at the time of discovery. Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility			K0321	The door to the soiled utility room EC11 was fixed. Specifically, the Director of EVS replaced the closer and shimmed the hinges. The door continued to rub in the top righthand corner of the door frame requiring belt sanding. The date certain is 8/28/26. Audits will be completed 2 times a week for 4 weeks to ensure hazardous rooms per NFPA and Life Safety Code are properly latching. Audits will be monitored by the safety committee during the audit period.		08/28/2026

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K0321 SS = D Bldg. 01	Continued from page 4 failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/28/2026 at 11:12 AM, it was revealed by observation that the door to the soiled utility room EC11 would not properly latch. An interview with the Director of Environmental Serves and Administration Interns verified this deficient finding at the time of discovery.			K0321			08/28/2026