DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
June 30, 2025

Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

RE: CCN: 245272
Cycle Start Date: June 12, 2025

Dear Administrator:

On June 12, 2025, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On June 10, 2025, the situation of immediate jeopardy to potential health and safety cited at F578 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 15, 2025.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective July 15, 2025, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 15, 2025, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 15, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Martin Luther Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 15, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE

SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 12, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 30, 2025

Administrator
Martin Luther Care Center
1401 East 100th Street
Bloomington, MN 55425

Re: State Nursing Home Licensing Orders
Event ID: U3C311

Dear Administrator:

The above facility was surveyed on June 9, 2025 through June 12, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 21, 2025

Administrator
Martin Luther Care Center
1401 EAST 100TH STREET
BLOOMINGTON, MN 55425

RE: CCN: 245272
Cycle Start Date: 6/12/25

Dear Administrator:

On June 30, 2025, we informed you of imposed enforcement remedies.

On July 15, 2025, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is as follows:

K923 - Gas Equipment - Cylinder and Container Storage

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 15, 2025.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 15, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 15, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of June 30, 2025, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 15, 2025.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 12, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

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.



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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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 6/9/25 to 6/12/25, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements, for Long Term Care Facilities was conducted during a standard recertification survey. Martin Luther Care Center was found to be in compliance with the requirements. 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		
F0000	INITIAL COMMENTS On 6/9/25 to 6/12/25, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were also completed. Martin Luther Care Center was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) at F578. The IJ began on 5/1/25, when a resident's Physician Orders for Life Sustaining Treatment (POLST) were not accurately transcribed into the electronic medical record (EMR) and, as a result, multiple nurses indicated they would perform resuscitation measures (i.e., CPR) against a resident's declared wishes. The assistant administrator (AA)-A and director of nursing (DON), along with multiple other management and/or corporate personnel via Teams, were notified of the IJ for R50 on 6/9/25 at 8:24 p.m. The IJ was removed on 6/10/25 at 4:00 p.m., after an acceptable removal plan was verified as having been implemented. The following complaints were reviewed with no deficiencies cited:	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

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0000	Continued from page 1 H52726527C (MN103405) H52726528C (MN105343) H52726530C (MN105824) H52726532C (MN109225) H52726534C (MN109290) H52726536C (MN110946) H52724367C (MN112880) H52726531C (MN113113) H52725127C (MN113178) H52726529C (MN113241) The following complaints were reviewed: H52726535C (MN112352), H52726533C (MN112451) with a deficiency cited at F804. 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		
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to-	F0577	The facility posted a sign visible to the public at the receptionist's front desk. Required Survey Posting Policy was reviewed and revised to include additional signage. Audits will be completed weekly for 3 weeks, then once a month for 2 months. Residents will be informed of the new signage at the upcoming resident	06/12/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0577 SS = C	Continued from page 2 (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to post survey results and/or a notice of the availability of such in areas of the facility that were prominent and accessible to the public. This had the potential to affect all 118 residents, families and visitors who may have wished to review the information without having to ask. Findings include: During survey entrance on 6/9/25 at 11:00 a.m., a three-ring binder labeled Survey Results was located on small table in an alcove around the corner inside the main entrance to facility. The receptionist desk had a stone front with a wreath and a sign posting "Happy Pride Month". Adjacent to the receptionist desk was a partial wall with postings of facility events, calendars, and information. There was no signage or notice posted anywhere in the main entrance including	F0577	Continued from page 2 council meeting. Audits will be reviewed quarterly by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance. The Administrator or designee is responsible for compliance.	

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0577 SS = C	Continued from page 3 the receptionist desk where individuals wishing to examine survey results did not have to ask to see them. During interview with lead receptionist (F-D) on 6/9/25 at 1:32 p.m., F-D stated, "no, there is nothing around here at the desk or on the front of the desk to say anything about the survey results. People [sic] would have to ask me if they want to know where that binder is." During observation on 6/9/25 at 3:15 p.m., a white paper was observed to be taped to the front of the receptionist desk next to the wreath stating location of survey results. During resident council meeting discussion with R3, R26, and R32 on 6/10/25 at 10:03 a.m., all stated they were unaware of any kind of posting anywhere at the entrance of the facility to direct residents, staff and visitors of the location of survey results. During observation and interview with R32 on 6/10/25 at 10:25 a.m., R32 pointed to the receptionist desk and stated, "See that sign on the left [white paper with directions to survey posting location], that was not there yesterday when I was up here. Someone must have taped it there yesterday but it was not there beforehand." During observation and interview with R319 on 6/10/25 at 1:06 p.m., R319 was sitting in wheelchair and stated, "I wheel myself past the front doors several times a per day to smoke. I noticed the sign today and it was not there until yesterday afternoon ... I know it was not there until yesterday afternoon." During interview with Administrator, assistant administrator (AA)-A, and administrative intern (AI) on 6/11/25 at 3:13 p.m., AA stated she was unaware of when the posting or notice for the location of survey results was posted at the receptionist desk. AA stated survey binder "is in a visible area of the front [main entrance] and did not need to have a notice [informing residents, staff, and visitors of location of survey results]". Facility policy titled Required Postings-State Survey	F0577		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0577 SS = C	Continued from page 4 Results with revision date of 6/1/23 directs, "Survey results must be: iii. Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public."	F0577		
F0578 SS = J	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information	F0578	Immediate Action: All active POLST forms and orders were reviewed for accuracy and immediately corrected in the electronic health record (EHR). Resident-Specific Correction: R50 POLST forms were corrected and updated in the medical record immediately. Staff Education: Immediate re-education was provided to all licensed nursing staff and Health Unit Coordinators (HUC) on proper POLST form completion, transcription, and timely EMR entry. Education was completed on 6/10/2025. Audit Schedule: Code status entry and POLST documentation for all residents will be audited weekly for 3 months Sustained Practice: Verification of code status on admission will be maintained as a standing requirement. Policy Review: The policy on Cardiopulmonary Resuscitation was reviewed; no revisions were made. QAPI Monitoring: Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance and determine next steps as necessary. Responsible Party: DON or designee	06/12/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0578 SS = J	Continued from page 5 to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: R321 R321's entry MDS was 6/6/25. An admission MDS had not been completed at this time. R321's face sheet indicated R321 admitted to the facility on 6/6/25. R321's diagnosis sheet included the following diagnosis: parkinsonism (a clinical syndrome characterized by tremors, rigidity and postural instability), restless legs syndrome, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and unspecified symptoms and signs involving cognitive functions and awareness. R321's Provider Orders for Life-Sustaining Treatment (POLST), signed by R321 on 6/6/25, identified R321 wishes where "Do Not Attempt Resuscitation/DNR (Allow Natural Death)" which was indicated by a check mark in a box in section A. Section B indicated R321's wishes were selective treatment which would not include intubation, advanced airway interventions or mechanical ventilation. The provider signed the document on 6/9/25 (three days after resident's wishes were known). During an interview on 6/09/25 at 6:30 p.m., registered nurse (RN)-B verified that they were responsible for R321's care as they were the nurse responsible for R321's this shift. RN-B reviewed R321's electronic medical record (EMR) and stated R321 was a full code. RN-B stated that if R321 was found unresponsive "we would call 911 and do everything possible," including CPR. RN-B stated they were trained to look at the banner in the EMR for a resident code status in an emergency. RN-B stated R321 should have a POLST in the chart but was unsure where to find it and re-iterated, "we go by the banner in the chart in an emergency." RN-B stated again, "we would start CPR on her since she is full code." During an interview on 6/09/25 at 7:02 p.m., R321 stated that if her heart were to stop, she has made it	F0578		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0578 SS = J	Continued from page 6 clear to staff to "just let me go" and stated "I don't want them to do anything." R321 stated she had signed a document that indicated this. R321 stated she would be very upset if CPR was performed on her in an emergency and she wouldn't feel very good about it. R321 stated, "I have stated my wishes clearly." During an interview on 6/9/25 at 7:31 p.m., registered nurse manager (RN)-E stated R321 was listed as a full code as the provider signed the POLST today (6/9/25). RN-E stated even if a resident signed a POLST, it would not be active until the provider signed it, even if it was days later. RN-E verified R321 signed the POLST on 6/6/25, indicating her wishes were to be DNR, however she continued to be listed as FULL code until 6/9/25 when the provider signed the POLST. RN-E again stated, "it is not an active order until the provider signs it." On 6/10/25 at 11:52 a.m., NP-A was interviewed, and verified they rounded on the transitional care unit (TCU) often. NP-A stated the care center nurses obtained a POLST upon admission and then the providers would address it "when here [onsite] next" adding often the staff would wait for it to be signed before it was accepted (i.e., implemented). NP-A stated they were aware the nurses also called and obtained a telephone order for code status despite the POLST, and expressed in "my opinion" a signed POLST would be an order. NP-A acknowledged with the current process a POLST "could sit for a little bit" before getting a provider signature, and expressed the nurses could send it to triage for a signature, too. NP-A stated they were unaware of the triage providers being unwilling to sign POLST(s). During an interview on 6/12/25 at 12:48 p.m., director of nursing (DON) verified that she had not talked to the medical director about the triage providers not wanting to sign POLSTs without seeing the residents which caused the lapse in POLSTs being signed prior to the immediate jeopardy. DON stated it had now been addressed. A facility provided Cardiopulmonary Resuscitation (CPR) (Code Blue) policy, dated 6/2024, identified licensed staff would be certified in CPR so they could respond appropriately to victims of cardiac arrest. A procedure was outlined which directed, "All residents, upon admission, will have their code status (CPR or DNR)	F0578		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0578 SS = J	Continued from page 7 reviewed and placed as a Physicians Code order ... CPR or DNR (Do Not Resuscitate) stipulations will be recorded on the POLST form and after completion of Section B and signature by MD/GNP [medical provider] will be filed under the advance directive tab in the chart." Furthermore, the document lacked identification to obtain a provider order (i.e., verbal order) in a timely fashion to ensure the resident's wishes are honored after their wishes have been identified. Based on observation, interview, and document review, the facility failed to ensure written Physician's Orders for Life Sustaining Treatment (i.e., POLST) were accurately entered, transcribed and reflected in the medical record in a timely manner to help guarantee correct resuscitation measures (i.e., DNR or CPR) would be performed in accordance with resident wishes for 2 of 2 residents (R50, R321) reviewed for advanced directives. These findings constituted an immediate jeopardy (IJ) situation for R50 who would have received cardiopulmonary resuscitation measures (CPR) against her declared wishes. The IJ began on 5/1/25, when R50's POLST, indicating R50's wishes for Do not Resusitate (DNR) was signed by the medical provider and it wasn't changed within the facility' electronic Medical Record (EMR) system (i.e., banner) to reflect R50's wishes. This error was not identified despite multiple opportunities; and a series of interviews with direct care nurses outlined they would implement the incorrect directions and begin CPR on R50 against her wishes due to this error. The assistant administrator (AA)-A, the director of nursing (DON), and several other management and/or corporate staff members (via Teams) were notified of the IJ for R50 on 6/9/25 at 8:24 p.m. The IJ was removed on 6/10/25 after a removal plan was implemented; however, non-compliance remained at an isolated scope with potential for more than minimal harm that is not immediate jeopardy (Level D). Findings include: R50 R50's admission Minimum Data Set (MDS), dated 3/11/25, identified R50 admitted to the care center on 3/5/25 from the acute care hospital, had intact cognition, and demonstrated no delusional thinking. Further, the MDS	F0578		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0578 SS = J	Continued from page 8 identified R50 as having a primary medical condition of, "Medically Complex Conditions," along with diagnoses of heart failure, high blood pressure, renal failure or insufficiency, and diabetes mellitus. R50's original POLST, dated 3/5/25, identified directions which included, "Follow these orders until orders change. These medical orders are based on the patient's current medical conditions and preferences." The POLST listed a series of sections to be completed using a marking (i.e., checkmark or "X") next to the desired wishes for resuscitation. This identified a checkmark placed next to the options which directed, "Do Not Attempt Resuscitation / DNR (Allow Natural Death)," and "Comfort-Focused Treatment (Allow Natural Death ..." The form was hand-signed by R50 on 3/5/25, and the medical provider on 3/7/25. R50's progress note, dated 4/30/25, identified R50 was re-admitted to the care center from the hospital with an admission diagnosis listed, "Acute Metabolic Encephalophagy [sic]," and a subsequent note, also dated 4/30/25, identified R50 as having bilateral lower extremity cellulitis and various bruises on her arms, legs, and abdomen. R50's (Hospital) After Discharge Orders, dated 4/30/25, identified R50's physician orders upon discharge back to the care center. This included, "Treatment Options: Full Resuscitation." R50's subsequent POLST, completed upon her return to the care center and dated 4/30/25, identified R50's name and had visible markings (i.e., selected) next to the options which read, "Do Not Attempt Resuscitation / DNR (Allow Natural Death)," and, "Selective Treatment ... Treatment Plan: provide basic medical treatments aimed at treating new or reversible illness." The POLST was signed by R50 and care center staff on 4/30/25, and the nurse practitioner (NP)-A on 5/1/25. R50's Care Conference Summary - V8, dated 5/16/25, identified a care conference was held with R50, their representative, social services, and nursing on 5/16/25. The summary contained a section labeled, "2. Nursing," which asked a question to be completed by staff which read, "1. POLST and Code Status match[?]," which was answered, "1. Yes." The summary outlined R50's advanced directives were reviewed and accurately reflected their wishes with a corresponding answer, "1. Yes."	F0578		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0578 SS = J	Continued from page 9 However, R50's facility' electronic medical record (EMR) was reviewed on 6/9/25 as part of the routine survey process. This EMR contained R50's assessments, progress notes, and other pertinent clinical information used by the staff to provide care for R50 while at the campus. The EMR included a banner along the top of the system which contained medical information such as the patient name, date of birth (DOB), allergies, and included a section labeled, "Code Status:," which had adjacent text reading, "(Advance Directives [link; click-able]) Full Code." The link included in the banner response labeled, "Advanced Directives," brought the user to R50's scanned POLST(s) within the medical record; both of which outlined R50's DNR/DNI wishes. The EMR banner information did not reflect or identify R50's wishes from the POLST, dated 4/30/25, to be a DNR. On 6/9/25 at 6:05 p.m., R50 was observed seated in a recliner chair while in her room on the transitional care unit (TCU). R50 had visible, white-colored bandages on both legs along with visible reddened skin on her right thigh and hip which had black-colored marker circling it's perimeter which R50 stated was a "skin infection." R50 was interviewed about her current wishes for resuscitation should she be found without a pulse or not breathing. R50 replied, "I'm a don't revive [DNR]." R50 stated she didn't want a situation to happen where her family member would have to make decisions about whether to stop life-extending measures after CPR (i.e., potential ventilation, tube feeding) adding, "I don't want my [family] to have to unplug me." R50 stated the care center had asked her about these wishes "several times" and she was frustrated there was potential confusion about it adding aloud, "I don't know why it's [DNR] not listed!" R50 stated she would be very upset if she underwent CPR against her wishes adding, "I wouldn't like it!" R50 reiterated she didn't want her family member placed in a situation of whether to end her life if she was hospitalized and on a ventilator after CPR adding, "I don't want to put [them] through all that." When interviewed on 6/9/25 at 6:10 p.m., registered nurse (RN)-B stated they were working on R50's unit and explained if a resident was found without a pulse or not breathing the first step would be "check their code status." RN-B stated this was done using the Medication Administration Record (MAR; used to pass medications from mobile laptop on carts), and pointed to an open MAR which listed a resident' name and other various	F0578		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0578 SS = J	Continued from page 10 clinical information including a section labeled, "Code Status," with corresponding directions (i.e., Full Code, DNR). RN-B verified the MAR is where they'd check for a code status and respond accordingly adding aloud, "We go here [MAR]." RN-B stated the health unit coordinator (HUC) was responsible to enter resident' POLST information into the EMR and nurses were not routinely auditing it to their recall adding, "The HUC [does]." RN-B stated it was important to ensure the code status matched the POLST adding if they were mis-matched then someone could get the wrong resuscitation efforts performed. RN-B added, "Chances are [they would]." When interviewed on 6/9/25 at 6:14 p.m., RN-C verified they were working on R50's unit, and stated if a resident, including R50, were found without a pulse or not breathing then staff would immediately assess them adding if it was "a 911 issue" then they would ask the charge nurse(s) for help to get them transferred to the hospital. RN-C stated they would "immediately" start CPR on the resident if their code status directed. RN-C stated they checked for a code status using the MAR and pointed to an open example on their computer screen adding, "This [pointing] is where you find it [status]." RN-C stated the code status was not kept anywhere else to their knowledge, and expressed they were unsure whom or how the code status information on the MAR gets updated with changes adding aloud, "I don't know." RN-C explained a POLST was obtained for every resident upon admission or re-admission from the hospital if they were absent over 24 hours; and the physician typically would sign it the next time they're onsite. RN-C stated the HUC was responsible to check the accuracy for the information within the EMR and MAR, and RN-C verified the POLST and EMR should match. On 6/9/25 at 6:18 p.m., RN-D was interviewed, and verified they were currently assigned to care for R50. RN-D stated if R50 was found without a pulse or not breathing then they'd check her code status using the MAR and, if needed, begin CPR adding aloud, "We do the CPR." RN-D reviewed R50's MAR screen with the surveyor and verified it directed to perform CPR on R50 with text reading, "Full Code." The MAR lacked the click-able hyper-link to R50's POLST(s) as is present within the actual EMR system. RN-D stated since 'Full Code' was outlined, then staff "do everything" to try to resuscitate her including CPR with chest compressions. RN-D stated the HUC was responsible to enter the POLST information into the EMR and expressed, at least to their knowledge, the nurses were not	F0578		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0578 SS = J	Continued from page 11 auditing this adding, "They [management] have never told us to." RN-D stated they were unsure who, if anyone, double checks entered resuscitation wishes once entered into the EMR system either adding aloud, "For that one, umm, not sure." RN-D then left R50's MAR and entered into the EMR system which had the POLST(s) scanned into it. RN-D reviewed R50's most recent POLST (dated 4/30/25) and verified it was signed with wishes for DNR/DNI. RN-D stated it was likely not updated in the EMR/MAR when it was signed and should have been; however, RN-D verified they would have performed CPR on R50 as directed by the MAR until seeing the signed POLST as pointed out by the surveyor. When interviewed on 6/9/25 at 6:29 p.m., the clinical services coordinator (CSC)-A verified they were responsible to manage the HUC staff. CSC-A explained the HUC would typically be the person to enter the POLST information into the EMR, however, if on a weekend then a nurse could do it, too. CSC-A stated when a POLST is obtained, then a corresponding order gets entered and it was important for every place with the information to match so "there's no misunderstanding or what not." CSC-A stated the nurses should be checking the entered information about code status after the HUC to ensure it is accurate adding, "Well, they're supposed to." CSC-A stated they had just recently started a "check off sheet" to audit code status within the EMR to ensure it matched the POLST for new admissions. CSC-A provided this orange-colored sheet and verified it started on 5/30/25, adding they had not been directed to go back and include residents who admitted prior to 5/30/25 (such as R50). CSC-A verified all POLST(s) were scanned into the EMR system, and none were kept within the hard chart or any other locations to their knowledge. CSC-A reviewed R50's medical record, including POLST(s) and EMR/MAR, and verified they didn't match. CSC-A expressed, "That is not good." CSC-A stated when the POLST was signed on 4/30/25, the nurses should have obtained a corresponding telephone order from the provider which would be kept within the hard chart. CSC-A then retrieved and examined the hard chart but was unable to locate this telephone order expressing the nurses "should have had it written in." CSC-A reiterated the nurses should be double-checking to ensure POLST(s) and the EMR match when POLST information is entered by the HUC. CSC-A acknowledged the potential for R50 to receive CPR against her wishes due to the mis-matched information adding aloud, "She would be revived when she doesn't want to be, which is not good." CSC-A stated the mis-matched code status information could also cause confusion about treatment as the nurses	F0578		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0578 SS = J	Continued from page 12 "wouldn't know which one [instructions] to follow." CSC-A stated they would immediately send an email to the medical provider to get this resolved adding, "Thank you for catching that." On 6/9/25 at 7:14 p.m., the director of nursing (DON) and unit nurse manager (RN)-E were interviewed. DON explained R50 admitted in March 2025 for wound care and was hospitalized in April 2025 before returning to the campus on 4/30/25. DON verified a new POLST was then obtained, and a corresponding telephone order was received from the NP on 5/2/25. RN-E then provided it for review. R50's sheet which was labeled, "Physician's Orders," and had three handwritten orders on it. This included, "5/2/25 [space] DNR/DNI," and was recorded as a telephone order from NP-A. The order had two separate sets of hand-written initials next to the order. DON and RN-E both verified the DNR wishes were not updated in the EMR when this POLST was obtained. DON stated if a resident was found without a pulse or not breathing, then staff should be clicking the 'Advanced Directives' link in the EMR to review the POLST for instructions. However, when questioned on the lack of that link on the MAR system, DON and RN-E pulled up the MAR to observe. They both verified it lacked the click-able link to take nurses to the POLST(s) in the EMR and just had immediate directions listed (i.e., Full Code) adding, "It just says code status." DON verified the two staff initials present on the signed order (dated 5/2/25) was supposed to mean it was checked for accuracy within the EMR system. DON acknowledged the likelihood of R50 getting CPR against her wishes based on the error adding, "You're not wrong." DON explained a similar situation happened several months prior where a resident received CPR against their wishes at the campus and, as a result of that, they changed their process to check code status and POLST(s) for matching information around the end of May 2025; however, the DON verified they had never directed staff to go to admissions prior to that and check for accuracy. DON stated they were unsure if anyone else had, either, adding aloud, "I have no idea." DON stated it was important to ensure the POLST and EMR system matched adding, "We don't want people to not get their choices honored." DON and RN-E both verified they would have started CPR on R50 if she had been found without pulse or not breathing based on the MAR instructions directing such, and the DON expressed	F0578		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0578 SS = J	Continued from page 13 they felt the error was due to the nurses not checking the code status orders in the EMR after they were obtained. DON expressed, "That's the point of the two-check system," adding further, "It's unfortunate [this happened]." On 6/10/25 at 11:52 a.m., NP-A was interviewed, and verified they were involved with R50's care at the campus. NP-A stated R50 had a history of cellulitis, history of cardiac disease, and stasis ulcers adding the wounds on her legs were unlikely to ever heal. NP-A described R50 as having "several co-morbidities" with her care and medical conditions. NP-A stated R50's wounds could deteriorate "quite quickly" and cause the need for hospitalization. NP-A stated they had been involved with R50's care since she admitted back in March 2025, and expressed she was a DNR/DNI the entire time to their knowledge adding aloud, "I don't think she's changed her mind [about that]." NP-A stated the care center nurses obtain a POLST upon admission and then the providers would address it "when here [onsite] next" adding often times the staff would wait for it to be signed before it was accepted (i.e., implemented). NP-A stated they felt R50's chances of successful resuscitation if she was found without pulse were "pretty limited," however, expressed R50 was older in age and, as a result, was at higher risk for any post-CPR issues such as fluid in the lungs or broken ribs. NP-A reiterated R50 as being unlikely to survive CPR but then added, "I've been wrong before too." A facility provided Cardiopulmonary Resuscitation (CPR) (Code Blue) policy, dated 6/2024, identified licensed staff would be certified in CPR so they could respond appropriately to victims of cardiac arrest. A procedure was outlined which directed, "All residents, upon admission, will have their code status (CPR or DNR) reviewed and placed as a Physicians Code order ... CPR or DNR (Do Not Resuscitate) stipulations will be recorded on the POLST form and after completion of Section B and signature by MD/GNP [medical provider] will be filed under the advance directive tab in the chart." The policy continued, "Code status physicians orders will be verified prior to initiating CPR. Verification of full code status should not significantly delay initiation of CPR." The policy directed CPR should be performed on a resident unless they have clinically irreversible signs of death (i.e., decapitation) or, "The patient has a Do Not Resuscitate (DNR) order is in place." However, the policy lacked any further information on where staff should go to obtain the most recent code status order (i.e., MAR,	F0578		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0578 SS = J	Continued from page 14 EMR, POLST) in an emergency situation. The IJ which began on 5/1/25 was removed on 6/10/25 after an acceptable removal plan was implemented. This plan included updating R50's code status to accurately reflect her wishes (i.e., DNR) in the EMR system; completing a whole-house audit of resident' code status(s) to ensure the POLST and EMR system information matched; and starting to educate staff on their policy and/or process to ensure no further mismatched information on resident' code status occurred. The removal plan was verified as having been implemented on 6/10/25, with multiple staff interviews outlining education had been started and was ongoing, and R50's EMR information being updated to reflect her current wishes for DNR/DNI.	F0578		
F0583 SS = B	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.	F0583	Immediate Action: All medication carts were audited and unsecured documents were removed. Staff Education: In-service education was provided to all staff on HIPAA privacy regulations and facility expectations for securing Protected Health Information (PHI). Privacy Tools: Privacy binders were added to all medication carts to cover report sheets and protect documentation tools. Audit Schedule: Unit managers or designees will conduct random audits: Two times weekly for 4 weeks then Once weekly for 2 months Policy Review: The policy on Confidentiality and HIPAA Compliance was reviewed; no revisions were made. QAPI Monitoring: Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance. Responsible Party: DON or designe	07/14/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0583 SS = B	Continued from page 15 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: During observation and interview, the facility failed to implement interventions to ensure resident's personal care information was kept secured and out of public view when stored on 2 of 4 facility units with mobile medication carts. This had the potential to affect 9 of 9 residents (R8, R106, R110, R173, R174, R177, R325, R326, and R330) on the transitional care unit, and 3 residents (R70, R88, and R99) on the long-term care unit whose private and personal information was left unattended on medication carts left out in the hallway corridor. Findings include: During continuous observation and interview on 6/9/25 at 12:29 p.m. to 12:37 p.m., on the transitional care unit of facility, an unattended medication cart with visible care sheet exposing "TEAM 4 NURSES CENSUS SHEET" including columns with resident name, room number, diagnoses, bath days, diet orders, nursing care notes, skin impairment and labs. This included 9 residents. Housekeeper (HK)-A walked past the unattended care sheet and stated, "I know the patient information should not be showing." In addition, there were thirteen instances of staff walking past the unattended care sheet and one instance where a resident was being transported in a wheelchair past the unattended cart. At 12:37 p.m., licensed practical nurse (LPN)-A approached the unattended med cart and stated, "[care sheet] should not have been left like that. People can see the names and information for these people [pointing to the care sheet] and it is a HIPAA issue." During continuous observation and interview on 6/9/25 at 5:36 p.m., on the long-term care unit, registered nurse (RN)-A walked away from medication cart with visible care sheet titled "Fox Crossing Group 3 Nurse Report Sheet" left unattended and exposing R70, R88, and R99 personal information. RN-A had medications in a medication cup and walked into another residents' room. During this time two staff walked past the medication cart. At 5:42 p.m., RN-A returned to the medication	F0583		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0583 SS = B	Continued from page 16 cart and stated, "It is not my info sheet. I don't know whose sheet that is. It should be covered." In addition, RN-A stated, "[patient information] not supposed to be visible because of HIPAA law and private information". During interview with RN-B on 6/9/25 at 6:26 p.m., RN-B stated expectation of staff to ensure resident care sheets are covered at all times, "for privacy and HIPAA purposes. Resident information is there." During interview on 6/10/25 at 8:59 a.m., trained medication aide (TMA)-A stated expectation of nursing staff, "to lock cart and lock [computer] screen for HIPAA. Care sheets should not be left unattended due to HIPAA privacy". Facility policy titled Confidentiality and HIPAA Compliance effective date of 10/24, identified "all resident information remains confidential and protected from unauthorized access or disclosure".	F0583		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services	F0584	Immediate Action: All medication carts were audited and unsecured documents were removed. Staff Education: In-service education was provided to all staff on HIPAA privacy regulations and facility expectations for securing Protected Health Information (PHI). Privacy Tools: Privacy binders were added to all medication carts to cover report sheets and protect documentation tools. Audit Schedule: Unit managers or designees will conduct random audits: Two times weekly for 4 weeks then Once weekly for 2 months Policy Review: The policy on Confidentiality and HIPAA Compliance was reviewed; no revisions were made. QAPI Monitoring: Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance. Responsible Party: DON or designee.	07/14/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0584 SS = E	Continued from page 17 necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe, comfortable and homelike environment for 2 of 4 shower rooms reviewed for cleanliness. Also, facility failed to ensure resident walls were in good condition for 3 of 3 resident rooms (R4, R28, and R77) reviewed for concerns of peeling and chipped paint. In addition, the facility failed to ensure a hallway handrail was secured firmly to wall outside resident room. Findings include: Shower Rooms: During observation and interview on 6/10/25 at 11:34 a.m., on the long-term care unit, the counter including the sink had two opened boxes of gloves and dry washcloths, a stack of opened 4x4 gauze, opened cotton tipped applicator, a used finger lancet, two unfolded towels with an opened one-gallon bottle of shampoo and body wash, and opened 8-ounce bottle of body lotion with screwcap not applied. The upper cabinet door next to sink had a door that was halfway opened hanging by one hinge rather than secured with two hinges. On the floor in front of the sink and next to a waste basket	F0584		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0584 SS = E	Continued from page 18 was crumpled up paper towels, one long cotton tipped applicator, foil wrapper, and one wheelchair footrest. The floor was dry in and by the shower stall with a crumpled up towel on the floor in front of the sink. On the door inside the shower room was a sign that stated, "BEFORE YOU GO DID YOU: Empty the trash, pick up all dirty clothes and towels, Sanitized the tub or shower. Please ensure this room is ready for the next person that is going to use it." The director of nursing (DON) observed room with surveyor and stated, "No this is not acceptable. There is a sharps right here and it is not cleaned up and put away the way it should be. The aides are responsible for cleaning up this room and after giving a bath or shower." During observation on 6/10/25 at 11:58 a.m., an unlocked shower room in memory care unit had an opened toothpaste container on the counter along with an opened bottle of body lotion. The cabinet doors adjacent to the sink had one missing handle and another one that was only attached by one of two screws hanging down. Next to the shower there was a blue knit hat and pair of eyeglasses resting on top of a bedside night table with drawers. A body wash container was opened with no cap on it. During interview with licensed practical nurse (LPN)-B on 6/10/25 at 12:04 p.m., LPN-B observed shower room and stated, "the blue hat and eyeglasses should not be in there because of sanitary [concerns]. Things need to be picked up. The handles need to be fixed or replaced." During interview with nursing assistant (NA)-A on 6/10/25 at 12:09 p.m., NA-A stated expectation of nursing assistants to clean and wipe down the shower room and pick up and remove trash after every shower. During interview with RN-H on 6/10/25 at 1:26 p.m., RN-H stated expectation of housekeeping and nursing assistant staff to wipe down and ensure every shower room is ready for next resident shower. During interview with NA-E on 6/10/25 at 1:49 p.m., NA-E stated expectation of nursing assistants to "clean up afterwards before the next person gets in there. Includes towels and garbage and we are to bring soiled linen to laundry room". Also, NA-E stated counters were to be picked up with "no open bottles of shampoo and	F0584		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0584 SS = E	Continued from page 19 lotion. Nothing on the floor." NA-E stated, "It is their house and it should be cleaned." During interview with NA-F on 6/11/25 at 7:11 a.m., NA-F stated the nursing assistant was responsible for cleaning up the shower room after each resident shower. Walls: R4 R4's quarterly Minimum Data Set (MDS) dated 5/5/25 identified R4 with intact cognition and admission date to facility on 2/24/22. During observation with R4 on 6/9/25 at 5:28 p.m., R4's room had multiple scratches and peeling paint on the wall at the head of the bed. During observation and interview with R4 on 6/11/25 at 7:38 a.m., the accent wall at the head of the bed had several white scrapes through the paint into the drywall. R4 stated, "I have been here about three years. Those scrapes have been there at least a year". R4 stated she thought the scrapes were from the "bed being too close at the time and scraping it. Staff are aware of it." R4 stated "I think it looks terrible. This is my house and I don't want to see that. I want it fixed up." During observation and interview with NA-F on 6/11/25 at 7:42 a.m., NA-F stated, "I have noticed it before. Don't know if it was ever mentioned to maintenance." During observation and interview with RN-I on 6/11/25 at 8:17 a.m., RN-I stated, "Yes that should be taken care of. I don't know if a work order was placed". During observation and interview with maintenance director (M)-D on 6/11/25 at 8:26 a.m., M-D stated, "we will repair the wall. Should be done. We need to match the paint. I did not know about it". R28	F0584		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0584 SS = E	Continued from page 20 R28's quarterly MDS dated 4/16/25 identified R28 with intact cognition and admission to facility on 2/8/21. During observation on 6/9/25 at 5:22 p.m., R28's had a shared room with the bed parallel to window overlooking the courtyard. The wall under the window ledge was visible from the hallway of the unit. It was light pale yellow in color with an eight-foot-long black marking one foot up from and parallel to the floor. A two-foot section of the black marking was torn down to the paper backing of drywall. Also, the wall at the foot of the bed with the chest of drawers aligned with it had peeling paint and black staining along ten feet of the wall which led out to the hallway of unit. During observation and interview with RN-A on 6/9/25 at 5:31 p.m., RN-A stated, "I did not notice it. It is all the way down [the wall] maybe from the wheelchair". During interview with R28 on 6/9/25 at 5:32 p.m., R28 stated, "they [facility] paint over it every once in a while. I think it looks awful." During observation and interview with NA-A on 6/9/25 at 5:57 p.m., NA-A stated expectation of staff to notify maintenance through a work order. "That looks bad too. Should be painted over." NA-A stated, "I would not like to see that in my home." During interview with RN-A on 6/9/25 at 5:35 p.m., RN-A stated expectation of staff to notify maintenance through a work order if a resident's wall needed to be repaired or painted. During observation and interview with NA-E on 6/10/25 at 1:53 p.m., NA-E stated, "I would not like that in my home. It looks very horrible." During interview with trained medication aide (TMA)-C on 6/11/25 at 7:12 a.m., TMA stated staff were expected to request a work order for maintenance to fix any paint or repairs needed. During observation and interview with RN-I on 6/11/25	F0584		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0584 SS = E	Continued from page 21 at 8:16 a.m., RN-I stated, "this should be addressed." During observation and interview with M-D on 6/11/25 at 8:27 a.m., M-D stated, "That is all bad. Wallpaper was there originally and the adhesive was not removed before replacing. Bad idea." R77 R77's quarterly MDS dated 3/19/25, identified R77 with intact cognition and facility admission to facility on 11/22/24. During observation and interview on 6/10/25 at 7:55 a.m., R77's accent wall aligning with head of bed was a green color with all other walls in the room a pale yellow. The green wall with the head of the bed against it had a 24-inch by 32-inch section of wall that was much lighter in color that the primary color of wall. R77 stated, "it has been like that since I have been here which is over a year". R77 stated she did not like the "patch work" on the wall and that it appeared to be a repair but not finished with matching color. During observation and interview with NA-F on 6/11/25 at 7:20 a.m., NA-F stated, "it is unfinished" and "I would not like to have those scuffs at my house". NA-F stated expectation of all staff to put in a maintenance work order for instances of paint repair. NA-F did not know if any staff submitted a work order. During observation and interview with RN-J on 6/11/25 at 8:00 a.m., RN-J looked at R77's wall and stated she was unaware of how long the mismatched colored section was present. "I think it was patched but the paint was not matched and left undone. I don't know how long it's been there". During observation and interview with M-D on 6/11/25 at 8:34 a.m., M-D looked at R77's wall and stated, "oh ok. We can do better than that." Handrail: During observation and interview on 6/9/25 at 2:38	F0584		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0584 SS = E	Continued from page 22 p.m., a hallway handrail was not securely attached to the wall. Point of connection to wall was one bolt which allowed handrail to spin and rotate freely. Licensed practical nurse (LPN)-A stated, "that is not secured". Housekeeper (HK)-A stated, "not safe for someone to grab onto". During observation and interview on 6/9/25 at 3:17 p.m., maintenance assistant (M)-B was removing the handrail and stated, "we will have to order another bolt so the unit can be attached using two bolts instead of the one here [that] allows it to spin. This is not safe. It is a life safety issue." During interview with NA-F on 6/11/25 at 7:11 a.m., NA-F stated, "I would not consider it safe to use [unsecured handrail] because there is no stability when someone grabs it." During interview with TMA-C on 6/11/25 at 7:14 a.m., TMA-C stated, "we should not use unsecured handrails." TMA-C stated expectation of all staff to notify maintenance to fix it. "Safety first." During interview with M-D on 6/11/25 at 8:36 a.m., M-D stated the handrail, "pivots and [sic]no anchoring point. We will replace it. Should not be loose so that it spins. Not safe for anyone to use." Facility policy titled Environmental Cleaning with revision date of 3/18 identified staff to "check the following areas: 1. Hinge areas, door facing and door handles". Policy on maintaining homelike environment including painting and wall repair and ensuring secured handrails was requested but not received.	F0584		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of	F0585	Administration conducted an investigation and interviewed R57, nursing staff, and therapy staff. On 6/12 R57 did not report any concerns regarding her toileting care during the time of interview. The Grievance Policy was reviewed and no changes were made. Education was done for all staff on the grievance policy, formal grievance form, and who the grievance official is. Audits will be conducted 2 times a week for 3 weeks and then weekly for the next 3 weeks. Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance. The Administrator or designee is responsible for compliance	07/14/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0585 SS = D	Continued from page 23 staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;	F0585		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0585 SS = D	Continued from page 24 (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure voiced complaints about nursing services were acted upon and, if needed, investigated or resolved for 1 of 1 resident (R57) reviewed who complained staff were placing two incontinent products on them at night, and they did not want a particular staff person to help with certain cares. Findings include: R57's admission Minimum Data Set (MDS) dated 3/24/25, indicated R57 had intact cognition and did not have hallucinations or delusions. R57 rejected care daily. R57 was dependent on staff for toileting hygiene, dressing, rolling left and right and transfers. R57's diagnoses included heart failure, hypertension, coronary artery disease, atrial fibrillation, chronic kidney disease, diabetes mellitus, hip fracture,	F0585		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0585 SS = D	Continued from page 25 Parkinson's Disease, malnutrition, anxiety, and depression. During interview on 6/9/25 at 2:35 p.m., R57 stated staff often turned off her call light but did not help her with what she needed. R57 stated staff double briefed her multiple times with two incontinent products. R57 stated she told the staff they were not supposed to double brief her but they did so anyways. R57 stated she felt one staff member was "angry" working with her and moved her around without communicating to her a few months ago. R57 stated she was able to avoid the staff member assisting her with a shower, but the staff member still assisted her with other cares. R57 described the situations as "disturbing." R57 stated floor staff, a nurse manager, and therapy staff were aware of the described situations. R57's progress notes lacked documentation to show R57's concerns were acted upon, investigated as needed, or resolved. The facility's Grievance Log entry dated 4/17/25, indicated R57 filed a verbal grievance related to "care concerns" and the nurse manager addressed the concerns. During interview on 6/12/25 at 9:36 a.m., the director of therapy (DT) reviewed notes from occupational therapy and stated there were notes which indicated R57 was observed double briefed and soiled. R57's Occupational Therapy Treatment Encounter Note(s) indicated: -5/29/25, R57 lacked awareness of soiled brief and bedding. Therapy staff assisted R57 with brief change and educated patient to use call light once awake for brief change to maintain skin integrity. -6/2/25, R57 was soiled through double briefs and nurse manager was notified. R57 was educated on using call light and requesting brief change as soon as wakes in the morning. Therapy assisted R57 with brief change and bed mobility.	F0585		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0585 SS = D	Continued from page 26 During interview on 6/12/25 at 10:20 a.m., nursing assistant (NA)-K stated R57 expressed concerns about being double briefed to them, and NA-K observed her double briefed. NA-K stated they did not report R57's concerns to anyone else, because R57 stated the nurse manager was already aware. NA-K stated R57 asked them to be switched to a morning shower, since R57 did not want a named nursing assistant to work with her. NA-K stated they mentioned the request to the evening shift. During interview on 6/12/25 at 10:47 a.m., registered nurse (RN)-O stated residents were not supposed to be double briefed and was not aware of any related concerns, nor was RN-O aware R57 did not want a certain staff member to work with her. During interview on 6/12/25 at 1:00 p.m., nurse manager, RN-I, stated they spoke with R57 about concerns related to staff not providing timely assistance and pulled call light reports but were not aware R57 had concerns related to being double briefed. RN-I stated residents who were double briefed had a risk for skin breakdown. RN-I stated they were not aware R57 had concerns with a certain staff member, and further stated the facility process was to fill out a grievance and self-report if needed when a resident reported a concern. During joint interview on 6/12/25 at 1:49 p.m., the administrator and director of nursing (DON) stated they had a formal grievance process for resident concerns, if the concerns were not able to be addressed right away. Staff were able to fill out a grievance form or escalate the concern to the supervisor. The administrator and DON were not aware of R57's concerns. During interview on 6/12/25 at 2:01 p.m., the administrator stated R57's listed grievance dated 4/17/25, was related to spiritual care. The administrator stated they did not have a grievance related to R57's concerns and expected R57's concerns to be addressed via grievance form. The facility's Grievance Policy revised October 2024, indicated all residents or representatives have the right to voice concerns, complaints, or grievances regarding their care or any other matter. The grievance process ensured grievances were investigated thoroughly, tracked, and resolved promptly, with	F0585		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0585 SS = D	Continued from page 27 outcomes communicated clearly. The facility designated the administrator as the grievance official. The policy indicated residents could file grievances orally or in writing. When staff received a formal grievance, they documented on the Formal Grievance/Concern Form and promptly forwarded to the grievance official. The grievance official then ensured appropriate departments were notified and involved in investigation, logged grievance into facility's grievance log for tracking and monitoring, and attempted to respond verbally or in writing to the resident or representative within seven business days.	F0585		
F0656 SS = D	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	F0656	Resident-Specific Action: R57's care plan was immediately reviewed and updated with appropriate interventions for weight management. All residents with weight parameters were re-evaluated for appropriateness, and care plans were updated to reflect any changes. Staff Education: Nurses and Registered Dietitians were educated on timely updates to care plans and implementation monitoring for change of condition. Audit Schedule: Care plans related to weight management will be audited: Twice weekly for 4 weeks, then Once weekly for 4 weeks, then Monthly for 2 months Policy Review: The Change of Condition/Notification policy was reviewed; no revisions were made. QAPI Monitoring: Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance. Responsible Party: Registered Dietitian or designee.	07/14/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0656 SS = D	Continued from page 28 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 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 interview and document reivew, the facility failed to ensure care planned interventions were followed for 1 of 1 resident (R57) reviewed for weight gain. Findings include: R57's admission Minimum Data Set (MDS) dated 3/24/25, indicated R57 had intact cognition and did not have hallucinations or delusions. R57 rejected care daily. R57 was dependent on staff for toileting hygiene, dressing, rolling left and right and transfers. R57's diagnoses included heart failure, hypertension, coronary artery disease, atrial fibrillation, chronic kidney disease, diabetes mellitus, hip fracture, Parkinson's Disease, malnutrition, anxiety, and depression. R57's care plan revised 6/9/25, indicated R57 had daily weights and directed staff to notify the provider for weight gain of more than three pounds per day or five pounds per week. R57's Weight Summary indicated: -5/31/25, 170 pounds with mechanical lift. -6/1/25, 170.4 pounds with Hoyer lift. -6/2/25, 171 pounds with Hoyer lift.	F0656		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0656 SS = D	Continued from page 29 -6/3/25, 172.2 pounds with mechanical lift. -6/4/25, 173.4 pounds with mechanical lift. -6/5/25, 175 pounds with mechanical lift. -6/6/25, 173.3 pounds with mechanical lift. -6/7/25, 175.6 pounds with mechanical lift. More than five pounds since 5/31/25. -6/8/25, 175.7 and 175.8 with mechanical lift. More than five pounds since 6/1/25. -6/10/25, 176.3 pounds with mechanical lift. -6/11/25, 177 pounds with sitting and mechanical lift. -6/12/25, 177.6 pounds with mechanical lift. R57's medical record lacked documentation related to notifying physician about weight gain. During interview on 6/12/25 at 10:20 a.m., nursing assistant (NA)-K stated R57 needed a daily weight, and nursing assistants documented the daily weights. NA-K stated R57's lower leg swelling increased and decreased and was not consistent. During interview on 6/12/25 at 10:47 a.m., registered nurse (RN)-O stated they followed given parameters to notify providers about increased weight or edema. RN-O stated R57 would let nursing know if she had concerns about her weight or edema. During interview on 6/12/25 at 12:29 p.m., the dietician (DD) stated the interdisciplinary team worked together to monitor weights and discussed weight concerns in their morning meetings. DD stated they worked with nursing to investigate if residents looked	F0656		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0656 SS = D	Continued from page 30 like they had fluid retention if they gained weight or other concerns. DD reviewed R57's weights and acknowledged the weight gain. DD stated they will put R57 on their "radar." During interview on 6/12/25 at 1:00 p.m., nurse manager, RN-I, reviewed R57's weights and expected staff to write a progress note to indicate they notified the provider about weight concerns and another progress note to indicate the provider's response. The facility's Individualized Care Plan dated policy dated 1/22/25, indicated a comprehensive care plan was created with comprehensive assessments and individualized to reflect resident's functional capacity and medical, nursing, psychosocial, activity, and other identified needs.	F0656		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: R25 R25's admission Minimum Data Set (MDS) dated 3/31/25, indicated R25 was cognitively intact, had no hallucinations, delusions, and didn't refuse personal cares. MDS indicated R25 received maximal assistance with toileting hygiene, bathing, sit to stand and was dependent with transfers. MDS also indicated R25 received moderate assistance with personal hygiene, dressing and received set up to eat, and oral hygiene. R25's Medical Diagnosis record printed 6/12/25, indicated diagnoses of acute respiratory failure with hypoxia (low level of oxygen in the blood), atrial fibrillation (irregular heart rhythm that can lead to blood clots in the heart), type II diabetes, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or the inability to move one side of the body) following cerebral infarction affecting right dominant side, and muscle weakness.	F0677	Immediate Action: R20 received nail care, and R25 was groomed upon identification of concern. All residents were assessed for nail care, hair care and beard trimming. Any residents that were identified as having a need, these cares were completed. Anyone refusing assistance was documented, and the care plan was updated. Staff Education: All licensed and CNA staff had an in-service on ADL responsibilities, including the importance of routine grooming and accurate documentation. Audit Schedule: Audits of grooming documentation and hygiene practices will be completed: Two times a week for 4 weeks, then Once weekly for 4 weeks, then Twice monthly for 1 month Policy Review: The policy on HS Cares and AM Cares was reviewed; no revisions were made. The Nails, Care policy was reviewed; revisions were made. QAPI Monitoring: Audits will be reviewed quarterly by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance and determine further actions as necessary. The DON or designee is responsible for compliance.	07/14/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0677 SS = D	Continued from page 31 R25's Activities of daily living (ADLS) care plan printed 6/12/25, indicated R25 had self-care performance deficit related to weakness, respiratory failure, obesity, right side weakness from previous cerebral vascular accident (damage to the brain from interruption of its blood supply). R25's care plan indicated he needed assistance of one staff with bathing/showering, and personal hygiene. During observation and interview on 6/9/25 at 1:05 p.m., R25 was in bed. R25 had long dull hair separated in locks and had long disheveled mustache and beard. R25 stated staff used shampoo caps, no water to wash his hair and staff had not offered to help trim his beard. R25 stated he had a big hair knot on the back of his head and staff had not helped him to untangle his hair. R25 added "Later today, I will have a bath. We will see how I will look tomorrow." During observation and interview on 6/10/25 at 1:35 p.m., R25 stated last night the staff used a shampoo cap (a hair cap that contains a dry substance) but staff didn't do a good job and still had the hair knot on the back of his head. The staff member only rubbed the top of his head two to three times, and it was done. Staff didn't offer to help him with his beard. R25's hair looked dull and R25 stated his hair didn't feel clean. During observation and interview on 6/10/25 at 1:42 p.m., registered nurse (RN)-J observed R25 and stated "he [R25] looks sweaty, his hair is greasy, and his beard should be trimmed". RN-J added his mustache was growing over his lower lip. R25 stated "Today, for the first time in three months I looked at myself in the mirror and eek." During interview on 6/10/25 at 1:48 p.m., nurse manager/registered nurse (RN)-I stated residents should be helped to shave and the clinical services coordinator (CSC) should schedule a haircut appointment. During interview on 6/10/25 at 1:52 p.m., CSC-A stated scheduling a hair cut will depend on the resident . CSC-A added, sometimes the social workers will start the process, including talking to the residents and making the hair appointment for them.	F0677		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0677 SS = D	Continued from page 32 During interview on 6/10/25 at 1:55 p.m., social worker (SW)-A stated R25 moved two weeks ago to her unit, and last week RN-I informed her R25 wanted a haircut, and his beard trimmed. SW-A stated social workers were responsible to schedule hair appointments. SW-A stated residents' personal appearance was important for dignity and quality of life. During interview on 6/12/25 at 9:11 a.m., director of nursing (DON) stated residents' hair should be brushed every day and washed on shower days. DON stated if residents' preference was to received sponge baths instead of showers, their hair could be washed with shampoo and water in bed. DON stated hair shower caps should not be used on regular bases. DON stated washing residents' hair and shaving were important for hygiene and dignity. Facility's policy titled AM cares (morning cares) dated 4/25, indicated all patients were provided with set up, assistance, or total assistance for AM (morning) cares unless the plan of care states otherwise. Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene and grooming (i.e., nail care, hair care, beard trimming) was provided for 2 of 3 residents (R20, R25) reviewed for activities of daily living (ADLs) and whom were dependent on staff for their care. Findings include: R20 R20's quarterly Minimum Data Set (MDS), dated 4/23/25, identified R20 had moderate cognitive impairment but demonstrated no delusional thinking or rejection of care behaviors. Further, the MDS outlined R20 required substantial assistance with personal hygiene cares. On 6/9/25 at 2:35 p.m., R20 was observed lying in bed while in his room. R20 had a meal tray placed on a bedside table over him while lying down, and he had rice and beans spilled onto his chest. R20's fingernails were observed and multiple nails had a	F0677		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0677 SS = D	Continued from page 33 visible, dark-colored substance or debris present under the edge of the nail to the nail bed. R20 was asked about his bathing and grooming at the care center and responded aloud, "Bed Bath." R20 looked at his nails when asked about them and expressed he was unsure when they were last cleaned or clipped with an audible, "I don't know." The following day, on 6/10/25 at 12:45 p.m., R20 was again observed lying in bed while in his room. R20's fingernails remained with visible dark-colored debris underneath of them as was observed the day prior. R20's care plan, dated 3/2025, identified R20 had an ADL self-care deficit due to limited mobility and weakness. The care plan listed multiple interventions for R20 including assistance of one with bathing and, "PERSONAL HYGIENE: Requires assistance by 1 staff with personal hygiene and oral care." R20's most recent Weekly Bath and Skin Sheet - V4, dated 6/5/25, identified R20 received bathing and his skin was intact. The form outlined a section labeled, "Nail Care, select all that apply," with options for staff to select from using a checkmark. This recorded a response, "3. Finger nails short and smooth; do not need trimming." However, the form lacked options to record the nail cleanliness or if they were offered to be cleaned. On 6/11/25 at 10:03 a.m., R20 was observed in bed. R20's fingernails remained soiled with visible, dark-colored debris and/or substance underneath multiple nails which had been observed since two days prior (on 6/9/25). Immediately following, on 6/11/25 at 10:06 a.m., nursing assistant (NA)-L was interviewed, and verified they had worked with R20 prior. NA-L explained R20 was bathed every week on Thursday morning and his fingernails should be clipped by the nurses if he was diabetic. NA-L verified there were clippers and a file to use for residents nail care, if needed. NA-L then observed R20 lying in bed at the request of the surveyor. NA-L verified their condition and expressed, "It's dirty." NA-L stated R20's fingernails needed to be cleaned and the aide could do that task using an edge device they had. NA-L stated nails would be cleaned on R20's bath day, however, expressed if noticed to be soiled then they could be cleaned whenever adding, "If you see it [can be cleaned]." NA-L stated clean nail beds and edges were important to	F0677		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0677 SS = D	Continued from page 34 reduce the risk of infection and general hygiene. When interviewed on 6/11/25 at 10:32 a.m., registered nurse (RN)-K stated they had worked with R20 only "once or twice" prior. RN-K explained the nurses would do nail clipping for R20 since he was diabetic, but the aides could clean his nails if they were found soiled. RN-K stated nails were cleaned on bath day but could be cleaned anytime they're noticed to be soiled adding aloud, "As needed as well." RN-K stated any attempt to clean them, including if R20 refused it, should be documented in the medical record. RN-K stated having clean nail beds and edges was important to reduce bacteria on the hands and "hygiene as well." R20's medical record was reviewed and lacked evidence R20 had been offered or had completed any nail care, including cleaning of them, since 6/5/25 despite being observed multiple days in a row with soiled nail beds and edges. On 6/11/25 at 11:08 a.m., unit manager (RN)-E and the director of nursing (DON) were interviewed. DON explained nail cleaning should be done on bath day and if refused, it should be recorded in the medical record. DON stated the aides could clean nails whenever noticed they needed it, too. This was important for personal hygiene care. A facility provided AM Cares policy, dated 4/25, identified all residents would be provided with assistance, as needed, for morning cares unless otherwise directed by the care plan. The procedure listed steps for the care including, "19. Nails are clean and trimmed to resident desired length." In addition, a provided Nails, Care Of policy, dated 9/2022, identified a purpose of providing cleanliness and preventing infection spread. The policy directed, "5. Complete nail care on bath day and as needed."	F0677		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents	F0684	Resident-Specific Action: Interdisciplinary team (IDT) reviewed and updated the comprehensive care plans for R1, R8, R10, R11, and R57. Specific interventions were implemented based on each resident's clinical condition (e.g., bowel program reviewed; diabetes management clarified, dietary preferences honored, edema treatments ordered, ear assessments completed, and skin care addressed). All care plan updates were completed and documented in	07/14/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 35 receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: EDEMA MANAGEMENT: R10's annual Minimum Data Set (MDS) dated 3/31/25, identified impaired cognition and diagnoses of Alzheimer's disease, diabetes mellitus, and hypertension. R10 used a wheelchair, relied on staff for personal hygiene, and for dressing. R10's active provider orders directed Velcro wraps (a skin protective device) be applied in the a.m. (morning) and removed in the p.m. (evening). The order specifically indicated black socks first, then foot piece, and lastly the calf piece, and for R10 to be monitored daily for edema. R10's care plan dated 4/14/25, indicated skin impairment and listed assessments and treatments to protect R10's skin. The plan also directed staff to place Velcro wraps on in the morning and remove at night. The directions were to apply black socks first then place foot piece, then calf piece and check for tightness. During an observation and interview on 6/9/25 at 3:11 p.m., R10 wore yellow grip socks slouched down to the ankles and black croc sandals. R10's Kardex (a version of the care plan for reference) hung in the wardrobe and was visible to staff. Nursing assistant (NA)-I stated the morning shift should have applied the black socks and Velcro wraps while R10 was in bed. NA-I attempted to apply the Velcro wraps over the yellow grip socks several times without looking at the instructions/diagram that hung over R10's bed. A large handwritten sign indicated, do not send Velcro wraps to laundry. NA-I was unable to identify black socks should be applied before the Velcro wraps. NA-I stated the previous shift would give directions on how to care for residents or the nurse would give updated information. NA-I was unaware the Kardex was available in R10's room, and confirmed the Velcro wraps were not put on according to the directions. During an interview on 6/9/25 at 3:30 p.m., licensed	F0684	Continued from page 35 the EMR A physician and/or Nurse Practitioner was notified of all changes. Bowel Management: R8's bowel program was reviewed and revised. A full house review was conducted by nursing leadership (DON/designee) to identify residents receiving specialized bowel programs. The Nurse Manager or designee will ensure bowel program protocols are reviewed quarterly and upon admission/readmission to assess need for interventions including scheduled bowel regimens, stool softeners, PRN laxatives, or stimulation. Pharmacy Follow-Up (related to diabetic management): R8 received the Continuous Glucose Monitors CGM on 6/11/25. All residents' orders were audited to ensure medications are in house. Nurses were educated on following up on any missing medication or devices. Skin Integrity: R1 had skin assessment done; no skin issues were noted at that time. Any residents identified with new or at-risk areas had interventions implemented and documented. The Nurse Managers were educated that they need to ensure that skin checks are completed and documented in Point Click Care on bath days. Nurse's and nursing assistants were educated on documenting follow-up including refusals. Dietary Preferences/Modifications: R57's dietary preferences were changed on 6/20/25. Residents requesting texture, consistency, or cultural modifications had updated assessments and documentation completed in EMR and care plans updated. Going forward, dietary preferences will be verified quarterly at care conferences, significant change in condition, and as necessary. Education was provided to dietary and nursing staff on the process for communicating, honoring, and documenting dietary changes. Edema Management: R10's care plan was reviewed and reviewed with staff to ensure care plan was followed. All residents with edema devices ordered in their EMR were reviewed by the nurse managers. Interventions were verified (e.g., elevation, compression, diuretic review, low-sodium diets) and added to care plans. IDT will review edema management in Grand Rounds weekly to ensure timely reassessment and updates. Hearing/Earwax Management: R11's ears were treated on 6/11/2025, R11 refused to have her ears flushed after the treatment. Residents with suspected or known hearing difficulties had their ears assessed for cerumen impaction and referrals to PCP or audiology as needed. The facility is implementing quarterly and as needed ear exams to assess wax build up, or any other concerns. Staff Education: Nursing and dietary staff received education on: Proper assessment, documentation, and care planning for bowel programs, CGMs, edema, hearing changes, and skin risk. Timely	

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 36 practical nurse (LPN)-C stated residents did not like to wear protective devices on the memory care unit and would often remove them, then confirmed the treatment assessment record (TAR) was used to document when the protective devices were applied and removed. During an observation on 6/10/25 at 9:03 a.m., R10 was holding a purse and seated in a wheelchair wearing gray long pants, yellow grip socks slouched to the ankles, and black crocs. No black socks were seen. R10's pant legs appeared bunched up in multiple spots below the knee. Review of R10's June 2025 TAR indicated staff documented having applied black socks and Velcro wraps. During an interview on 6/10/25 at 9:09 a.m., nursing assistant (NA)-H stated the residents told them what they needed, and the nurse told the assistants what cares to complete. If there was a change in an order the night shift would report that information. During an interview on 6/10/25 at 9:13 a.m., licensed practical nurse (LPN)-B stated the assistants completed cares and referenced the computer and assignment sheets, and knew the residents well. LPN-B confirmed the aides applied the protective equipment, but the nurse was responsible to document their use. LPN-B confirmed the aids knew to use the Kardex to complete all ordered cares and the nurse was responsible to ensure those orders were carried out. During observation on 6/10/25 at 12:56 a.m., R10 sat in a wheelchair and wore yellow grip socks slouched to the ankles with black crocs. No black socks were seen. During an observation and interview on 6/11/25 at 11:44 a.m., R10 sat in a wheelchair with yellow grip socks slouched to the ankle and wore black crocs, the Velcro wraps were visible under black long pants. LPN-B stated the nursing assistants would be reminded on the importance of the black socks under the Velcro wraps, but currently R10 did not have black socks, as they were sent to laundry a few months ago and never returned. The nurse manager was notified, and LPN-B received no response.	F0684	Continued from page 36 communication of dietary change requests and honoring resident choices. Audits: The Director of Nursing or designee will conduct audits on bowel programs, medication follow up, edema, hearing and skin integrity: Twice weekly for 4 weeks Once weekly for 4 weeks Monthly for 1 months The Registered Dietician or designee will conduct audits on dietary changes due to resident preference and requests: Twice weekly for 4 weeks Once weekly for 4 weeks Monthly for 2 months Policy Review & Education: The Ear Irrigation policy was reviewed; revisions were made. The Bowel Management policy was reviewed; no revisions were made. The Blood Sugar Monitoring policy was reviewed; no revisions were made. The Skin Alterations policy was reviewed; no revisions were made. The Care Plan Individualized policy was reviewed; no revisions were made. The Resident Rights policy was reviewed; no revisions were made (related to dietary preference). QAPI Monitoring: Audits will be reviewed quarterly by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance. The DON or designee is responsible for compliance	

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 37 R10's progress notes lacked documentation R10's black socks were lost by laundry or that the nurse manager was notified R10 needed black socks. During an interview on 6/12/25 at 11:29 a.m., director of nursing (DON) nodded and agreed while taking notes regarding nursing assistants not following R10's orders or care plan and acknowledged the importance of protective equipment applied as directed. The facility policy, Individualized Care Plan dated 1/22/25, identified that all interventions flow into the nursing assistance Kardex for the nursing assistant to use to provide resident cares. Hearing R11's quarterly Minimum Data Set (MDS) dated 4/3/25, indicated R11 was cognitively intact and had diagnoses of schizophrenia, bipolar disorder, respiratory failure, and was on hospice. R11 required partial to moderate assistance with personal hygiene, used a wheelchair for mobility, and required substantial to maximal assistance with shower transfers. R11 did not wear hearing aids. R11's care plan last revised 4/16/25, indicated R11 required assist of one with bathing and personal hygiene. The care plan also indicated staff to report any unusual activity, discomfort or pain to the nurse. R11's April 2025 hearing assessment indicated adequate ability to hear, and no hearing aids or appliances were used. During observation and interview on 6/9/25 at 1:13 p.m., maintenance (M)-B attempted to communicate with R11, to which R11 replied over and over, "I cannot hear you my, ears are plugged". M-B attempted to converse wither her again and R11 repeated her ears were plugged, and she could not hear him. M-B stated he would come back later and left. R11 stated again, "I can't hear". Surveyor attempted to communicate and used a laptop and large print questions for the initial interview, but R11 declined to complete the interview.	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 38 During an observation on 6/9/25 at 6:03 p.m., nursing assistant (NA)-J entered R11's room and told R11 he would return to complete cares. R11 didn't respond. NA-J continued to talk to R11 about his plan to finish work down the hall and he would return to help R11, and asked if that was ok. R11 did not respond. R11 then turned around and said "Oh", called NA-J by name, motioned for him to come inside the room, then stated both of her ears were plugged and asked NA-J to speak into the right ear. During observation and interview on 6/10/25 at 9:39 a.m., R11 stated she couldn't hear, needed her ears flushed out, and asked to be taken to the ear doctor today. R11 was unable to hear surveyor, shook her head, continued to speak loudly, and stated, "I cannot hear you, my ears are plugged". R11 had visible, thick, yellow, debris on the opening of the right ear canal and a small amount of yellow debris on the left ear canal. R11 fell asleep during the interview. During observation and interview on 6/10/25 at 1:13 p.m., licensed practical nurse (LPN-D) stated R11 could hear today during cares, was responding back during conversation, and had not complained of hearing concerns. LPN-D stated if a resident complained of hearing concerns she would assess their hearing by bending down and talking directly into the resident's ears. LPN-D confirmed this was how to assess for hearing. LPN-D stated the psychologist was in the facility today and R11 mentioned she could not hear the psychologist. R11 approached LPN-D and asked if she could see the nurse practitioner (NP)-A the following day, and when LPN-D asked why R11 would like to see NP-A R11 did not answer. LPN-D asked three separate times if R11 could hear, to which R11 did not respond. Finally, R11 said she need to see NP-A because she couldn't hear. LPN-D confirmed she would contact NP-A. During an interview on 6/10/25 at 1:30 p.m., LPN-D stated she had removed dried skin from the outside of the earlobe earlier that day and the inside was clear. During an interview on 6/10/25 at 1:38 p.m., RN-I was unaware R11 had complaints of hearing loss and would place an order for debrox (ears cleaned). R11's progress notes indicated on 6/10/25 at 3:50 p.m., hospice documented R11 could not hear the psychologist	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 39 but was able to hear the hospice nurse. The nurse checked R11's ear canal and reported no wax, and added R11 to the audiologist list for an appointment. R11's progress notes dated 6/10/25 at 6:53 p.m., indicated RN-I followed up with R11 regarding complaints of hearing loss and R11 did not display any difficult in hearing. During observation and interview on 6/11/25 at 7:32 a.m., R11's right ear no longer had visible debris, however R11 stated her ears were still plugged and she still couldn't hear. During interview on 6/11/25 at 7:34 a.m., RN-D, stated the off-going nurse did not report R11 had hearing concerns. RN-D had no concerns while administering morning medications and therefore did not assess R11's hearing. During observation on 6/11/25 at 7:44 a.m., a staff member exited the elevator and walked over and spoke to R11. When R11 stated she could not hear them, they got down and spoke directly in R11's ear and repeated themselves twice before R11 responded. During observation and interview at 6/11/25 at 8:06 a.m., trained medical assistant (TMA-C) wore a mask and talked closely to R11's ear with no response. TMA-C removed her mask several times to talk closely to R11's ear. TMA-C stated R11 did not have behaviors, could usually have a conversation, and R11 was unable to hear her. During observation and interview on 6/11/25 at 11:23 a.m., NP-A assessed R11's ears while R11 stayed silent. NP-A used an otoscope to examine R11's right ear and stated R11's ear was "completely caked" with wax. NP-A told R11 she had a lot of wax, then proceeded to use a curette to scoop the wax out of the right ear. NP-1 stated the facility should be assessing ears, and indicated the could have seen the wax if they lifted up on the ear. NP-A stated the wax was occluded and hard, and they would order debrox to soften the wax. NP-A confirmed R11's left ear was also full of wax, and stated with the amount of wax R11 had in her ears, it would "clearly, most definitely" affect hearing.	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 40 During an interview with 6/12/25 at 11:27 a.m., director of nursing (DON) stated nurses should assess residents hearing with cares, and nodded as R11's interviews and observations were discussed. Facility policy, Consult Visit Policy- [Audiology] ... dated 10/24, identified changes in hearing or vision noted by staff, residents, or family members will prompt immediate referrals. NON-PRESSURE SKIN: R1's quarterly Minimum Data Set (MDS) dated 4/3/25, indicated R1 had intact cognition and no hallucinations or delusions. R1 had other behavioral symptoms not directed toward others and did not reject cares. R1's diagnoses included hyperlipidemia, dementia, hemiplegia and hemiparesis, and stroke. The MDS indicated R1 had no ulcers, wounds, or other skin problems. R1 had application of ointments/medications other than to feet. R1's skin integrity care plan revised 7/24/24, indicated R1 had potential for impaired skin integrity related to fragile skin and limited mobility. Interventions included assess skin with weekly bath, barrier cream as needed, observe for signs/symptoms of infection, observe skin with daily cares, turn and reposition every two hours in bed and/or chair, and use a draw sheet or lifting device to move. R1's personal preferences care plan revised 7/24/24, indicated R1 signed a risk vs benefits form on 8/1/23 for occasional refusals of showers and/or baths. R1's medication and treatment administration record dated 6/1/25 to 6/12/25 indicated: -8/18/21, mometasone furoate external ointment 0.1% apply to left arm/right leg topically one time a day for skin allergies. -1/3/23, tacrolimus ointment 0.1% apply to eye lids, neck, topically as needed for itch twice a day as needed.	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0684 SS = E	Continued from page 41 -3/13/23, apply house barrier cream to buttocks twice a day and as needed per standing house orders for redness. -5/28/24, calmoseptine external ointment 0.44-20.6% apply to perineal area topically three times a day for IAD (incontinence-associated dermatitis). -7/18/24, weekly skin body audit and pain assessment performed. If any new alterations in skin integrity, follow the Skin Alterations and Wounds checklist. One time a day every Thursday evening. The entry for 6/5/25 was blank. -11/6/24, ammonium lactate external lotion 12% apply to bilateral lower feet and/or lower legs topically two times a day for xerosis (severely dry skin). -11/13/24, cetirizine HCl (hydrochloride) tablet 5 milligram (mg) by mouth one time a day for eczema (skin condition which causes a skin rash, dry skin, and itchiness). -11/23/24, bath/shower every Thursday evening shift. The entry for 6/5/25 was blank. R1's Assessments, indicated the last documented Weekly Bath and Skin Sheet assessment was 5/8/25. The assessment indicated a bath/shower was completed. The assessment further indicated R1's skin was not clear and intact, and the skin issue was a known concern and was monitored. R1's progress notes lacked information on weekly skin checks after 5/8/25 and did not mention skin alterations or monitoring from 5/8/25 or after. During observation and interview on 6/9/25 at 1:53 p.m., R1 was observed lying in bed. R1's forehead and left cheek were visibly dry with area of white-colored skin (i.e., flaky) present. R1 stated his wife put Aveno lotion on his face. R1 stated the staff were aware he should have lotion on his face but did not assist him as often as they should.	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 42 During interview on 6/11/25 at 1:47 p.m., trained medication assistant (TMA)-A, who also worked as a nursing assistant, stated R1 had barrier cream staff applied to R1's bottom during incontinent cares and no creams for R1's face, arms, or legs. TMA-A stated they were not aware of any skin concerns for R1. During observation and interview on 6/11/25 at 1:54 p.m., registered nurse (RN)-H stated they did not frequently work with R1 and were not aware of any skin concerns. RN-H stated they applied barrier cream to R1's bottom and would have to defer to his chart to recall if they applied other creams to him. R1 stated staff had "facility" lotion if there were concerns regarding R1's face. RN-H entered R1's room and observed his face. R1's face looked the same as previously mentioned. R1 stated his face itched, and he had Aveno lotion in his drawer. RN-H stated she would check R1's orders to see if there were any creams for his face. R1's progress note on 6/11/25 at 2:04 p.m., indicated tacrolimus ointment 1% was applied as needed for itch. A follow-up progress note on 6/11/25 at 6:20 p.m., indicated the treatment was effective. During follow-up interview on 6/12/25 at 10:04 a.m., TMA-A acknowledged R1's dry face and stated R1 did not always allow staff to help him with dressing, personal hygiene, or showers/bed baths. TMA-A stated bed bath/shower refusals were charted in residents' charts, and nurses could complete skin assessments even when residents refused showers/bed baths. During interview on 6/12/25 at 10:47 a.m., registered nurse (RN)-O stated they completed weekly skin checks for residents on their shower days. If there was a change in skin condition, staff were to document in the skin check or skin alteration assessment. Resident refusals of showers/bed baths were recorded under the weekly skin assessments or in progress notes. During interview on 6/12/25 at 1:00 p.m., nurse manager, RN-I, expected staff to recognize changes in skin conditions and follow-up on observations of skin concerns. RN-I expected staff to complete weekly skin assessments or open a skin assessment and mark refused if the resident did not allow a skin check. RN-I stated R1 often refused cares.	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 43 The facility's Management of Skin Alterations policy dated 5/1/25, indicated staff would identify and review residents whose clinical conditions increase the risk for skin breakdown to ensure necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, alterations from worsening and new injuries from developing. The policy indicated each resident would have a weekly body audit performed by a licensed nurse, and residents' skin would be observed daily and as needed. Staff were to complete a checklist for skin alterations when identified and initiate daily skin alteration monitoring checks to document if signs of worsening. DIET MODIFICATION: R57's admission Minimum Data Set (MDS) dated 3/24/25, indicated R57 had intact cognition and did not have hallucinations or delusions. R57 rejected care daily. R57 required supervision/touching assitance for eating and was dependent on staff for rolling left and right and transfers. R57's diagnoses included heart failure, hypertension, coronary artery disease, atrial fibrillation, chronic kidney disease, diabetes mellitus, hip fracture, Parkinson's Disease, malnutrition, anxiety, and depression. The MDS indicated R57 had a mechanically altered and therapeutic diet. R57's care plan dated revised 6/9/25, indicated R57 required assistance of one staff to eat in dining room. R57's diet order dated 3/18/25, indicated R57 had a regular diet with minced and moist texture and regular consistency liquids. R57's Nutrition Progress Note dated 4/2/25, indicated R57 was to move to long term care, remained on a regular diet with minced and moist level texture and regular consistency liquids. R57 required one to one assistance with meals related to cognition and/or dementia. During interview on 6/9/25 at 2:54 p.m., R57 stated she had an "almost pureed" diet and wanted her diet	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 44 changed. R57 stated staff members were aware about her request for a diet change for at least a month and a half. During observation on 6/11/25 at 8:04 a.m., R57 sat at a table in the dining area. R57 had oatmeal, fruit, and other food items which complied with a minced and moist diet. R57 ate her breakfast without staff assistance. During interview on 6/12/25 at 9:36 a.m., the director of therapy (DT) stated speech saw R57 for swallowing dysfunction and R57 was discharged due to meeting all goals on a minced and moist diet with thin liquids. DT stated speech therapy was able to see R57 again if she desired to advance her diet texture. R57's Speech Language Pathologist Discharge Summary dated 3/27/25, indicated a discharge recommendation to assess diet texture if R57 desired an advanced diet at next level of care. During interview on 6/12/25 at 10:20 a.m., nursing assistant (NA)-K stated R57 used to need more help to eat but now ate by herself. NA-K stated R57 wanted their diet changed to a regular diet for the past couple weeks. NA-K stated they would normally alert the nurse about diet change requests. NA-K stated they did not communicate R57's request to the nurse, because R57 stated they talked to the dietician. During interview on 6/12/25 at 10:47 a.m., registered nurse (RN)-O stated R57 was diabetic and did not know about any concerns with her diet. During interview on 6/12/25 at 1:00 p.m., nurse manager, RN-I, stated they were not aware about R57's request for a changed diet and would contact speech therapy. RN-I stated it was important for R57 to enjoy her food and eat enough from a nutritional standpoint. The facility's Therapeutic Diets policy dated 5/29/25, indicated the facility would provide an individualized therapeutic diet to meet the clinical needs and desires of a resident to achieve outcomes/goals of care. Based on observation, interview, and document review,	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0684 SS = E	Continued from page 45 the facility failed to comprehensively assess and develop a bowel management program to meet voiced needs and wishes for 1 of 1 residents (R8) who needed digital stimulation; failed to ensure physician orders for diabetic monitoring devices were acted upon and implemented timely to prevent unnecessary distress (i.e., finger sticks, pain) for 1 of 1 residents (R8); failed to ensure a developed skin condition was assessed and appropriately treated for 1 of 2 residents (R1); failed to ensure a request for diet modification was appropriately and timely referred for evaluation for 1 of 1 resident (R57); and failed to ensure medical devices were consistently applied to reduce edema for 1 of 1 resident (R10) reviewed for edema management; and failed to recognize and comprehensively assess a resident's hearing concerns resulting in a delay in identification and treatment of cerumen (earwax) impaction for 1 of 1 resident (R11) reviewed who had difficulty with hearing. Findings include: BOWEL MANAGEMENT: R8's admission Minimum Data Set (MDS), dated 5/13/25, identified R8 had intact cognition and demonstrated no delusional thinking. The MDS recorded R8 as having a history of traumatic spinal cord dysfunction with quadriplegia, and also being frequently incontinent of bowel. R8's Bowel and Bladder Assessment - V3, dated 5/12/25, identified R8 was incontinent of bowel and demonstrated no observed patterns. The evaluation contained a section labeled, "Bowel," but this was left blank and not completed. A subsequent section labeled, "Bowel Planning," had areas to mark what, if any, interventions would be done or added to the care plan. However, this just had a single checkmark next to an option which read, "Focus: Has bowel incontinence ...," and no interventions were selected. On 6/9/25 at 2:01 p.m., R8 was observed lying in bed while in her room. R8 stated she was a quadriplegic and was having ongoing frustrations with her bowel management at the care center. R8 explained "at home" she used to have someone help her with digital stimulation (technique used to help empty the bowel by manually stimulating the rectum) which worked the best	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0684 SS = E	Continued from page 46 to help her avoid feeling bloated. R8 stated she had tried multiple laxatives and they just do not work well. R8 explained she had ask care center staff to help her with digital stimulation, however, they told her doing that was "against their policy" and couldn't be done so, as a result, a bunch of laxatives were ordered and those "just stay in my body" without offering relief. R8 reiterated she needed someone to help her with digital stimulation to most effectively empty her bowels and voiced frustration with repeatedly being told by staff "we don't do that." R8 stated the rationale she was provided by the staff was doing that technique was "like an invasion or something [bodily privacy]." R8's medical record was reviewed, and a series of medical provider note(s) and/or orders were identified. These included: R8's Standing Orders for Skilled Nursing Facilities, undated, outlined the orders listed on the document applied to patients in skilled nursing facilities (SNF) and outlined actions nursing staff could take for various scenarios. This included a section labeled, "Constipation (Perform steps sequentially)," and listed a first step reading, "1. Consider rectal check to determine if impaction is present." On 5/8/25, a Comprehensive Visit was completed by the nurse practitioner (NP) for R8's initial assessment to the care center. The evaluation outlined R8 had been hospitalized for a wound and outlined R8's hospital discharge summary which included, "Neurogenic bladder/bowel ... *Urinates via urostomy. Uses rectal stimulation every other day for BM [bowel movement] ... patient care order for digital stimulation every other day entered." The NP note included a section labeled, "Assessment and Plan," which outlined, " - bowels regimen - pt [patient] has established regimen with dig/stim and does not tolerate meds well - will check with staff regarding ability to meet with her and establish routine." On 5/12/25, a physician order was placed in the hard chart which directed no enemas and, "[2] Start rectal stimulation along with manual removal of feces every other day when diarrhea symptoms resolve." On 5/19/25, a Follow-up Visit note was completed by the	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 47 NP. The evaluation outlined, "Since last visit, [R8] reports frustration with the bowel regimen at the [care center]. Nurse manager reports they are unable to provide dig stimulation and manual removal of stool. [R8] reports she has been waking up every day with various amt [amount] of stoll in her pad because of not getting her routine/she is concerned about skin breakdown ... [R8] notes at home that she has a good routine established with her PCAs [aides]." The evaluation including a section labeled, "Assessment and Plan," which outlined, " ... [R8] frustrated by facility being unable to accommodate her bowel regimen. Several other options offered - laxatives, dulcolax suppository ... does not want enema unless pink lady which not available per facility ... she prefers to get home as soon as possible." On 5/21/25, a series of physician orders were placed. These included, "Recommend dulcolax supp now and can repeat tomorrow if no BM," and again, "If facility will do dig stim - this would also work with dulcolax supp." In addition, a hand-written order outlined to give Sennosides (laxative) 8.6 milligrams (mg) two tablets orally everyday for three days as needed (PRN). On 5/25/25, a handwritten order was recorded which directed to give Miralax (another laxative) 17 g (gram) every day for constipation. On 5/27/25, a set of orders were obtained which outlined PRN orders for a docusate sodium enema and a bisacodyl suppository for constipation. The order concluded with, "4. If not success from enema - can administer bisacodyl 5 mg tablet - take 1 [by mouth] daily as needed for constipation." On 5/30/25, a Follow-up Visit noted was completed by the NP. The evaluation outlined, "Since last visit, [R8] notes ongoing frustration with her bowel management. She had several bowel meds over the past week without any success. She reports over a week since last BM. She notes requiring dig/stimulation in order for bowel movement and facility reports they are not able to perform this activity." The evaluation including a section labeled, "Assessment and Plan," which outlined, " - bowel management continues to be an issue. Also checked with pharmacy and we are unable to get the pink lady enema that she request [sic] due to it being a compound medication. Continue bowel meds, ok to send [R8] into ER for further management if develops	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 48 nausea or abdominal pain." R8's care plan, printed 6/11/25, identified R8's actual or potential issues along with interventions to address them. The plan outlined R8 had bowel incontinence with a initiation date listed, "05/10/2025," and listed two interventions which included to provide peri-care after each incontinence episode and to see her other care plans for mobility, ADLs, cognition and communication. A subsequent section, revised 5/28/25, identified R8 had constipation due to decreased mobility and quadriplegia with a goal listed, "[R8] will have a normal bowel movement at least every 2 to 3 days through the review date." The plan listed several interventions including following the facility' bowel protocol, giving medications for constipation per physician orders, and recording R8's bowel movements every day. However, the care plan lacked any rationale for why a digital stimulation could not be performed in accordance with R8's voiced wishes. In addition, R8's medical record lacked any rationale or dictation explaining why the care center could not perform a digital stimulation for R8 in accordance with her wishes to help promote more consistent bowel movements. On 6/11/25 at 9:02 a.m., nursing assistant (NA)-C was interviewed, and verified they had worked with R8 multiple times prior. NA-C stated R8 had "a catheter" which they emptied the urine from and would, at times, call to use the bed pan for stools. NA-C stated R8 had no bowel incontinence they'd ever seen adding, "No, not with me." NA-C stated they had never heard R8 complain about her bowels, either, and verified the NA staff recorded the bowel movements in the record. R8's POC (Point of Care) Response History, printed 6/11/25, identified the past 14 day(s) worth of NA charting for R8's bowel movements with spacing to record what size of stool occurred (i.e., small, medium, large). This report showed R8 had only one stool for the entire period with a small bowel movement recorded on 6/5/25. The remainder of the days and each shift were each answered with, "None." R8's Treatment Administration Record (TAR), dated 6/2025, identified R8's current treatments along with spacing to record their administration. This included a nursing order which read, "Monitor BM," and listed a start date, "05/07/2025." The TAR provided spacing to record a BM for every shift (i.e., three times a day) and recorded the following: From 6/1 to 6/5/25, R8 had only a, "1" recorded which, per the legend on the TAR, meant, "1 =	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 49 Away from home with Meds." On 6/6/25, R8 had a medium BM recorded. On 6/7/25, R8 had a small BM recorded. There were not other recorded BM(s) since 6/7/25 and, in total, only two verified BM(s) were recorded on the TAR. R8's corresponding Medication Administration Record (MAR), dated 6/2025, identified R8's medications and their administrations. These included orders for Miralax daily which was recorded as administered for each day except two doses (6/7, 6/8); along with space to record what, if any, PRN bowel medications were given. However, the MAR lacked evidence any PRN bowel medications were given despite R8 only having three (inc. two small) recorded BM(s) for the previous 11 day period. On 6/11/25 at 9:17 a.m., registered nurse (RN)-R was interviewed, and verified they were assigned to care for R8 currently but added, "I've never worked with her before." RN-R stated "from [their] understanding" R8 had bowel incontinence and had not been having complaints of constipation to their knowledge. RN-R reviewed R8's MAR and verified several PRN medications for bowels were available, and explained residents' were evaluated for constipation through "nursing assessment" which included asking the resident, in this case R8, if they had a bowel movement or felt constipated. RN-R stated they had just talked with R8 who reported they had not had a bowel movement recently. RN-R stated the NA staff would record BM(s) in the record and that information could be reviewed by the nurses, too, to help determine if intervention is warranted. RN-R stated R8 had hemiplegia and that "could cause problems" with her bowels. RN-R then reviewed the completed NA charting for R8's bowel movements (i.e., POC) and verified only one bowel movement was recorded for the past 14 day period adding aloud, "I'm not liking what I'm seeing." RN-R stated the lack of a bowel movement gave "some cause for concern" adding, "This would require intervention." RN-R stated they had not been told of R8 having only a single recorded BM (via POC) for the past several days in report and expressed the lack of information from night shift, at times, could be "challenging." RN-R stated they were unsure if the campus allowed digital stimulation of the bowels and expressed they would check the facility' policy before doing it; however, if needed, RN-R stated performing a digital stimulation and manual removal of the bowels "potentially could be something we could implement." RN-R stated they felt they could perform the technique if it was allowed via policy. RN-R stated there was not much difference between a rectal check (as outlined on the standing orders) and digital stimulation, either. RN-R stated	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 50 they were unaware R8 had been told she couldn't have a digital stimulation done and expressed aloud, "That doesn't make sense to me." RN-R stated the person responsible to assess and, if needed, implement more parameters for R8's bowel regimen would be "the charge nurses" or nurse manager adding, "Typically it's assigned to them." When interviewed on 6/11/25 at 9:38 a.m., RN-L verified they were the current charge nurse, and explained they had been told by the director of nursing (DON) that digital stimulation and manual removal of stool wasn't allowed under facility' policy. This was due "mostly to the risk of injury," and RN-L added, "That was my understanding." RN-L reviewed R8's POC and MAR charting and verified the lack of consistent bowel movement adding, "That is what I'm seeing [too]." RN-L stated the floor nurses should be monitoring this charting and responding, if needed. RN-L stated there were no set parameters for R8's bowel regimen, such as do this then that, and they would get clarification from the medical provider about it. RN-L stated they were aware the NP was involved and ordering different things and "bowel meds" to help R8 regulate her bowel better. RN-L stated any further assessment of R8's bowel management program or regimen would likely be done in the interdisciplinary team (IDT) process and directed the surveyor to speak with the DON. On 6/11/25 at 11:11 a.m., unit manager (RN)-E and the DON were interviewed. RN-E explained a bowel diary was implemented for three days upon admission to track BM patterns then, afterwards, the bowel and bladder assessment would be completed by either the managers, charge nurses, or cart nurses. RN-E explained the NP would typically discuss bowel regimens with patients, too, and also help to formulate a plan for them. RN-E stated R8 was a quadriplegic and "more complex" so the NP was involved. DON stated the "cart nurses" should be noticing if a resident is going extended periods without a BM and evaluating their patterns then adding, "It should be the cart nurses who are noticing that." DON stated this could be tracked within the record system using a "clinical alert" as well so next shifts were aware of it, too. DON reviewed the provided Bowel Management Program policy (dated 4/2025) and verified it did not forbid use of digital stimulation or manual removal of stool. DON stated the nurses could complete a digital stimulation as long as they were trained to do so and an order was obtained for it. DON acknowledged the "scattered notes" of R8's charted bowel movements and expressed more information would be	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 51 gathered upon the next assessment which happened "quarterly." DON stated evaluating bowels and providing a bowel management program for R8 was important so as to help prevent bowel obstruction. A facility provided Bowel Management Program policy, dated 4/2025, identified all bowel records would be reviewed by the night nurse or designee, and standing orders could be followed for residents with constipation. This included completion of a rectal check, encouraging fluid intake, and offering PRN bowel medications. The policy lacked any dictation or direction not allowing a digital stimulation and manual removal of stool. DIABETIC DEVICE: R8's admission Minimum Data Set (MDS), dated 5/13/25, identified R8 had intact cognition and demonstrated no delusional thinking. Further, the MDS recorded R8 as having diabetes mellitus and receiving near-daily insulin injections during the review period. On 6/9/25 at 1:55 p.m., R8 was interviewed, and expressed her blood glucose levels had been "going really high" since she came to the care center which she attributed to eating more since admission. R8 denied concerns about the elevated glucose levels, however, expressed frustration with the lack of a Libra device to monitor her glucose levels with on her own. R8 stated she had asked about getting one from someone at the care center awhile prior, but no follow-up was done and she never heard about it again adding, "It never showed up." R8 reiterated she'd like to have one as it wouldn't require so many finger sticks to check her glucose then adding, "I really would like that." R8's Telephone Encounter note, dated 5/28/25, identified an order from the nurse practitioner (NP) which outlined, "Okay to use FreeStyle Libre for blood sugar checks." The note had handwritten initials on the left margin. R8's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 5/2025, identified R8's current physician orders and treatments with spacing to record their administration. These identified an order, "FreeStyle Libre 2 Sensor ...	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0684 SS = E	Continued from page 52 Apply 1 device transdermally one time a day every 14 day(s) for [diabetes]," with an order date recorded, "05/28/2025." The MAR provided a single space to record this administration on 5/30/25, however, it was answered with, "9 [Other/See Nurse's Notes]" and staff initials only. R8's corresponding progress note, dated 5/30/25, identified the FreeStyle device text per the order with documentation, "Not available." The note lacked what, if any, actions were taken to obtain it despite being ordered. When interviewed on 6/11/25 at 9:17 a.m., registered nurse (RN)-R verified they were assigned to care for R8 currently but added, "I've never worked with her before." RN-R verified R8 used insulin and the MAR directed she was "supposed to have a FreeStyle Libre" in place, however, they hadn't seen one on her when helping her earlier that day. RN-R stated, "I'm not sure if that's true [MAR order]." RN-R explained the devices were obtained with a provider order and then nurses would apply them after they're sent from pharmacy. RN-R stated the care center had switched pharmacy services and the new one "tends to be a little slower" getting items and prescriptions to them. RN-R stated they were unsure why R8 didn't have the Libre, as ordered, and expressed aloud, "I will need to do some digging [into it]." RN-R stated any floor nurse could send the prescription to pharmacy or follow-up about it, if needed. RN-R verified there wasn't one in the medication cart, either, to their knowledge adding aloud, "I haven't seen one." On 6/11/25 at 10:40 a.m., RN-L was interviewed, and verified they were the current charge nurse working on R8's unit. RN-L stated they had reviewed R8's medical record and found the provider order (dated 5/28) for the FreeStyle Libre and, due to the surveyor asking about the lack of it, had just called pharmacy who voiced they had faxed a clarification to the campus on 5/29/25, however, this was unable to be located. RN-L added, "I did not see any clarifications [from pharmacy]." RN-L stated they updated the pharmacy with the needed information and the device would be sent out that same day. RN-L stated nobody had reported the device not being present until that day to them and expressed the nurse who charted it as not available (on 5/30) should have followed-up to ensure it was ordered and available. RN-L stated this was important so "we're providing the best care and following the doctor's orders," adding use of the device would save R8 having to receive so many finger sticks with a lancet. RN-L verified this was not identified or acted upon until	F0684		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0684 SS = E	Continued from page 53 that day (6/11). A facility policy on diabetic equipment management was requested, however, none was received.	F0684		
F0685 SS = D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a referral for potential cataract surgery was facilitated and/or completed in a timely manner to help improve vision and quality of life for 1 of 1 resident (R20) reviewed who was diagnosed with cataracts and expressed difficulty with his vision. Findings include: R20's quarterly Minimum Data Set (MDS), dated 4/23/25, identified R20 had moderate cognitive impairment. The section to record R20's vision status, located under Section B - Hearing, Speech, and Vision (B1000, B1200) - was left blank. On 6/9/25 at 2:32 p.m., R20 was observed lying in bed while in his room and his television was turned on and positioned on the opposite wall of the head of the bed. R20 had no eye glasses on at this time. R20 was interviewed and spoke with a soft, at times mumbling, voice but articulated clearly, "My eyes aren't good."	F0685	Immediate Correction: R20’s provider and guardian were contacted, and an ophthalmology referral was made. Follow-up appointments are scheduled and documented in the EMR. All residents with identified vision concerns and/or diagnoses of cataracts were audited to verify appropriate referrals and follow-up were in place. Staff Education: Nursing, HUCs and social services staff were re-educated on the process and timeliness of specialist referrals, including documentation requirements and communication with providers and families. Audits: Audits on Optometry referral logs will be reviewed to ensure timeliness and follow-through: Twice weekly for 4 weeks, then Once weekly for 4 weeks, then monthly for 2 months Policy Review: The Consultant Visits policy-Audiology, Optometry, Podiatry and Dental services was reviewed; revisions were made QAPI Monitoring: Audits will be reviewed quarterly by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance. Responsible Party: Medical Records Director or Designee	07/14/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0685 SS = D	Continued from page 54 R20 was unsure if he'd seen an eye doctor recently when asked and then voiced aloud, "Been awhile." On the bedside dresser, a single pair of black-framed eye glasses were present. R20 didn't respond when asked if they were his or not, however, held out his hand and took the glasses from the surveyor. R20 placed them on his face and looked at the television. R20 expressed the glasses helped "a little bit" to see the television. R20 nodded to affirm he'd like to see any eye doctor about his vision when asked. R20's In-House Senior Services Consent, dated 2/2023, identified R20 was offered and accepted to be seen by the care center's in-house optometry services. R20's care plan, printed 6/10/25, identified R20's actual or potential problems along with goals and interventions to address them. This outlined R20 had a guardian in place and planned to remain in long-term care (LTC). However, the care plan lacked any further actual or potential problem statements about R20's vision. R20's In-House Follow-Up Visit, dated 4/22/25, identified R20 was seen by the optometry service and listed dictation, "Patient reports having trouble reading." R20 was listed as having high blood pressure, diabetes and and several other medical conditions. A section labeled, "Recommendations," outlined R20 was found to have cataracts in both eyes that were limiting his vision. The text continued, "On 10/23/24, [physician] called guardian [GA-B] ... to discuss cataract surgery. It said the mailbox was full and couldn't leave a message ... SMS message was sent to him to call back ... never called back so no referral was sent ... If facility and/or guardian wish to have surgery done for [R20], please contact INHSS [In-House] and a referral can be sent." The recommendations concluded, "4) I have discussed with him that the new glasses will improve the patients vision BUT WILL STILL BE BLURRY DUE TO CATARACTS." R20's Care Conference Summary - V8, dated 5/7/25, identified R20's resident representative (i.e., guardian) was included in the meeting along with the registered nurse manager (RN)-Q and licensed social worker (SW)-A. However, the completed form lacked evidence the recommendation for cataract surgery was discussed or reviewed. On 6/10/25 at 12:59 p.m., R20's listed guardian (GA)-A was interviewed via telephone. GA-A explained they had	F0685		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0685 SS = D	Continued from page 55 just recently resigned a few days prior from the service of being R20's guardian; however, prior, had been working with him for over a year. GA-A denied knowledge of R20 needing cataract surgery or the In-House note (dated 4/22) which outlined that. GA-A expressed, "That's brand new to me." GA-A expressed another guardian whom worked with R20 before them may have more information and provided their contact information. Following, on 6/10/25 at 1:15 p.m., a telephone interview was completed with R20's now current guardian (GA)-B, who stated they had been with R20 for "many years" and were versed in his care needs. GA-B stated nobody from the care center had ever discussed or presented anything about R20 needing cataract surgery adding, "They haven't communicated that." GA-B stated cataract surgery was fairly mild and he would be in agreement to pursue that if R20 needed it or wanted it. R20's medical record was reviewed and lacked evidence the recommendation for cataract surgery was discussed or offered to R20's guardian(s) despite the initial recommendation from the optometry service being dated several months prior (10/2024); nor did the record have evidence the facility had made any subsequent attempts to contact them about it since the optometry service had been unsuccessful. On 6/10/25 at 1:37 p.m., SW-A was interviewed, and stated the nursing department would address optometry appointments "more than I would." SW-A stated they had not had any calls or discussion with R20's guardian(s) about the need for cataract surgery and expressed they were "not exactly sure" of the process for that. SW-A stated nobody had told them about the optometry note which outlined the need for cataract surgery and expressed, had someone, then they would have contacted the medical provider and guardian about it. When interviewed on 6/12/25 at 9:02 a.m., RN-Q verified they were the nurse manager who helped oversee R20 until just recently. RN-Q verified they had reviewed R20's medical record, and explained they recalled contacting R20's guardian at some point about the cataract surgery referral, however, failed to document it within the medical record. RN-Q stated they had talked with R20 himself about it and, at that time, R20 didn't want to pursue it. However, RN-Q expressed R20 was likely "not able to make that decision himself." RN-Q verified the record lacked documented evidence of any discussion, either with R20 or his guardian(s), and	F0685		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0685 SS = D	Continued from page 56 expressed the follow-up afterward must had been missed adding, "Life happened and we just moved on." RN-Q stated the manager or social worker would typically try to keep contacting guardians if there was a medical need to be addressed and reiterated those attempts should be documented within the medical record. This was important to do for "patient's rights for care" and "just his [R20' well-being." On 6/12/25 at 9:34 a.m., the director of nursing (DON) was interviewed. DON verified attempts to contact family or guardians for medical care input should be documented within the medical record. DON stated they believed the cataract referral was never completed as the person who helps set-up appointments usually follows through on them adding the referral likely "never reached" them. DON stated following up on medical referrals was important for R20's quality of life and "so he can see." A facility provided Consultant Visit Policy - Audiology, Optometry, Podiatry, and Dental Services policy, dated 10/2024, identified the facility would be responsible for scheduling and coordinating consultations for residents. The policy outlined, "The staff will ensure that all necessary appointments, follow-ups, and documentation are completed in compliance with regulatory standards." The policy outlined a section labeled, "Audiology and Optometry Services," which directed vision needs would be assessed upon admission and referrals would be made if the resident required glasses or other corrective devices.	F0685		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F0688	Immediate Action Taken: New order for PT/OT eval was initiated for R74 to confirm appropriateness of ROM program, and documentation was updated. A full review of all residents with ordered or required ROM programs was completed to ensure care was being delivered and documented appropriately. Staff Education: Nursing staff were re-educated on identifying residents at risk for ROM decline and implementing/documenting ROM programs according to the care plan. Audits: The Unit Managers will conduct audits on ROM care plans and implementation: Twice weekly for 4 weeks, then Once weekly for 4 weeks, then Monthly for 2 months Policy Review: The Range of Motion policy was reviewed; no revisions were made. QAPI Monitoring: Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance and determine if further action is necessary. Responsible Party: DON or designee	07/14/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0688 SS = D	Continued from page 57 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a range of motion (ROM) program was provided for 1 of 1 resident (R74) reviewed for mobility. Finding includes: R74's quarterly Minimum Data Set (MDS) dated 4/30/25, indicated R74 was cognitively intact, had no delusions, hallucinations, had no behaviors and refused cares one to three days during a 7-day period. MDS indicated R74 had limited lower extremity ROM and did not received ROM in the last 7 days prior the MDS assessment date. R74's MDS indicated she received set up assistance for oral hygiene and eating, maximal assistance with showers/bathing, toileting hygiene, dressing, personal hygiene, and was dependent with transfers, and wheelchair mobility. R74's clinical diagnosis report printed on 6/12/25, indicated chronic respiratory failure, chronic pain, anxiety, restless leg syndrome, weakness, unspecified abnormalities of gait and mobility, chronic congestive diastolic heart failure(a condition where the heart muscle stiffens, making it difficult for the heart to relax and fill with blood during the relaxation phase), subluxation (is a partial dislocation, where the bones in a joint are still partially touching) of the hips, and diabetes type II. R74's care plan printed 6/12/25, indicated R74 had limited ROM related to multiple sclerosis, chronic pain, and recurrent bilateral hip subluxations. The care plan's interventions directed nursing staff to assist resident in daily performance of supine ROM, strengthening exercises. It indicated a printout was on the bulletin board and resident also had a copy, and directed staff to please attempt this in the afternoon per R74's preference. This care plan was initiated in 9/6/22, had a revision date of 11/14/24, and indicated 7/29/25 as a target day.	F0688		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0688 SS = D	Continued from page 58 R74's ROM/Mobility assessments dated 3/24/25, and 4/24/25, indicated R74 had limited ROM of lower extremities, used a wheelchair, and her care plan was current. R74's treatment administration record (TAR) for the month of June 2025 printed on 6/12/25, indicated an order to "Assist with lower extremity ROM program. Directions are on the resident's bulletin board. Two times a day per therapy." This order was dated 5/9/23. A review of R74's TAR records for the last 7 months revealed the following information: - December 2024, R74 received ROM 18 times out of 50 opportunities, and refused or did not receive ROM 32 times out of 50 opportunities. - January 2025, R74 did not received ROM 44 of 44 opportunities. - February 2025, R74 either refused or did not receive ROM 49 out of 49 opportunities. - March 2025, R74 either refused or did not receive ROM 44 out of 44 opportunities. - April 2025, R74 either she refused or did not receive ROM 60 out of 60 opportunities. - May 2025, R74 either refused or did not receive ROM 62 of 62 opportunities. - June 2025 - R74 either refused or did not receive ROM 20 out 20 opportunities. During interview on 6/9/25 at 3:34 p.m., R74 indicated the nursing staff was supposed to assist her twice a day with her ROM program. R74 stated her care plan indicated she had to receive assistance every day.	F0688		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0688 SS = D	Continued from page 59 During interview on 6/11/25 at 11:01 a.m., nurse manager/registered nurse (RN)-I stated R74 always refused ROM exercises in the mornings. RN-I stated, often R74 didn't like how staff did it. RN-I stated based on documentation, R74 was refusing to participate and they would need to investigate why, talk to the nurse practitioner, and request an order to reassess R74. During interview on 6/11/25 at 1:57 p.m., RN-J stated "today, I went into her room to do wound care, but I didn't talk to her about her ROM program, and I didn't do it." During interview on 6/11/25 at 2:04 p.m., RN-P stated he didn't really do ROM with R74, but while performing wound care, he straightened R74's legs. RN-P added "we only get to move her legs when we boost her up in bed." On 6/12/25 at 9:07 a.m., RN-I provided written information which indicated "R74 had the right to refuse to participate. She has exercise bands in her room and self exercises using them." During interview on 6/12/25 at 9:07 a.m., director of nursing (DON) verified TARs documentation, ROM assessments and the failure to reassess R74 in a timely manner. DON stated the provider needed to be updated about resident's refusal to participate in the ROM program. DON stated "we need to get another physical therapy and/or occupational therapy assessment for [R74]. Maybe we need to give her pain medication before receiving assistance with her ROM program". DON added her care plan also needed to be reviewed. Facility's policy titled Restorative Nursing program, dated 10/2021 indicated the purpose of the program was to ensure resident's abilities in ADLs did not deteriorate and residents maintain their highest practicable well-being. The policy indicated; the restorative nursing programs will be identified in the resident's care plan. The care plan must identify the resident's strengths, problems, risks, measurable goals, outcome-based goals and who is responsible for the implementation of the plan. The policy also indicated the RN will be responsible for assessing the resident's strengths and needs.	F0688		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs	F0757	Immediate Action: R50’s MAR and clinical notes were	07/14/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0757 SS = D	Continued from page 60 CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure acute symptoms of distress or pain were recorded; and non-pharmacological interventions attempted or documented prior to the use of as-needed (i.e., PRN) narcotic medications to help promote continuity of care and care-planning for 1 of 5 residents (R50) reviewed for unnecessary medication use. Findings include: R50's admission Minimum Data Set (MDS), dated 3/11/25, identified R50 had intact cognition and demonstrated no delusional thinking. Further, the MDS outlined R50 received scheduled pain medication but no PRN pain medications; and reported occasional pain which she rated at 4/10 on the numeric rating scale.	F0757	Continued from page 60 reviewed. Non-pharmacological interventions were added to their EMR. All residents with PRN narcotics were reviewed, and non-pharmacological interventions will be added to their EMR. Staff Education: Licensed nursing staff were re-educated on pain assessment requirements, documentation standards, and the use of non-pharmacological interventions prior to PRN narcotic administration. Audits: The Unit Managers will conduct audits on PRN narcotic use and proper non-pharmacological interventions and implementation. Three times weekly for 4 weeks Two times weekly for 4 weeks One time a week for 4 weeks. Policy Review: The Medication-Administration General Guidelines policy was reviewed, no revisions were made.	

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0757 SS = D	Continued from page 61 On 6/9/25 at 12:40 p.m., R50 was observed seated in a recliner chair while in her room. R50 had visible white-colored bandages on both legs and reported she sustained a fall the week prior which she felt injured her hip adding, "I think I cracked it." R50 denied significant, unresolved pain issues at this time when asked. R50's care plan, printed 6/9/25, identified R50's actual and potential problems along with interventions to address them. This outlined R50 had pain related to bilateral venous wounds and listed a goal, "Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain ...," along with several interventions including administering pain medication and monitoring the response, encouraging her to report pain at the onset, and a series of non-pharmacological interventions which could be attempted including redirection, offering food, music, and ice/heat. The care plan also directed to "monitor/record/report" any pain characteristics every shift and PRN; and "monitor/record/report" an non-verbal signs of pain. R50's Orders, dated 5/1/25, identified the nurse practitioner (NP) wrote orders for R50 which included, "Add tramadol [a narcotic] 50 mg [milligrams] every day PRN [for] chronic pain." In addition, the order directed R50 to remain on the current tramadol 50 mg twice a day which was scheduled. R50's Medication Administration Record (MAR), dated 6/2025, identified a total of nine (9) administrations of the PRN tramadol for the month thus far. These included: On 6/3/25 at 5:37 a.m., R50 received a dose which was recorded as, "E [effective]." A corresponding progress note, dated 6/3/25, identified the medication was provided with dictation, "per pt [patient] request." However, the note lacked any recorded symptoms or what, if any, non-pharmacological interventions were attempted prior to the narcotic being provided. On 6/7/25 at 6:04 a.m., R50 received a dose which was recorded as, "E." A corresponding progress note, dated 6/7/25, identified the medication was provided but lacked any recorded symptoms of pain or what, if any, non-pharmacological interventions had been attempted prior to the narcotic being provided.	F0757		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0757 SS = D	Continued from page 62 On 6/9/25 at 3:00 a.m., R50 received a dose which had results recorded as, "U [unknown]." A corresponding progress note, dated 6/9/25, identified the medication was provided but lacked any recorded symptoms of pain or what, if any, non-pharmacological interventions had been attempted prior to the narcotic being provided. A subsequent note, also dated 6/9/25, was authored nearly 12 hours later in the day which outlined, "[R50] presents with complains [sic] of Right hip pain ... describes as throbbing ... rated 9/10 ... Care team updated." However, again, this note lacked what, if any, non-pharmacological interventions were being attempted to reduce the PRN narcotic use, if able, or supplement it to promote comfort. On 6/10/25 at 2:59 a.m., R50 received a dose which was recorded as, "E." A corresponding progress note, dated 6/10/25, identified the medication was provided but lacked any recorded symptoms of pain or what, if any, non-pharmacological interventions had been attempted prior to the narcotic being provided. In total, the nine administered doses had only one (1) dictated note which outlined any rationale for the medication being provided (6/3/25); and all of the notes located within the record for the provided doses lacked evidence of what, if any, non-pharmacological interventions had been attempted prior to giving the PRN narcotic to see if those would help reduce the need for medication. When interviewed on 6/12/25 at 9:43 a.m., nursing assistant (NA)-M stated they had worked with R50 prior and described her as "heavy a little bit" with cares. NA-M stated R50 would "sometimes" have complaints of pain and then they just "tell the nurse." NA-M stated they didn't offer ice packs or anything to R50 but expressed they would if asked by the nurse or R50 herself. NA-M stated R50 would often just ask them "about the pain pill." NA-M expressed R50 rarely had complaints of pain until she sustained a fall (on 6/3/25) adding, "That is when the pain started." On 6/12/25 at 10:20 a.m., licensed practical nurse (LPN)-E stated they had worked with R50 prior and helped with her wound cares. LPN-E stated R50 did have complaints of pain, at times, and would often request her PRN tramadol to help. LPN-E stated they "do ask" her about using ice packs and expressed R50 would	F0757		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0757 SS = D	Continued from page 63 accept them, at times, adding aloud, "She does." LPN-E explained if R50 requested her PRN tramadol, then they'd assess her using the pain scale (0-10 rated) and the orders as there was possibly something else she could be given like her scheduled Tylenol. LPN-E stated symptoms of pain or the rationale for giving PRN medication should be recorded in the notes along with what non-pharmacological interventions were attempted adding, "[recorded] in the nurses notes." On 6/12/25 at 12:21 p.m., the director of nursing (DON) was interviewed. DON verified a PRN narcotic medication should have pain symptoms recorded to justify the medication along with what non-pharmacological interventions were attempted prior. DON stated this would typically be recorded in the progress notes and should be done "to show what helps." DON stated providing non-pharmacological interventions prior helps to "go minimal before you use the meds." DON stated they were reviewing R50's medical record for this information, however, hadn't finished yet so they would provide additional documentation showing this, if located. No further information was received during the recertification survey (exited 6/12/25). A facility provided Medication Administration policy, dated 3/2023, identified steps to giving medication which included, "20. Whenever a PRN medication is given, the licensed nurse/TMA [trained medication aide] administering the medication documents on the EMAR (MAR) in the appropriate space as indicated by the date and the PRN order entry," adding further the documentation should included, " ... The residents specific complaint or the symptoms for which the medication is being given." However, this policy lacked information on non-pharmacological interventions with PRN or how such should be recorded.	F0757		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F0761	Immediate Action: All medication carts were secured, and contents reviewed. Staff Education: All staff were re-educated on safe medication storage procedures, including always locking carts when not in use and never leaving them unattended in accessible areas. “Lock the Cart” reminder labels were affixed to all medication carts. Audits: The Unit Managers or designee will conduct audits ensuring the medication carts are locked. Three times weekly for 4 weeks Two times weekly for 4 weeks One time a week for 4 weeks. Policy Review: The Medication Storage policy was reviewed; no	07/14/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0761 SS = E	Continued from page 64 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure medications were securely stored safely and under direct observation of authorized staff in areas where residents, staff and guests could access medications in two medication carts affecting 2 of 4 units of the facility. Findings include: During a continual observation on 6/10/25 at 3:00 p.m., an unattended and unlocked medication cart was observed in the hallway of the "Bridgeway" unit against the wall right outside a resident room with two other resident room doors facing the cart. During observation, a resident was observed sitting on her walker approximately 3 feet away from the unattended unlocked medication cart. Numerous unidentified staff members walked past the cart, along with another resident and family member. At 3:18 p.m., registered nurse (RN)-H returned to the medication cart and was observed interacting with the resident on the walker, reviewing the electronic medical record, and opening the cart without unlocking it. RN-H did not remove keys from their pocket to unlock the medication cart. RN-H verified they were the nurse responsible for the medication cart, had gone on break over an hour ago, and had been working on an admission since their break. RN-H stated, "I don't remember if it was locked," when asked if the cart was locked or unlocked, adding "I am	F0761	Continued from page 64 revisions were made. QAPI Monitoring: Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance and determine if further action is necessary. Responsible Party: DON or Designee	

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0761 SS = E	Continued from page 65 not really sure, the keys are in my pocket." RN-H stated that it had been a long day and might have forgotten to lock it. RN-H stated it was important that medication carts were locked as there were medications and narcotics in the carts and didn't want people to come in and open it up. During an observation on 6/11/25 on 7:41 a.m., an unattended and unlocked medication cart was observed in the hallway of the "Fox Crossing" unit against the wall right outside a resident room. RN-K returned to the medication cart and verified they were responsible for the medication cart, and stated they left the medication cart when they were distracted as the aid needed assistance. RN-K verified the medication cart was unlocked and unattended, and stated they should have locked the cart before they left as other people could have gotten in the cart and taken medications that didn't belong to them and that could be dangerous for them. During an observation at 6/11/25 at 8:30 a.m., an unattended and unlocked medication cart was observed in the hallway of the "Fox Crossing" unit against the wall right outside a resident room. During the observation, two unidentified staff walked past the unlocked medication cart. Upon returning to the unlocked and unattended medication cart, RN-K verified the medication cart was unlocked and stated they should have locked it before going into the resident room. During an interview on 6/12/25 at 12:47 p.m., director of nursing (DON) stated the expectation would be unattended medication carts are locked as they contain medications. DON verified unlocked and unattended medication carts would be a safety concern. A facility policy titled Medication storage, revision date 10/21, indicated "medication rooms, carts, and medication supplies are locked or attended by persons with authorized access."	F0761		
F0790 SS = D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F0790	Immediate Action: R25's dental referral was re-submitted and resident went to dentist on 7/7/2025. All residents who declined, missed dental appointments, or had unresolved dental concerns were reviewed for status and follow-up needs. Audit & Review: All residents who declined or missed dental appointments or had unresolved dental concerns were reviewed for status and follow-up needs. Staff Education: Social Services	07/14/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0790 SS = D	Continued from page 66 §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(f) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental needs were coordinated with a dental provider for further care to reduce the risk of complication [i.e., cavities, oral pain] for 1 of 1 resident (R25) reviewed for dental care and services. Findings include:	F0790	Continued from page 66 and nursing staff were educated on ensuring timely referrals, dental follow-up tracking, and accurate documentation. Audits: HUCs or designee will conduct audits on Dental referral logs will be reviewed to ensure timeliness and follow-through. Twice weekly for 4 weeks Once weekly for 4 weeks Monthly for 2 months Policy Review: The Consultant Visits policy-Audiology, Optometry, Podiatry and Dental services was reviewed; revisions were made. QAPI Monitoring: Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance. Responsible Party: DON or designee	

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0790 SS = D	Continued from page 67 R25's admission Minimum Data Set (MDS) dated 3/31/25, indicated R25 was cognitively intact, had no hallucinations, delusions, and didn't refuse personal cares. MDS indicated R25 received maximal assistance with toileting hygiene, bathing, sit to stand and was dependent with transfers. MDS indicated R25 received moderate assistance with personal hygiene, dressing and received set up for eating and oral hygiene. MDS section L-oral/dental status indicated R25 had "obvious or likely cavity or broken natural teeth". R25's Medical Diagnosis record printed 6/12/25, indicated diagnoses of acute respiratory failure with hypoxia (a medical emergency that occurs when the body's tissues don't have enough oxygen), atrial fibrillation (irregular heart rhythm that can lead to blood clots in the heart) , type II diabetes mellitus, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or the inability to move one side of the body) following cerebral infarction (stroke) affecting right dominant side and muscle weakness. R25's care plan of Activities of daily living (ADLs) printed 6/12/25, indicated R25 had an ADL self-care performance deficit related to weakness, respiratory failure, right side weakness from previous cerebral vascular infarction and directed staff to assist resident with brushing teeth twice daily. R25's Admission assessment dated 3/25/25, included Section H which assessed oral and dental status, indicated "obvious or likely cavity or broken natural teeth." This section also indicated R25 had not seen a dentist for two years and wanted to see the dentist. R25's electronic medical record (EMR) included an Apple Tree Dental consent form signed by R25 on 3/26/25. The consent authorized Apple Tree to provide comprehensive and periodic oral care, evaluation, x-rays, preventive care and a house call/facility visit. During observation and interview on 6/9/25 at 12:13 p.m., R25 stated he had some teeth needing repair. R25 said he lost a crown, the other tooth "just" broke, and he had some cavities on his front lower teeth. R25 said the staff knew he had broken teeth.	F0790		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0790 SS = D	Continued from page 68 During interview on 6/11/25 at 8:33 a.m., charge nurse/registered nurse (RN)-L indicated on resident's admission dental status was assessed and dental services were offered. RN-L stated if residents signed a dental consent, the consent was faxed to Apple Tree Dental by the clinical services coordinator (CSC)-A. During interview on 6/11/25 at 9:33 a.m., CSC-A stated R25 was seen by Apple Tree Dental on 4/7/25. Apple Tree Dental report indicated resident had two fractured teeth. During interview on 6/11/25 at 9:35 a.m., health unit coordinator (HUC)-1 stated Apple Tree Dental could not treat R25 at the facility. HUC-1 stated R25 needed to be seen at an off-site clinic. HUC-1 stated she contacted R25's son, who stated going to an appointment with R25 was not convenient. HUC-1 stated she had not investigated other transportation options. During interview on 6/12/25 at 9:18 a.m., director of nursing (DON) stated an appointment needed to be made and "worst case scenario, the facility will have to send an employee with him. We have sent employees with residents before, because nobody could accompany them to their appointments." DON stated even if R25's teeth were not bothering him now, his teeth could eventually cause pain and problems while eating. DON stated facility needed to aid residents to meet their needs. Facility's policy titled Consultant Visit Policy - Audiology, Optometry, Podiatry, and Dental Services dated 10/2024 indicated "the facility will be responsible for scheduling audiology, optometry, podiatry, and dental consultation for residents. The staff will ensure that all necessary appointments, follow-ups and documentation are completed in compliance with regulatory standards."	F0790		
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve	F0804	A review of delivery systems and procedures was completed. Meal Service policy and procedures were reviewed with no necessary revisions. Education was provided to the culinary team on temperature requirements and timely service. Audits will be conducted 4 times a week for 5 weeks and then weekly for 3 weeks tracking the temperatures and timeliness of the meal services. Focus will be on residents R1, R3, R40, and R113 Audits will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee	07/14/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0804 SS = E	Continued from page 69 nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served in a timely manner to preserve desired temperatures of food for 4 of 4 residents (R1, R3, R40, R113) reviewed who expressed concerns for food temperatures and palatability. This had the potential to affect all residents who consumed food from the facility kitchenettes. Findings include: During survey entrance on 6/9/25 at 11:00 a.m., the facility provided a document titled "Mealtimes for Fox, TCU, Eagle Crest, Prairie Spirit: Breakfast-7:45 am Lunch-11:45 am Dinner-4:45 pm". During observation of the facility's three kitchenettes, a sign was posted on the walls adjacent to the serving line facing the dining rooms. It stated: "Menu Cheat Sheet" with instructions to obtain meal tickets "in advance to meal service" and "staff should be taking the resident's meal orders WITH the resident, not for them." Review of resident council (RC) meeting minutes for: 6/10/24: indicated 19 residents were in attendance for the meeting and section identified as Nutrition state, "Residents reported that some items are still arriving cold at times." 8/16/24, and 9/17/24: identified residents concern with	F0804	Continued from page 69 to ensure compliance. The Culinary Director or designee is responsible for compliance.	

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0804 SS = E	Continued from page 70 portion sizes and staff not picking up meal ticket requests early enough which caused residents to wait longer and took too much time in the dining rooms. 10/14/24: new process for obtaining resident meal preferences. "Nursing aides will collect meal tickets electronically before meals occur and the dietary staff will then prepare resident trays". 11/11/24: "residents reported that meals are being served late" 12/16/24: "Resident reported that meals are not being served in a timely manner and are arriving cold at times; resident reported that there are still errors in what they are served vs. what they ordered". 3/10/25: "Residents reported staff and residents are still struggling at times to use the new ordering system". 4/7/25: "residents turned in a petition for returning to the old menu system (paper)" 6/9/25: "Residents reported that service is still slow at times and food is cold at times; " During interview with nursing assistant (NA)-A on 6/9/25 at 5:57 p.m., NA-A stated residents "complain about the food. Most say that it is cold or that we ran out of something." During interview with registered nurse (RN)-B on 6/9/25 at 6:26 p.m., RN-B stated he had heard residents complaining about the food but did not document or follow up with dietician or supervisor. During interview with NA-B and NA-C on 6/9/25 at 6:32 p.m., both stated, "food complaints are mostly about the food they [residents] get is not what they [residents] ordered." NA-B stated expectation of nursing assistants to use an iPad (tablet computer) to ask each resident what they would like for their meal for the following day. The information was then printed in the dining room kitchenettes where the dietary aides	F0804		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0804 SS = E	Continued from page 71 would obtain the food and serve it onto a meal tray with requested food and drink orders. Then the nursing assistants and staff would serve the residents in the dining rooms first before serving room trays for residents who eat in their rooms. During interview with licensed practical nurse (LPN)-B on 6/10/25 at 8:28 a.m., LPN-B stated she was familiar with resident complaints concerning food including receiving food that was not ordered or requested. R1 R1's quarterly Minimum Data Set (MDS) dated 4/3/25, indicated R1 had intact cognition and no hallucinations or delusions. R1 had other behavioral symptoms not directed toward others and did not reject cares. R1's diagnoses included hyperlipidemia, dementia, hemiplegia and hemiparesis, and stroke. R1 required setup and clean-up assistance with eating. During interview on 6/9/25 at 1:57 p.m., R1 stated he ate breakfast and the evening meal in the dining area. R1 stated sometimes he waited for his food for a while, and the food was not always warm when he received the meal. R1 stated he would ask staff to "electrify" his food, but staff were usually busy and had other residents to take care of to. R3 R3's annual Minimum Data Set (MDS) assessment, dated 3/26/25, indicated R3 had intact cognition with no hallucinations or delusions and was independent with eating. During an interview on 6/09/25 at 3:22 p.m., R3 stated meals were served warm "off and on" and sometimes served cold. R3 stated he typically eats breakfast and lunch in the dining room and supper in his room. R3 further indicated, staff have not offered to reheat meals and this has been and issue for "awhile." R40	F0804		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0804 SS = E	Continued from page 72 R40's quarterly MDS, dated 3/12/25, indicated R40 had intact cognition with no hallucinations or delusions and was independent with eating. During an interview on 6/09/25 at 3:39 p.m., when R40 was asked about the food was, "it really isn't very good" and "I don't know if there's anything anybody can do about it." Furthermore, R40 stated there are "good cooks and bad cooks." R40 stated sometimes the food is warm and other times it is not. R40 stated she eats meals in the dining room. R113 R113's admission MDS, dated 4/27/25, indicated R113 had intact cognition with no hallucinations or delusions and was independent with eating. During an interview on 6/9/25 at 2:50 p.m., R113 stated the food was "horrible." R113 stated she eats meals in her room and the food cold when it gets delivered to her. R113 stated she orders the meals and when she gets her meals, it is not what she ordered and is told they don't have it. R113 stated the "kitchen is a hot mess." R113 stated she ordered chicken strips, and they were cold and overcooked to the point she couldn't cut them with a knife. R113 stated her meal the other day was brought with completely melted ice cream. During interview with R113 on 6/10/25 at 1:33 p.m., R113 stated nursing assistants, "don't talk [to residents] and help them put in [food order/requests]." R113 stated, "happens all the time." R113 stated, "food feels like it was prepared the day before and given to me the next day. It is always cold. I have asked the aides to heat up my food but I feel like I am a troublemaker. If I lived here long term, I would not be happy with the service." During interview with NA-E on 6/10/25 at 1:42 p.m., NA-E stated expectation for nursing assistants to obtain resident meal preferences and options the day before service. NA-E stated staff helped enter orders for residents who could not talk, and "some [residents] complain that they get food they did not order". During continuous observation and interview with	F0804		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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
F0804 SS = E	Continued from page 73 culinary supervisor (CS) on 6/11/25 at 11:57 a.m., CS was approached by a dietary aide and was informed that R89 did not have a meal ticket printed up. CS reviewed the electronic meal ticket system and stated R89 was not "asked what she wanted for meals yesterday which is why she did not get a meal ticket for today". CS walked with surveyor to R89's room and asked R89 if she was asked about her meal preferences and options for 6/11/25. R89 stated, "no one took my order yesterday". During interview with CS on 6/11/25 at 12:11 p.m., CS stated "I am aware of many residents complaining of missing meals or cold food or [not] getting the correct that was ordered." During interview with culinary director (C)-D on 6/11/25 at 12:16 p.m., C-D stated, "I am aware of the complaints and we are trying to address the food temp and deliver of food once it [sic]is gets up [sic] the floors." During interview with CS on 6/11/25 at 12:18 p.m., CS stated the food issues were related to nursing aides with their role in obtaining resident food orders. "There is a disconnect in the process with aides taking the orders and the staff delivering the trays." In addition, "We keep educating and encouraging the aides. Everyone should get the correct food and appetizing temp of food". During dining room observation and interview with CS on 6/11/25 at 12:30 p.m., in dining room serving both long term care residents and transitional care unit residents, CS stated expectation of lunch meal to be served at 11:45 a.m. Staff were serving food trays to residents in the dining room and began to start serving resident room trays. CS stated, "We are running late today." There was a dining room table with a male and female resident seated at it and no food had been delivered to it. At 12:33 p.m., CS stated, "I am aware of complaints from resident council[sic] I am aware of cold food complaints. I will get feedback from dietician that food is [sic] late". At 1:06 p.m., kitchenette was still preparing a resident room tray for delivery. A test tray was requested at 1:11 p.m., for surveyor and CS to review. Temperature of the Chicken and Dumpling soup was 133.7 degrees Fahrenheit (F). CS stated expectation of serving temperature to be 135 degrees. F. The mashed potatoes and gravy was 111.3 degrees F. CS stated expectation of serving temperature	F0804		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
F0804 SS = E	Continued from page 74 to be 135 degrees F. CS tasted the meal and stated, "mashed potatoes are not hot. Temp could be warmer." Facility policy on food temperatures and timing of serving food was requested but not received.	F0804		
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 meals and snacks. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assessed and care-planned adaptive equipment for eating was provided to promote independence and personal hygiene during meals for 1 of 1 residents (R20) reviewed who needed special utensil handles. Findings include: R20's quarterly Minimum Data Set (MDS), dated 4/23/25, identified R20 had moderate cognitive impairment and required set-up assistance with eating. On 6/9/25 at 2:35 p.m., R20 was observed lying in bed while in his room. R20 had a meal tray placed on a bedside table over him while lying down, and he had rice and beans spilled onto his chest. R20 took more bites of food from the provided tray which had a ceramic plate with regular, metallic utensils (i.e., fork, spoon) on it. The meal tray had a white-colored menu slip on it which recorded R20 as having a diabetic diet and no adaptive equipment was listed on it; however, on the wall immediately next to R20's bed was a white-colored sign which had black writing, "Keep red [bold] foam utensils in resident's room. Hand wash after meals." R20's room and meal tray were observed and no red-colored foam utensils were visible despite R20 eating his meal unattended in his room. R20 had a soft, mumbled voiced but responded, "I use these [pointing to utensils]" when asked if he used other silverware usually.	F0810	R20's assistive devices during meals and food services were reviewed, and the care plan was reviewed to reflect accuracy. All residents with necessary assistive devices, equipment, and utensils were reviewed to verify accurate meal ticket identifications. Education was completed for all staff on the recognition of assistive devices during meal services. Additional education was provided on adaptive devices on meal tickets. Adaptive Eaiting and Equipment Policy was reviewed no changes were necessary. Audits will be completed 3 times a week for 4 weeks, and then weekly for 2 weeks. Audits will be reviewed quarterly by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure compliance. The Director of Nursing or designee is responsible for compliance.	07/14/2025

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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 75 Following, on 6/9/25 at 2:42 p.m., nursing assistant (NA)-L stated they had worked with R20 prior, and explained the lunch meal was typically passed around 11:45 a.m. to residents in their rooms. NA-L observed R20 in bed with the surveyor and stated R20 was a "slow eater" so he was still eating his lunch meal. NA-L was questioned on the white-colored signage which directed the use of red-colored handles, and NA-L responded aloud, "He's supposed to use those." NA-L then opened R20's bedside dresser drawer and located two red-colored, foam handles which slide over the regular utensil to provide a thicker surface to hold onto. NA-L added aloud, "Here they are." NA-L stated they should be used for all meals as they were "adaptable equipment I think." NA-L verified R20 would not be able to apply or remove them without help and expressed for some reason they weren't used for the lunch meal adding, "I don't know why not, maybe [the aide] forgot." R20's medical record was reviewed and lacked documented rationale or evidence why R20 had not been provided the red-colored handles for meal as just observed. R20's care plan, printed 6/10/25, identified R20's current or actual problems along with interventions to address them. The plan identified R20 had an ADL (activities of daily living) self-care deficit due to limited mobility and weakness. The care plan directed, "Please leave the built up red foam handled utensils in [R20] room. Wash between uses. Please provide [R20] a clothing protector with each meal per his preference." This intervention had a date listed, "01/02/2025." On 6/10/25 at 9:00 a.m., occupational therapist (OT)-A was interviewed, and verified they had worked with him and his eating abilities prior due to "difficulty with feeding himself." OT-A explained R20 struggled using regular utensils and, as a result, they placed a communication to nursing for the red-colored foam handles. OT-A verified R20 should be using them at all meals adding, "He does the best job feeding and drinking himself with these things." OT-A then provided the communication forms which had been sent to the nursing department. R20's Therapy-Nursing Communication Form, dated 1/7/25, identified R20's name along with directions, " - Please leave the built-up handled (red foamed utensils)	F0810		

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 06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	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 76 utensils in his room. Wash them please." On 6/10/25 at 1:44 p.m., the director of nursing (DON) stated they were covering R20's unit since the previous nurse manager took a new role. DON stated they were aware of R20 using the red-colored foam handles and verified they should be used at meals since they're listed on the care plan. DON stated using them would help with "better nutrition" and "a better quality of life" for R20. Further, DON verified the handles would be considered adaptive equipment. A facility provided Adaptive Eating Equipment policy, dated 3/2024, identified the care center would provide special eating equipment, utensils, and assistance as appropriate to assure the person can use the devices while consuming meals and snacks. The policy directed, "Adaptive/assistive devices should be noted on each individual's meal identification (ID) card/ticket and in the person-centered care plan and or in the medical record."	F0810		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/9/25 to 6/12/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were completed. Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20000	Continued from page 1 The following complaints were reviewed with no licensing orders issued: H52726527C (MN103405) H52726528C (MN105343) H52726530C (MN105824) H52726532C (MN109225) H52726534C (MN109290) H52726536C (MN110946) H52724367C (MN112880) H52726531C (MN113113) H52725127C (MN113178) H52726529C (MN113241) The following complaints were reviewed with licensing orders at 0960: H52726535C (MN112352) H52726533C (MN112451) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the	20000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20000	Continued from page 2 correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		
20845	Adequate and Proper Nursing Care; Shampoo CFR(s): MN Rule 4658.0520 Subp. 2 C Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: C. A shampoo at least weekly and assistance with daily hair grooming as needed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene and grooming (i.e., nail care, hair care, beard trimming) was provided for 2 of 3 residents (R20, R25) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care.	20845	corrected	07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20845	Continued from page 3 Findings include: R20 R20's quarterly Minimum Data Set (MDS), dated 4/23/25, identified R20 had moderate cognitive impairment but demonstrated no delusional thinking or rejection of care behaviors. Further, the MDS outlined R20 required substantial assistance with personal hygiene cares. On 6/9/25 at 2:35 p.m., R20 was observed lying in bed while in his room. R20 had a meal tray placed on a bedside table over him while lying down, and he had rice and beans spilled onto his chest. R20's fingernails were observed, and multiple nails had a visible, dark-colored substance or debris present under the edge of the nail to the nail bed. R20 was asked about his bathing and grooming at the care center and responded aloud, "Bed Bath." R20 looked at his nails when asked about them and expressed he was unsure when they were last cleaned or clipped with an audible, "I don't know." The following day, on 6/10/25 at 12:45 p.m., R20 was again observed lying in bed while in his room. R20's fingernails remained with visible dark-colored debris underneath of them as was observed the day prior. R20's care plan, dated 3/2025, identified R20 had an ADL self-care deficit due to limited mobility and weakness. The care plan listed multiple interventions for R20 including assistance of one with bathing and, "PERSONAL HYGIENE: Requires assistance by 1 staff with personal hygiene and oral care." R20's most recent Weekly Bath and Skin Sheet - V4, dated 6/5/25, identified R20 received bathing and his skin was intact. The form outlined a section labeled, "Nail Care, select all that apply," with options for staff to select from using a checkmark. This recorded a response, "3. Finger nails short and smooth; do not need trimming." However, the form lacked options to record the nail cleanliness or if they were offered to be cleaned. On 6/11/25 at 10:03 a.m., R20 was observed in bed. R20's fingernails remained soiled with visible,	20845		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20845	Continued from page 4 dark-colored debris and/or substance underneath multiple nails which had been observed since two days prior (on 6/9/25). Immediately following on 6/11/25 at 10:06 a.m., nursing assistant (NA)-L was interviewed, and verified they had worked with R20 prior. NA-L explained R20 was bathed every week on Thursday morning and his fingernails should be clipped by the nurses if he was diabetic. NA-L verified there were clippers and a file to use for residents' nail care, if needed. NA-L then observed R20 lying in bed at the request of the surveyor. NA-L verified their condition and expressed, "It's dirty." NA-L stated R20's fingernails needed to be cleaned, and the aide could do that task using an edge device they had. NA-L stated nails would be cleaned on R20's bath day, however, expressed if noticed to be soiled then they could be cleaned whenever adding, "If you see it [can be cleaned]." NA-L stated clean nail beds and edges were important to reduce the risk of infection and general hygiene. When interviewed on 6/11/25 at 10:32 a.m., registered nurse (RN)-K stated they had worked with R20 only "once or twice" prior. RN-K explained the nurses would do nail clipping for R20 since he was diabetic, but the aides could clean his nails if they were found soiled. RN-K stated nails were cleaned on bath day but could be cleaned anytime they're noticed to be soiled adding aloud, "As needed as well." RN-K stated any attempt to clean them, including if R20 refused it, should be documented in the medical record. RN-K stated having clean nail beds and edges was important to reduce bacteria on the hands and "hygiene as well." R20's medical record was reviewed and lacked evidence R20 had been offered or had completed any nail care, including cleaning of them, since 6/5/25 despite being observed multiple days in a row with soiled nail beds and edges. On 6/11/25 at 11:08 a.m., unit manager (RN)-E and the director of nursing (DON) were interviewed. DON explained nail cleaning should be done on bath day and if refused, it should be recorded in the medical record. DON stated the aides could clean nails whenever noticed they needed it, too. This was important for personal hygiene care. A facility provided AM Cares policy, dated 4/25, identified all residents would be provided with assistance, as needed, for morning cares unless	20845		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20845	Continued from page 5 otherwise directed by the care plan. The procedure listed steps for the care including, "19. Nails are clean and trimmed to resident desired length." In addition, a provided Nails, Care Of policy, dated 9/2022, identified a purpose of providing cleanliness and preventing infection spread. The policy directed, "5. Complete nail care on bath day and as needed." R25 R25's admission Minimum Data Set (MDS) dated 3/31/25, indicated R25 was cognitively intact, had no hallucinations, delusions, and didn't refuse personal cares. MDS indicated R25 received maximal assistance with toileting hygiene, bathing, sit to stand and was dependent with transfers. MDS also indicated R25 received moderate assistance with personal hygiene, dressing and received set up to eat, and oral hygiene. R25's Medical Diagnosis record printed 6/12/25, indicated diagnoses of acute respiratory failure with hypoxia (low level of oxygen in the blood), atrial fibrillation (irregular heart rhythm that can lead to blood clots in the heart), type II diabetes, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or the inability to move one side of the body) following cerebral infarction affecting right dominant side, and muscle weakness. R25's Activities of daily living (ADLS) care plan printed 6/12/25, indicated R25 had self-care performance deficit related to weakness, respiratory failure, obesity, right side weakness from previous cerebral vascular accident (damage to the brain from interruption of its blood supply). R25's care plan indicated he needed assistance of one staff with bathing/showering, and personal hygiene. During observation and interview on 6/9/25 at 1:05 p.m., R25 was in bed. R25 had long dull hair separated in locks and had long disheveled mustache and beard. R25 stated staff used shampoo caps, no water to wash his hair and staff had not offered to help trim his beard. R25 stated he had a big hair knot on the back of his head and staff had not helped him to untangle his hair. R25 added "Later today, I will have a bath. We will see how I will look tomorrow."	20845		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20845	Continued from page 6 During observation and interview on 6/10/25 at 1:35 p.m., R25 stated last night the staff used a shampoo cap (a hair cap that contains a dry substance) but staff didn't do a good job and still had the hair knot on the back of his head. The staff member only rubbed the top of his head two to three times, and it was done. Staff didn't offer to help him with his beard. R25's hair looked dull and R25 stated his hair didn't feel clean. During observation and interview on 6/10/25 at 1:42 p.m., registered nurse (RN)-J observed R25 and stated "he [R25] looks sweaty, his hair is greasy, and his beard should be trimmed". RN-J added his mustache was growing over his lower lip. R25 stated "Today, for the first time in three months I looked at myself in the mirror and eek." During interview on 6/10/25 at 1:48 p.m., nurse manager/registered nurse (RN)-I stated residents should be helped to shave and the clinical services coordinator (CSC) should schedule a haircut appointment. During interview on 6/10/25 at 1:52 p.m., CSC-A stated scheduling a haircut will depend on the resident. CSC-A added, sometimes the social workers will start the process, including talking to the residents and making the hair appointment for them. During interview on 6/10/25 at 1:55 p.m., social worker (SW)-A stated R25 moved two weeks ago to her unit, and last week RN-I informed her R25 wanted a haircut, and his beard trimmed. SW-A stated social workers were responsible to schedule hair appointments. SW-A stated residents' personal appearance was important for dignity and quality of life. During interview on 6/12/25 at 9:11 a.m., director of nursing (DON) stated residents' hair should be brushed every day and washed on shower days. DON stated if residents' preference was to received sponge baths instead of showers, their hair could be washed with shampoo and water in bed. DON stated hair shower caps should not be used on regular bases. DON stated washing residents' hair and shaving were important for hygiene and dignity.	20845		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20845	Continued from page 7 Facility's policy titled AM cares (morning cares) dated 4/25, indicated all patients were provided with set up, assistance, or total assistance for AM (morning) cares unless the plan of care states otherwise. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could update policies as needed. Appropriate staff could be trained. Observations and audits could be conducted to ensure residents' hair is shampooed and combed and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20845		
20850	Adequate and Proper Nursing Care; Shaving CFR(s): MN Rule 4658.0520 Subp. 2 D Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene and grooming (i.e., nail care, hair care, beard trimming) was provided for 2 of 3 residents (R20, R25) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R20 R20's quarterly Minimum Data Set (MDS), dated 4/23/25, identified R20 had moderate cognitive impairment but demonstrated no delusional thinking or rejection of care behaviors. Further, the MDS outlined R20 required substantial assistance with personal hygiene cares. On 6/9/25 at 2:35 p.m., R20 was observed lying in bed while in his room. R20 had a meal tray placed on a bedside table over him while lying down, and he had	20850	corrected	07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20850	Continued from page 8 rice and beans spilled onto his chest. R20's fingernails were observed, and multiple nails had a visible, dark-colored substance or debris present under the edge of the nail to the nail bed. R20 was asked about his bathing and grooming at the care center and responded aloud, "Bed Bath." R20 looked at his nails when asked about them and expressed he was unsure when they were last cleaned or clipped with an audible, "I don't know." The following day, on 6/10/25 at 12:45 p.m., R20 was again observed lying in bed while in his room. R20's fingernails remained with visible dark-colored debris underneath of them as was observed the day prior. R20's care plan, dated 3/2025, identified R20 had an ADL self-care deficit due to limited mobility and weakness. The care plan listed multiple interventions for R20 including assistance of one with bathing and, "PERSONAL HYGIENE: Requires assistance by 1 staff with personal hygiene and oral care." R20's most recent Weekly Bath and Skin Sheet - V4, dated 6/5/25, identified R20 received bathing and his skin was intact. The form outlined a section labeled, "Nail Care, select all that apply," with options for staff to select from using a checkmark. This recorded a response, "3. Finger nails short and smooth; do not need trimming." However, the form lacked options to record the nail cleanliness or if they were offered to be cleaned. On 6/11/25 at 10:03 a.m., R20 was observed in bed. R20's fingernails remained soiled with visible, dark-colored debris and/or substance underneath multiple nails which had been observed since two days prior (on 6/9/25). Immediately following on 6/11/25 at 10:06 a.m., nursing assistant (NA)-L was interviewed, and verified they had worked with R20 prior. NA-L explained R20 was bathed every week on Thursday morning and his fingernails should be clipped by the nurses if he was diabetic. NA-L verified there were clippers and a file to use for residents' nail care, if needed. NA-L then observed R20 lying in bed at the request of the surveyor. NA-L verified their condition and expressed, "It's dirty." NA-L stated R20's fingernails needed to be cleaned, and the aide could do that task using an edge device they had. NA-L stated nails would be cleaned on R20's bath day, however, expressed if noticed to be soiled then they could be cleaned	20850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20850	Continued from page 9 whenever adding, "If you see it [can be cleaned]." NA-L stated clean nail beds and edges were important to reduce the risk of infection and general hygiene. When interviewed on 6/11/25 at 10:32 a.m., registered nurse (RN)-K stated they had worked with R20 only "once or twice" prior. RN-K explained the nurses would do nail clipping for R20 since he was diabetic, but the aides could clean his nails if they were found soiled. RN-K stated nails were cleaned on bath day but could be cleaned anytime they're noticed to be soiled adding aloud, "As needed as well." RN-K stated any attempt to clean them, including if R20 refused it, should be documented in the medical record. RN-K stated having clean nail beds and edges was important to reduce bacteria on the hands and "hygiene as well." R20's medical record was reviewed and lacked evidence R20 had been offered or had completed any nail care, including cleaning of them, since 6/5/25 despite being observed multiple days in a row with soiled nail beds and edges. On 6/11/25 at 11:08 a.m., unit manager (RN)-E and the director of nursing (DON) were interviewed. DON explained nail cleaning should be done on bath day and if refused, it should be recorded in the medical record. DON stated the aides could clean nails whenever noticed they needed it, too. This was important for personal hygiene care. A facility provided AM Cares policy, dated 4/25, identified all residents would be provided with assistance, as needed, for morning cares unless otherwise directed by the care plan. The procedure listed steps for the care including, "19. Nails are clean and trimmed to resident desired length." In addition, a provided Nails, Care Of policy, dated 9/2022, identified a purpose of providing cleanliness and preventing infection spread. The policy directed, "5. Complete nail care on bath day and as needed." R25 R25's admission Minimum Data Set (MDS) dated 3/31/25, indicated R25 was cognitively intact, had no hallucinations, delusions, and didn't refuse personal cares. MDS indicated R25 received maximal assistance	20850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20850	Continued from page 10 with toileting hygiene, bathing, sit to stand and was dependent with transfers. MDS also indicated R25 received moderate assistance with personal hygiene, dressing and received set up to eat, and oral hygiene. R25's Medical Diagnosis record printed 6/12/25, indicated diagnoses of acute respiratory failure with hypoxia (low level of oxygen in the blood), atrial fibrillation (irregular heart rhythm that can lead to blood clots in the heart), type II diabetes, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or the inability to move one side of the body) following cerebral infarction affecting right dominant side, and muscle weakness. R25's Activities of daily living (ADLS) care plan printed 6/12/25, indicated R25 had self-care performance deficit related to weakness, respiratory failure, obesity, right side weakness from previous cerebral vascular accident (damage to the brain from interruption of its blood supply). R25's care plan indicated he needed assistance of one staff with bathing/showering, and personal hygiene. During observation and interview on 6/9/25 at 1:05 p.m., R25 was in bed. R25 had long dull hair separated in locks and had long disheveled mustache and beard. R25 stated staff used shampoo caps, no water to wash his hair and staff had not offered to help trim his beard. R25 stated he had a big hair knot on the back of his head and staff had not helped him to untangle his hair. R25 added "Later today, I will have a bath. We will see how I will look tomorrow." During observation and interview on 6/10/25 at 1:35 p.m., R25 stated last night the staff used a shampoo cap (a hair cap that contains a dry substance) but staff didn't do a good job and still had the hair knot on the back of his head. The staff member only rubbed the top of his head two to three times, and it was done. Staff didn't offer to help him with his beard. R25's hair looked dull and R25 stated his hair didn't feel clean. During observation and interview on 6/10/25 at 1:42 p.m., registered nurse (RN)-J observed R25 and stated "he [R25] looks sweaty, his hair is greasy, and his beard should be trimmed". RN-J added his mustache was growing over his lower lip. R25 stated "Today, for the	20850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20850	Continued from page 11 first time in three months I looked at myself in the mirror and eek." During interview on 6/10/25 at 1:48 p.m., nurse manager/registered nurse (RN)-I stated residents should be helped to shave and the clinical services coordinator (CSC) should schedule a haircut appointment. During interview on 6/10/25 at 1:52 p.m., CSC-A stated scheduling a haircut will depend on the resident. CSC-A added, sometimes the social workers will start the process, including talking to the residents and making the hair appointment for them. During interview on 6/10/25 at 1:55 p.m., social worker (SW)-A stated R25 moved two weeks ago to her unit, and last week RN-I informed her R25 wanted a haircut, and his beard trimmed. SW-A stated social workers were responsible to schedule hair appointments. SW-A stated residents' personal appearance was important for dignity and quality of life. During interview on 6/12/25 at 9:11 a.m., director of nursing (DON) stated residents' hair should be brushed every day and washed on shower days. DON stated if residents' preference was to received sponge baths instead of showers, their hair could be washed with shampoo and water in bed. DON stated hair shower caps should not be used on regular bases. DON stated washing residents' hair and shaving were important for hygiene and dignity. Facility's policy titled AM cares (morning cares) dated 4/25, indicated all patients were provided with set up, assistance, or total assistance for AM (morning) cares unless the plan of care states otherwise. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependent on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20850 20895	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2.B Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a range of motion (ROM) program was provided for 1 of 1 resident (R74) reviewed for mobility. Finding includes: R74's quarterly Minimum Data Set (MDS) dated 4/30/25, indicated R74 was cognitively intact, had no delusions, hallucinations, had no behaviors and refused cares one to three days during a 7-day period. MDS indicated R74 had limited lower extremity ROM and did not received ROM in the last 7 days prior the MDS assessment date. R74's MDS indicated she received set up assistance for oral hygiene and eating, maximal assistance with showers/bathing, toileting hygiene, dressing, personal hygiene, and was dependent with transfers, and wheelchair mobility. R74's clinical diagnosis report printed on 6/12/25, indicated chronic respiratory failure, chronic pain, anxiety, restless leg syndrome, weakness, unspecified abnormalities of gait and mobility, chronic congestive diastolic heart failure(a condition where the heart muscle stiffens, making it difficult for the heart to relax and fill with blood during the relaxation phase), subluxation (is a partial dislocation, where the bones in a joint are still partially touching) of the hips, and diabetes type II.	20850 20895	corrected	07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20895	Continued from page 13 R74's care plan printed 6/12/25, indicated R74 had limited ROM related to multiple sclerosis, chronic pain, and recurrent bilateral hip subluxations. The care plan's interventions directed nursing staff to assist resident in daily performance of supine ROM, strengthening exercises. It indicated a printout was on the bulletin board and resident also had a copy, and directed staff to please attempt this in the afternoon per R74's preference. This care plan was initiated in 9/6/22, had a revision date of 11/14/24, and indicated 7/29/25 as a target day. R74's ROM/Mobility assessments dated 3/24/25, and 4/24/25, indicated R74 had limited ROM of lower extremities, used a wheelchair, and her care plan was current. R74's treatment administration record (TAR) for the month of June 2025 printed on 6/12/25, indicated an order to "Assist with lower extremity ROM program. Directions are on the resident's bulletin board. Two times a day per therapy." This order was dated 5/9/23. A review of R74's TAR records for the last 7 months revealed the following information: - December 2024, R74 received ROM 18 times out of 50 opportunities, and refused or did not receive ROM 32 times out of 50 opportunities. - January 2025, R74 did not received ROM 44 of 44 opportunities. - February 2025, R74 either refused or did not receive ROM 49 out of 49 opportunities. - March 2025, R74 either refused or did not receive ROM 44 out of 44 opportunities. - April 2025, R74 either she refused or did not receive ROM 60 out of 60 opportunities. - May 2025, R74 either refused or did not receive ROM 62 of 62 opportunities.	20895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20895	Continued from page 14 - June 2025 - R74 either refused or did not receive ROM 20 out 20 opportunities. During interview on 6/9/25 at 3:34 p.m., R74 indicated the nursing staff was supposed to assist her twice a day with her ROM program. R74 stated her care plan indicated she had to receive assistance every day. During interview on 6/11/25 at 11:01 a.m., nurse manager/registered nurse (RN)-I stated R74 always refused ROM exercises in the mornings. RN-I stated, often R74 didn't like how staff did it. RN-I stated based on documentation, R74 was refusing to participate and they would need to investigate why, talk to the nurse practitioner, and request an order to reassess R74. During interview on 6/11/25 at 1:57 p.m., RN-J stated "today, I went into her room to do wound care, but I didn't talk to her about her ROM program, and I didn't do it." During interview on 6/11/25 at 2:04 p.m., RN-P stated he didn't really do ROM with R74, but while performing wound care, he straightened R74's legs. RN-P added "we only get to move her legs when we boost her up in bed." On 6/12/25 at 9:07 a.m., RN-I provided written information which indicated "R74 had the right to refuse to participate. She has exercise bands in her room and self exercises using them." During interview on 6/12/25 at 9:07 a.m., director of nursing (DON) verified TARs documentation, ROM assessments and the failure to reassess R74 in a timely manner. DON stated the provider needed to be updated about resident's refusal to participate in the ROM program. DON stated "we need to get another physical therapy and/or occupational therapy assessment for [R74]. Maybe we need to give her pain medication before receiving assistance with her ROM program". DON added her care plan also needed to be reviewed. Facility's policy titled Restorative Nursing program, dated 10/2021 indicated the purpose of the program was to ensure resident's abilities in ADLs did not	20895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20895	Continued from page 15 deteriorate and residents maintain their highest practicable well-being. The policy indicated; the restorative nursing programs will be identified in the resident's care plan. The care plan must identify the resident's strengths, problems, risks, measurable goals, outcome-based goals and who is responsible for the implementation of the plan. The policy also indicated the RN will be responsible for assessing the resident's strengths and needs. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate responsible staff to ensure implementation of restorative maintenance for residents' dependent on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of maintenance programs to ensure range of motion programs are done. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20895		
20920	Rehab - ADLs CFR(s): MN Rule 4658.0525 Subp. 6 B Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene and grooming (i.e., nail care, hair care, beard trimming) was provided for 2 of 3 residents (R20, R25) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R20 R20's quarterly Minimum Data Set (MDS), dated 4/23/25, identified R20 had moderate cognitive impairment but demonstrated no delusional thinking or rejection of	20920	corrected	07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20920	Continued from page 16 care behaviors. Further, the MDS outlined R20 required substantial assistance with personal hygiene cares. On 6/9/25 at 2:35 p.m., R20 was observed lying in bed while in his room. R20 had a meal tray placed on a bedside table over him while lying down, and he had rice and beans spilled onto his chest. R20's fingernails were observed, and multiple nails had a visible, dark-colored substance or debris present under the edge of the nail to the nail bed. R20 was asked about his bathing and grooming at the care center and responded aloud, "Bed Bath." R20 looked at his nails when asked about them and expressed he was unsure when they were last cleaned or clipped with an audible, "I don't know." The following day, on 6/10/25 at 12:45 p.m., R20 was again observed lying in bed while in his room. R20's fingernails remained with visible dark-colored debris underneath of them as was observed the day prior. R20's care plan, dated 3/2025, identified R20 had an ADL self-care deficit due to limited mobility and weakness. The care plan listed multiple interventions for R20 including assistance of one with bathing and, "PERSONAL HYGIENE: Requires assistance by 1 staff with personal hygiene and oral care." R20's most recent Weekly Bath and Skin Sheet - V4, dated 6/5/25, identified R20 received bathing and his skin was intact. The form outlined a section labeled, "Nail Care, select all that apply," with options for staff to select from using a checkmark. This recorded a response, "3. Finger nails short and smooth; do not need trimming." However, the form lacked options to record the nail cleanliness or if they were offered to be cleaned. On 6/11/25 at 10:03 a.m., R20 was observed in bed. R20's fingernails remained soiled with visible, dark-colored debris and/or substance underneath multiple nails which had been observed since two days prior (on 6/9/25). Immediately following on 6/11/25 at 10:06 a.m., nursing assistant (NA)-L was interviewed, and verified they had worked with R20 prior. NA-L explained R20 was bathed every week on Thursday morning and his fingernails should be clipped by the nurses if he was diabetic. NA-L verified there were clippers and a file to use for residents' nail care, if needed. NA-L	20920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20920	Continued from page 17 then observed R20 lying in bed at the request of the surveyor. NA-L verified their condition and expressed, "It's dirty." NA-L stated R20's fingernails needed to be cleaned, and the aide could do that task using an edge device they had. NA-L stated nails would be cleaned on R20's bath day, however, expressed if noticed to be soiled then they could be cleaned whenever adding, "If you see it [can be cleaned]." NA-L stated clean nail beds and edges were important to reduce the risk of infection and general hygiene. When interviewed on 6/11/25 at 10:32 a.m., registered nurse (RN)-K stated they had worked with R20 only "once or twice" prior. RN-K explained the nurses would do nail clipping for R20 since he was diabetic, but the aides could clean his nails if they were found soiled. RN-K stated nails were cleaned on bath day but could be cleaned anytime they're noticed to be soiled adding aloud, "As needed as well." RN-K stated any attempt to clean them, including if R20 refused it, should be documented in the medical record. RN-K stated having clean nail beds and edges was important to reduce bacteria on the hands and "hygiene as well." R20's medical record was reviewed and lacked evidence R20 had been offered or had completed any nail care, including cleaning of them, since 6/5/25 despite being observed multiple days in a row with soiled nail beds and edges. On 6/11/25 at 11:08 a.m., unit manager (RN)-E and the director of nursing (DON) were interviewed. DON explained nail cleaning should be done on bath day and if refused, it should be recorded in the medical record. DON stated the aides could clean nails whenever noticed they needed it, too. This was important for personal hygiene care. A facility provided AM Cares policy, dated 4/25, identified all residents would be provided with assistance, as needed, for morning cares unless otherwise directed by the care plan. The procedure listed steps for the care including, "19. Nails are clean and trimmed to resident desired length." In addition, a provided Nails, Care Of policy, dated 9/2022, identified a purpose of providing cleanliness and preventing infection spread. The policy directed, "5. Complete nail care on bath day and as needed."	20920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20920	Continued from page 18 R25 R25's admission Minimum Data Set (MDS) dated 3/31/25, indicated R25 was cognitively intact, had no hallucinations, delusions, and didn't refuse personal cares. MDS indicated R25 received maximal assistance with toileting hygiene, bathing, sit to stand and was dependent with transfers. MDS also indicated R25 received moderate assistance with personal hygiene, dressing and received set up to eat, and oral hygiene. R25's Medical Diagnosis record printed 6/12/25, indicated diagnoses of acute respiratory failure with hypoxia (low level of oxygen in the blood), atrial fibrillation (irregular heart rhythm that can lead to blood clots in the heart), type II diabetes, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or the inability to move one side of the body) following cerebral infarction affecting right dominant side, and muscle weakness. R25's Activities of daily living (ADLS) care plan printed 6/12/25, indicated R25 had self-care performance deficit related to weakness, respiratory failure, obesity, right side weakness from previous cerebral vascular accident (damage to the brain from interruption of its blood supply). R25's care plan indicated he needed assistance of one staff with bathing/showering, and personal hygiene. During observation and interview on 6/9/25 at 1:05 p.m., R25 was in bed. R25 had long dull hair separated in locks and had long disheveled mustache and beard. R25 stated staff used shampoo caps, no water to wash his hair and staff had not offered to help trim his beard. R25 stated he had a big hair knot on the back of his head and staff had not helped him to untangle his hair. R25 added "Later today, I will have a bath. We will see how I will look tomorrow." During observation and interview on 6/10/25 at 1:35 p.m., R25 stated last night the staff used a shampoo cap (a hair cap that contains a dry substance) but staff didn't do a good job and still had the hair knot on the back of his head. The staff member only rubbed the top of his head two to three times, and it was done. Staff didn't offer to help him with his beard. R25's hair looked dull and R25 stated his hair didn't feel clean.	20920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20920	Continued from page 19 During observation and interview on 6/10/25 at 1:42 p.m., registered nurse (RN)-J observed R25 and stated "he [R25] looks sweaty, his hair is greasy, and his beard should be trimmed". RN-J added his mustache was growing over his lower lip. R25 stated "Today, for the first time in three months I looked at myself in the mirror and eek." During interview on 6/10/25 at 1:48 p.m., nurse manager/registered nurse (RN)-I stated residents should be helped to shave and the clinical services coordinator (CSC) should schedule a haircut appointment. During interview on 6/10/25 at 1:52 p.m., CSC-A stated scheduling a haircut will depend on the resident. CSC-A added, sometimes the social workers will start the process, including talking to the residents and making the hair appointment for them. During interview on 6/10/25 at 1:55 p.m., social worker (SW)-A stated R25 moved two weeks ago to her unit, and last week RN-I informed her R25 wanted a haircut, and his beard trimmed. SW-A stated social workers were responsible to schedule hair appointments. SW-A stated residents' personal appearance was important for dignity and quality of life. During interview on 6/12/25 at 9:11 a.m., director of nursing (DON) stated residents' hair should be brushed every day and washed on shower days. DON stated if residents' preference was to received sponge baths instead of showers, their hair could be washed with shampoo and water in bed. DON stated hair shower caps should not be used on regular bases. DON stated washing residents' hair and shaving were important for hygiene and dignity. Facility's policy titled AM cares (morning cares) dated 4/25, indicated all patients were provided with set up, assistance, or total assistance for AM (morning) cares unless the plan of care states otherwise. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable care plans and policies to ensure hygiene and personal care needs	20920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20920	Continued from page 20 are provided to dependent residents; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 days	20920		
20945	Assistance with Eating - Nursing Personnel CFR(s): MN Rule 4658.0530 Subp. 1 Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assessed and care-planned adaptive equipment for eating was provided to promote independence and personal hygiene during meals for 1 of 1 residents (R20) reviewed who needed special utensil handles. Findings include: R20's quarterly Minimum Data Set (MDS), dated 4/23/25, identified R20 had moderate cognitive impairment and required set-up assistance with eating. On 6/9/25 at 2:35 p.m., R20 was observed lying in bed while in his room. R20 had a meal tray placed on a bedside table over him while lying down, and he had rice and beans spilled onto his chest. R20 took more bites of food from the provided tray which had a ceramic plate with regular, metallic utensils (i.e., fork, spoon) on it. The meal tray had a white-colored menu slip on it which recorded R20 as having a diabetic diet and no adaptive equipment was listed on it; however, on the wall immediately next to R20's bed was a white-colored sign which had black writing, "Keep red	20945	corrected	07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20945	Continued from page 21 [bold] foam utensils in resident's room. Hand wash after meals." R20's room and meal tray were observed and no red-colored foam utensils were visible despite R20 eating his meal unattended in his room. R20 had a soft, mumbled voiced but responded, "I use these [pointing to utensils]" when asked if he used other silverware usually. Following, on 6/9/25 at 2:42 p.m., nursing assistant (NA)-L stated they had worked with R20 prior, and explained the lunch meal was typically passed around 11:45 a.m. to residents in their rooms. NA-L observed R20 in bed with the surveyor and stated R20 was a "slow eater" so he was still eating his lunch meal. NA-L was questioned on the white-colored signage which directed the use of red-colored handles, and NA-L responded aloud, "He's supposed to use those." NA-L then opened R20's bedside dresser drawer and located two red-colored, foam handles which slide over the regular utensil to provide a thicker surface to hold onto. NA-L added aloud, "Here they are." NA-L stated they should be used for all meals as they were "adaptable equipment I think." NA-L verified R20 would not be able to apply or remove them without help and expressed for some reason they weren't used for the lunch meal adding, "I don't know why not, maybe [the aide] forgot." R20's medical record was reviewed and lacked documented rationale or evidence why R20 had not been provided the red-colored handles for meal as just observed. R20's care plan, printed 6/10/25, identified R20's current or actual problems along with interventions to address them. The plan identified R20 had an ADL (activities of daily living) self-care deficit due to limited mobility and weakness. The care plan directed, "Please leave the built up red foam handled utensils in [R20] room. Wash between uses. Please provide [R20] a clothing protector with each meal per his preference." This intervention had a date listed, "01/02/2025." On 6/10/25 at 9:00 a.m., occupational therapist (OT)-A was interviewed, and verified they had worked with him and his eating abilities prior due to "difficulty with feeding himself." OT-A explained R20 struggled using regular utensils and, as a result, they placed a communication to nursing for the red-colored foam handles. OT-A verified R20 should be using them at all meals adding, "He does the best job feeding and drinking himself with these things." OT-A then provided	20945		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20945	Continued from page 22 the communication forms which had been sent to the nursing department. R20's Therapy-Nursing Communication Form, dated 1/7/25, identified R20's name along with directions, " - Please leave the built-up handled (red foamed utensils) utensils in his room. Wash them please." On 6/10/25 at 1:44 p.m., the director of nursing (DON) stated they were covering R20's unit since the previous nurse manager took a new role. DON stated they were aware of R20 using the red-colored foam handles and verified they should be used at meals since they're listed on the care plan. DON stated using them would help with "better nutrition" and "a better quality of life" for R20. Further, DON verified the handles would be considered adaptive equipment. A facility provided Adaptive Eating Equipment policy, dated 3/2024, identified the care center would provide special eating equipment, utensils, and assistance as appropriate to assure the person can use the devices while consuming meals and snacks. The policy directed, "Adaptive/assistive devices should be noted on each individual's meal identification (ID) card/ticket and in the person-centered care plan and or in the medical record." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable care plans and policies to ensure current; then educate staff and audit to ensure ongoing compliance with adaptive equipment use. TIME PERIOD FOR CORRECTION: 21 days	20945		
20960	Dietary Service - Food Quality CFR(s): MN Rule 4658.0600 Subp. 1 Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served in a timely manner to preserve desired temperatures of food	20960	corrected	07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20960	Continued from page 23 for 4 of 4 residents (R1, R3, R40, R113) reviewed who expressed concerns for food temperatures and palatability. This had the potential to affect all residents who consumed food from the facility kitchenettes. Findings include: During survey entrance on 6/9/25 at 11:00 a.m., the facility provided a document titled "Mealtimes for Fox, TCU, Eagle Crest, Prairie Spirit: Breakfast-7:45 am Lunch-11:45 am Dinner-4:45 pm". During observation of the facility's three kitchenettes, a sign was posted on the walls adjacent to the serving line facing the dining rooms. It stated: "Menu Cheat Sheet" with instructions to obtain meal tickets "in advance to meal service" and "staff should be taking the resident's meal orders WITH the resident, not for them." Review of resident council (RC) meeting minutes for: 6/10/24: indicated 19 residents were in attendance for the meeting and section identified as Nutrition state, "Residents reported that some items are still arriving cold at times." 8/16/24, and 9/17/24: identified residents concern with portion sizes and staff not picking up meal ticket requests early enough which caused residents to wait longer and took too much time in the dining rooms. 10/14/24: new process for obtaining resident meal preferences. "Nursing aides will collect meal tickets electronically before meals occur and the dietary staff will then prepare resident trays".	20960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20960	Continued from page 24 11/11/24: "residents reported that meals are being served late" 12/16/24: "Resident reported that meals are not being served in a timely manner and are arriving cold at times; resident reported that there are still errors in what they are served vs. what they ordered". 3/10/25: "Residents reported staff and residents are still struggling at times to use the new ordering system". 4/7/25: "residents turned in a petition for returning to the old menu system (paper)" 6/9/25: "Residents reported that service is still slow at times and food is cold at times; " During interview with nursing assistant (NA)-A on 6/9/25 at 5:57 p.m., NA-A stated residents "complain about the food. Most say that it is cold or that we ran out of something." During interview with registered nurse (RN)-B on 6/9/25 at 6:26 p.m., RN-B stated he had heard residents complaining about the food but did not document or follow up with dietician or supervisor. During interview with NA-B and NA-C on 6/9/25 at 6:32 p.m., both stated, "food complaints are mostly about the food they [residents] get is not what they [residents] ordered." NA-B stated expectation of nursing assistants to use an iPad (tablet computer) to ask each resident what they would like for their meal for the following day. The information was then printed in the dining room kitchenettes where the dietary aides would obtain the food and serve it onto a meal tray with requested food and drink orders. Then the nursing assistants and staff would serve the residents in the dining rooms first before serving room trays for residents who eat in their rooms. During interview with licensed practical nurse (LPN)-B on 6/10/25 at 8:28 a.m., LPN-B stated she was familiar with resident complaints concerning food including receiving food that was not ordered or requested.	20960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20960	Continued from page 25 R1 R1's quarterly Minimum Data Set (MDS) dated 4/3/25, indicated R1 had intact cognition and no hallucinations or delusions. R1 had other behavioral symptoms not directed toward others and did not reject cares. R1's diagnoses included hyperlipidemia, dementia, hemiplegia and hemiparesis, and stroke. R1 required setup and clean-up assistance with eating. During interview on 6/9/25 at 1:57 p.m., R1 stated he ate breakfast and the evening meal in the dining area. R1 stated sometimes he waited for his food for a while, and the food was not always warm when he received the meal. R1 stated he would ask staff to "electrify" his food, but staff were usually busy and had other residents to take care of to. R3 R3's annual Minimum Data Set (MDS) assessment, dated 3/26/25, indicated R3 had intact cognition with no hallucinations or delusions and was independent with eating. During an interview on 6/09/25 at 3:22 p.m., R3 stated meals were served warm "off and on" and sometimes served cold. R3 stated he typically eats breakfast and lunch in the dining room and supper in his room. R3 further indicated, staff have not offered to reheat meals and this has been and issue for "awhile." R40 R40's quarterly MDS, dated 3/12/25, indicated R40 had intact cognition with no hallucinations or delusions and was independent with eating. During an interview on 6/09/25 at 3:39 p.m., when R40 was asked about the food was, "it really isn't very good" and "I don't know if there's anything anybody can do about it." Furthermore, R40 stated there are "good cooks and bad cooks." R40 stated sometimes the food is warm and other times it is not. R40 stated she eats	20960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20960	Continued from page 26 meals in the dining room. R113 R113's admission MDS, dated 4/27/25, indicated R113 had intact cognition with no hallucinations or delusions and was independent with eating. During an interview on 6/9/25 at 2:50 p.m., R113 stated the food was "horrible." R113 stated she eats meals in her room and the food cold when it gets delivered to her. R113 stated she orders the meals and when she gets her meals, it is not what she ordered and is told they don't have it. R113 stated the "kitchen is a hot mess." R113 stated she ordered chicken strips, and they were cold and overcooked to the point she couldn't cut them with a knife. R113 stated her meal the other day was brought with completely melted ice cream. During interview with R113 on 6/10/25 at 1:33 p.m., R113 stated nursing assistants, "don't talk [to residents] and help them put in [food order/requests]." R113 stated, "happens all the time." R113 stated, "food feels like it was prepared the day before and given to me the next day. It is always cold. I have asked the aides to heat up my food but I feel like I am a troublemaker. If I lived here long term, I would not be happy with the service." During interview with NA-E on 6/10/25 at 1:42 p.m., NA-E stated expectation for nursing assistants to obtain resident meal preferences and options the day before service. NA-E stated staff helped enter orders for residents who could not talk, and "some [residents] complain that they get food they did not order". During continuous observation and interview with culinary supervisor (CS) on 6/11/25 at 11:57 a.m., CS was approached by a dietary aide and was informed that R89 did not have a meal ticket printed up. CS reviewed the electronic meal ticket system and stated R89 was not "asked what she wanted for meals yesterday which is why she did not get a meal ticket for today". CS walked with surveyor to R89's room and asked R89 if she was asked about her meal preferences and options for 6/11/25. R89 stated, "no one took my order yesterday".	20960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20960	Continued from page 27 During interview with CS on 6/11/25 at 12:11 p.m., CS stated "I am aware of many residents complaining of missing meals or cold food or [not] getting the correct that was ordered." During interview with culinary director (C)-D on 6/11/25 at 12:16 p.m., C-D stated, "I am aware of the complaints and we are trying to address the food temp and deliver of food once it [sic]is gets up [sic] the floors." During interview with CS on 6/11/25 at 12:18 p.m., CS stated the food issues were related to nursing aides with their role in obtaining resident food orders. "There is a disconnect in the process with aides taking the orders and the staff delivering the trays." In addition, "We keep educating and encouraging the aides. Everyone should get the correct food and appetizing temp of food". During dining room observation and interview with CS on 6/11/25 at 12:30 p.m., in dining room serving both long term care residents and transitional care unit residents, CS stated expectation of lunch meal to be served at 11:45 a.m. Staff were serving food trays to residents in the dining room and began to start serving resident room trays. CS stated, "We are running late today." There was a dining room table with a male and female resident seated at it and no food had been delivered to it. At 12:33 p.m., CS stated, "I am aware of complaints from resident council[sic] I am aware of cold food complaints. I will get feedback from dietician that food is [sic] late". At 1:06 p.m., kitchenette was still preparing a resident room tray for delivery. A test tray was requested at 1:11 p.m., for surveyor and CS to review. Temperature of the Chicken and Dumpling soup was 133.7 degrees Fahrenheit (F). CS stated expectation of serving temperature to be 135 degrees. F. The mashed potatoes and gravy was 111.3 degrees F. CS stated expectation of serving temperature to be 135 degrees F. CS tasted the meal and stated, "mashed potatoes are not hot. Temp could be warmer." Facility policy on food temperatures and timing of serving food was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure proper temperature for meals served. The facility could update	20960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
20960	Continued from page 28 or create policies and procedures, and educate staff on proper temperature for meals served to residents. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure proper temperatures of meals served to residents. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 days	20960		
21535	Unnecessary Drug Usage; General CFR(s): MN Rule4658.1315 Subp.1 ABCD Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure acute symptoms of distress or pain were recorded; and non-pharmacological interventions attempted or documented prior to the use of as-needed (i.e., PRN) narcotic medications to help promote continuity of care and care-planning for 1 of 5 residents (R50) reviewed for unnecessary medication use.	21535	corrected	07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21535	Continued from page 29 Findings include: R50's admission Minimum Data Set (MDS), dated 3/11/25, identified R50 had intact cognition and demonstrated no delusional thinking. Further, the MDS outlined R50 received scheduled pain medication but no PRN pain medications; and reported occasional pain which she rated at 4/10 on the numeric rating scale. On 6/9/25 at 12:40 p.m., R50 was observed seated in a recliner chair while in her room. R50 had visible white-colored bandages on both legs and reported she sustained a fall the week prior which she felt injured her hip adding, "I think I cracked it." R50 denied significant, unresolved pain issues at this time when asked. R50's care plan, printed 6/9/25, identified R50's actual and potential problems along with interventions to address them. This outlined R50 had pain related to bilateral venous wounds and listed a goal, "Will verbalize adequate relief of pain or ability to cope with incompletely relieved pain ...," along with several interventions including administering pain medication and monitoring the response, encouraging her to report pain at the onset, and a series of non-pharmacological interventions which could be attempted including redirection, offering food, music, and ice/heat. The care plan also directed to "monitor/record/report" any pain characteristics every shift and PRN; and "monitor/record/report" an non-verbal signs of pain. R50's Orders, dated 5/1/25, identified the nurse practitioner (NP) wrote orders for R50 which included, "Add tramadol [a narcotic] 50 mg [milligrams] every day PRN [for] chronic pain." In addition, the order directed R50 to remain on the current tramadol 50 mg twice a day which was scheduled. R50's Medication Administration Record (MAR), dated 6/2025, identified a total of nine (9) administrations of the PRN tramadol for the month thus far. These included: On 6/3/25 at 5:37 a.m., R50 received a dose which was recorded as, "E [effective]." A corresponding progress note, dated 6/3/25, identified the medication was provided with dictation, "per pt [patient] request."	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21535	Continued from page 30 However, the note lacked any recorded symptoms or what, if any, non-pharmacological interventions were attempted prior to the narcotic being provided. On 6/7/25 at 6:04 a.m., R50 received a dose which was recorded as, "E." A corresponding progress note, dated 6/7/25, identified the medication was provided but lacked any recorded symptoms of pain or what, if any, non-pharmacological interventions had been attempted prior to the narcotic being provided. On 6/9/25 at 3:00 a.m., R50 received a dose which had results recorded as, "U [unknown]." A corresponding progress note, dated 6/9/25, identified the medication was provided but lacked any recorded symptoms of pain or what, if any, non-pharmacological interventions had been attempted prior to the narcotic being provided. A subsequent note, also dated 6/9/25, was authored nearly 12 hours later in the day which outlined, "[R50] presents with complains [sic] of Right hip pain ... describes as throbbing ... rated 9/10 ... Care team updated." However, again, this note lacked what, if any, non-pharmacological interventions were being attempted to reduce the PRN narcotic use, if able, or supplement it to promote comfort. On 6/10/25 at 2:59 a.m., R50 received a dose which was recorded as, "E." A corresponding progress note, dated 6/10/25, identified the medication was provided but lacked any recorded symptoms of pain or what, if any, non-pharmacological interventions had been attempted prior to the narcotic being provided. In total, the nine administered doses had only one (1) dictated note which outlined any rationale for the medication being provided (6/3/25); and all of the notes located within the record for the provided doses lacked evidence of what, if any, non-pharmacological interventions had been attempted prior to giving the PRN narcotic to see if those would help reduce the need for medication. When interviewed on 6/12/25 at 9:43 a.m., nursing assistant (NA)-M stated they had worked with R50 prior and described her as "heavy a little bit" with cares. NA-M stated R50 would "sometimes" have complaints of pain and then they just "tell the nurse." NA-M stated they didn't offer ice packs or anything to R50 but expressed they would if asked by the nurse or R50	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21535	Continued from page 31 herself. NA-M stated R50 would often just ask them "about the pain pill." NA-M expressed R50 rarely had complaints of pain until she sustained a fall (on 6/3/25) adding, "That is when the pain started." On 6/12/25 at 10:20 a.m., licensed practical nurse (LPN)-E stated they had worked with R50 prior and helped with her wound cares. LPN-E stated R50 did have complaints of pain, at times, and would often request her PRN tramadol to help. LPN-E stated they "do ask" her about using ice packs and expressed R50 would accept them, at times, adding aloud, "She does." LPN-E explained if R50 requested her PRN tramadol, then they'd assess her using the pain scale (0-10 rated) and the orders as there was possibly something else she could be given like her scheduled Tylenol. LPN-E stated symptoms of pain or the rationale for giving PRN medication should be recorded in the notes along with what non-pharmacological interventions were attempted adding, "[recorded] in the nurses notes." On 6/12/25 at 12:21 p.m., the director of nursing (DON) was interviewed. DON verified a PRN narcotic medication should have pain symptoms recorded to justify the medication along with what non-pharmacological interventions were attempted prior. DON stated this would typically be recorded in the progress notes and should be done "to show what helps." DON stated providing non-pharmacological interventions prior helps to "go minimal before you use the meds." DON stated they were reviewing R50's medical record for this information, however, hadn't finished yet so they would provide additional documentation showing this, if located. No further information was received during the recertification survey (exited 6/12/25). A facility provided Medication Administration policy, dated 3/2023, identified steps to giving medication which included, "20. Whenever a PRN medication is given, the licensed nurse/TMA [trained medication aide] administering the medication documents on the EMAR (MAR) in the appropriate space as indicated by the date and the PRN order entry," adding further the documentation should included, " ... The residents specific complaint or the symptoms for which the medication is being given." However, this policy lacked information on non-pharmacological interventions with PRN or how such should be recorded.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21535	Continued from page 32 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies for PRN narcotic use; then educate staff and audit to ensure ongoing compliance with documentation to support the use of the medication. TIME PERIOD FOR CORRECTION: 21 days	21535		
21610	Medicine Cabinet and Preparation Area;Storage CFR(s): MN Rule 4658.1340 Subp. 1 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure medications were securely stored safely and under direct observation of authorized staff in areas where residents, staff and guests could access medications in two medication carts affecting 2 of 4 units of the facility. Findings include: During a continual observation on 6/10/25 at 3:00 p.m., an unattended and unlocked medication cart was observed in the hallway of the "Bridgeway" unit against the wall right outside a resident room with two other resident room doors facing the cart. During observation, a resident was observed sitting on her walker approximately 3 feet away from the unattended unlocked medication cart. Numerous unidentified staff members walked past the cart, along with another resident and family member. At 3:18 p.m., registered nurse (RN)-H returned to the medication cart and was observed interacting with the resident on the walker, reviewing the electronic medical record, and opening the cart without unlocking it. RN-H did not remove keys from their pocket to unlock the medication cart. RN-H verified they were the nurse responsible for the medication cart, had gone on break over an hour ago, and had been working on an admission since their break. RN-H stated, "I don't remember if it was locked," when asked if the cart was locked or unlocked, adding "I am not really sure, the keys are in my pocket." RN-H	21610	corrected	07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21610	Continued from page 33 stated that it had been a long day and might have forgotten to lock it. RN-H stated it was important that medication carts were locked as there were medications and narcotics in the carts and didn't want people to come in and open it up. During an observation on 6/11/25 on 7:41 a.m., an unattended and unlocked medication cart was observed in the hallway of the "Fox Crossing" unit against the wall right outside a resident room. RN-K returned to the medication cart and verified they were responsible for the medication cart, and stated they left the medication cart when they were distracted as the aid needed assistance. RN-K verified the medication cart was unlocked and unattended, and stated they should have locked the cart before they left as other people could have gotten in the cart and taken medications that didn't belong to them and that could be dangerous for them. During an observation at 6/11/25 at 8:30 a.m., an unattended and unlocked medication cart was observed in the hallway of the "Fox Crossing" unit against the wall right outside a resident room. During the observation, two unidentified staff walked past the unlocked medication cart. Upon returning to the unlocked and unattended medication cart, RN-K verified the medication cart was unlocked and stated they should have locked it before going into the resident room. During an interview on 6/12/25 at 12:47 p.m., director of nursing (DON) stated the expectation would be unattended medication carts are locked as they contain medications. DON verified unlocked and unattended medication carts would be a safety concern. A facility policy titled Medication storage, revision date 10/21, indicated "medication rooms, carts, and medication supplies are locked or attended by persons with authorized access." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance.	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21610	Continued from page 34 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21695	Plant Housekeeping, Operation, & Maintenance CFR(s): MN Rule 4658.1415 Subp. 4 Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe, comfortable and homelike environment for 2 of 4 shower rooms reviewed for cleanliness. Also, facility failed to ensure resident walls were in good condition for 3 of 3 resident rooms (R4, R28, and R77) reviewed for concerns of peeling and chipped paint. In addition, the facility failed to ensure a hallway handrail was secured firmly to wall outside resident room. Findings include: Shower Rooms: During observation and interview on 6/10/25 at 11:34 a.m., on the long-term care unit, the counter including the sink had two opened boxes of gloves and dry washcloths, a stack of opened 4x4 gauze, opened cotton tipped applicator, a used finger lancet, two unfolded towels with an opened one-gallon bottle of shampoo and body wash, and opened 8-ounce bottle of body lotion with screwcap not applied. The upper cabinet door next to sink had a door that was halfway opened hanging by one hinge rather than secured with two hinges. On the floor in front of the sink and next to a waste basket was crumpled up paper towels, one long cotton tipped applicator, foil wrapper, and one wheelchair footrest. The floor was dry in and by the shower stall with a crumpled up towel on the floor in front of the sink. On the door inside the shower room was a sign that stated, "BEFORE YOU GO DID YOU: Empty the trash, pick up all dirty clothes and towels, Sanitized the tub or shower. Please ensure this room is ready for the next person that is going to use it." The director of nursing (DON) observed room with surveyor and stated, "No this is not	21695	corrected	07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21695	Continued from page 35 acceptable. There is a sharps right here and it is not cleaned up and put away the way it should be. The aides are responsible for cleaning up this room and after giving a bath or shower. During observation on 6/10/25 at 11:58 a.m., an unlocked shower room in memory care unit had an opened toothpaste container on the counter along with an opened bottle of body lotion. The cabinet doors adjacent to the sink had one missing handle and another one that was only attached by one of two screws hanging down. Next to the shower there was a blue knit hat and pair of eyeglasses resting on top of a bedside night table with drawers. A body wash container was opened with no cap on it. During interview with licensed practical nurse (LPN)-B on 6/10/25 at 12:04 p.m., LPN-B observed shower room and stated, "the blue hat and eyeglasses should not be in there because of sanitary [concerns]. Things need to be picked up. The handles need to be fixed or replaced." During interview with nursing assistant (NA)-A on 6/10/25 at 12:09 p.m., NA-A stated expectation of nursing assistants to clean and wipe down the shower room and pick up and remove trash after every shower. During interview with RN-H on 6/10/25 at 1:26 p.m., RN-H stated expectation of housekeeping and nursing assistant staff to wipe down and ensure every shower room is ready for next resident shower. During interview with NA-E on 6/10/25 at 1:49 p.m., NA-E stated expectation of nursing assistants to "clean up afterwards before the next person gets in there. Includes towels and garbage and we are to bring soiled linen to laundry room". Also, NA-E stated counters were to be picked up with "no open bottles of shampoo and lotion. Nothing on the floor." NA-E stated, "It is their house and it should be cleaned." During interview with NA-F on 6/11/25 at 7:11 a.m., NA-F stated the nursing assistant was responsible for cleaning up the shower room after each resident shower. Walls:	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21695	Continued from page 36 R4 R4's quarterly Minimum Data Set (MDS) dated 5/5/25 identified R4 with intact cognition and admission date to facility on 2/24/22. During observation with R4 on 6/9/25 at 5:28 p.m., R4's room had multiple scratches and peeling paint on the wall at the head of the bed. During observation and interview with R4 on 6/11/25 at 7:38 a.m., the accent wall at the head of the bed had several white scrapes through the paint into the drywall. R4 stated, "I have been here about three years. Those scrapes have been there at least a year". R4 stated she thought the scrapes were from the "bed being too close at the time and scraping it. Staff are aware of it." R4 stated "I think it looks terrible. This is my house and I don't want to see that. I want it fixed up." During observation and interview with NA-F on 6/11/25 at 7:42 a.m., NA-F stated, "I have noticed it before. Don't know if it was ever mentioned to maintenance." During observation and interview with RN-I on 6/11/25 at 8:17 a.m., RN-I stated, "Yes that should be taken care of. I don't know if a work order was placed". During observation and interview with maintenance director (M)-D on 6/11/25 at 8:26 a.m., M-D stated, "we will repair the wall. Should be done. We need to match the paint. I did not know about it". R28 R28's quarterly MDS dated 4/16/25 identified R28 with intact cognition and admission to facility on 2/8/21. During observation on 6/9/25 at 5:22 p.m., R28's had a shared room with the bed parallel to window overlooking the courtyard. The wall under the window ledge was visible from the hallway of the unit. It was light pale	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21695	Continued from page 37 yellow in color with an eight-foot-long black marking one foot up from and parallel to the floor. A two-foot section of the black marking was torn down to the paper backing of drywall. Also, the wall at the foot of the bed with the chest of drawers aligned with it had peeling paint and black staining along ten feet of the wall which led out to the hallway of unit. During observation and interview with RN-A on 6/9/25 at 5:31 p.m., RN-A stated, "I did not notice it. It is all the way down [the wall] maybe from the wheelchair". During interview with R28 on 6/9/25 at 5:32 p.m., R28 stated, "they [facility] paint over it every once in a while. I think it looks awful." During observation and interview with NA-A on 6/9/25 at 5:57 p.m., NA-A stated expectation of staff to notify maintenance through a work order. "That looks bad too. Should be painted over." NA-A stated, "I would not like to see that in my home." During interview with RN-A on 6/9/25 at 5:35 p.m., RN-A stated expectation of staff to notify maintenance through a work order if a resident's wall needed to be repaired or painted. During observation and interview with NA-E on 6/10/25 at 1:53 p.m., NA-E stated, "I would not like that in my home. It looks very horrible." During interview with trained medication aide (TMA)-C on 6/11/25 at 7:12 a.m., TMA stated staff were expected to request a work order for maintenance to fix any paint or repairs needed. During observation and interview with RN-I on 6/11/25 at 8:16 a.m., RN-I stated, "this should be addressed." During observation and interview with M-D on 6/11/25 at 8:27 a.m., M-D stated, "That is all bad. Wallpaper was there originally and the adhesive was not removed before replacing. Bad idea." R77	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21695	Continued from page 38 R77's quarterly MDS dated 3/19/25, identified R77 with intact cognition and facility admission to facility on 11/22/24. During observation and interview on 6/10/25 at 7:55 a.m., R77's accent wall aligning with head of bed was a green color with all other walls in the room a pale yellow. The green wall with the head of the bed against it had a 24-inch by 32-inch section of wall that was much lighter in color that the primary color of wall. R77 stated, "it has been like that since I have been here which is over a year". R77 stated she did not like the "patch work" on the wall and that it appeared to be a repair but not finished with matching color. During observation and interview with NA-F on 6/11/25 at 7:20 a.m., NA-F stated, "it is unfinished" and "I would not like to have those scuffs at my house". NA-F stated expectation of all staff to put in a maintenance work order for instances of paint repair. NA-F did not know if any staff submitted a work order. During observation and interview with RN-J on 6/11/25 at 8:00 a.m., RN-J looked at R77's wall and stated she was unaware of how long the mismatched colored section was present. "I think it was patched but the paint was not matched and left undone. I don't know how long it's been there". During observation and interview with M-D on 6/11/25 at 8:34 a.m., M-D looked at R77's wall and stated, "oh ok. We can do better than that." Handrail: During observation and interview on 6/9/25 at 2:38 p.m., a hallway handrail was not securely attached to the wall. Point of connection to wall was one bolt which allowed handrail to spin and rotate freely. Licensed practical nurse (LPN)-A stated, "that is not secured". Housekeeper (HK)-A stated, "not safe for someone to grab onto". During observation and interview on 6/9/25 at 3:17 p.m., maintenance assistant (M)-B was removing the	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21695	Continued from page 39 handrail and stated, "we will have to order another bolt so the unit can be attached using two bolts instead of the one here [that] allows it to spin. This is not safe. It is a life safety issue." During interview with NA-F on 6/11/25 at 7:11 a.m., NA-F stated, "I would not consider it safe to use [unsecured handrail] because there is no stability when someone grabs it." During interview with TMA-C on 6/11/25 at 7:14 a.m., TMA-C stated, "we should not use unsecured handrails." TMA-C stated expectation of all staff to notify maintenance to fix it. "Safety first." During interview with M-D on 6/11/25 at 8:36 a.m., M-D stated the handrail, "pivots and [sic]no anchoring point. We will replace it. Should not be loose so that it spins. Not safe for anyone to use." Facility policy titled Environmental Cleaning with revision date of 3/18 identified staff to "check the following areas: 1. Hinge areas, door facing and door handles". Policy on maintaining homelike environment including painting and wall repair and ensuring secured handrails was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21840	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 12 Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the	21840	corrected	07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21840	Continued from page 40 information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure written Physician's Orders for Life Sustaining Treatment (i.e., POLST) were accurately entered, transcribed and reflected in the medical record in a timely manner to help guarantee correct resuscitation measures (i.e., DNR or CPR) would be performed in accordance with resident wishes for 2 of 2 residents (R50, R321) reviewed for advanced directives. Findings include: R50 R50's admission Minimum Data Set (MDS), dated 3/11/25, identified R50 admitted to the care center on 3/5/25 from the acute care hospital, had intact cognition, and demonstrated no delusional thinking. Further, the MDS identified R50 as having a primary medical condition of, "Medically Complex Conditions," along with diagnoses of heart failure, high blood pressure, renal failure or insufficiency, and diabetes mellitus. R50's original POLST, dated 3/5/25, identified directions which included, "Follow these orders until orders change. These medical orders are based on the patient's current medical conditions and preferences." The POLST listed a series of sections to be completed using a marking (i.e., checkmark or "X") next to the desired wishes for resuscitation. This identified a checkmark placed next to the options which directed, "Do Not Attempt Resuscitation / DNR (Allow Natural Death)," and "Comfort-Focused Treatment (Allow Natural Death ..." The form was hand-signed by R50 on 3/5/25, and the medical provider on 3/7/25.	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21840	Continued from page 41 R50's progress note, dated 4/30/25, identified R50 was re-admitted to the care center from the hospital with an admission diagnosis listed, "Acute Metabolic Encephalophagy [sic]," and a subsequent note, also dated 4/30/25, identified R50 as having bilateral lower extremity cellulitis and various bruises on her arms, legs, and abdomen. R50's (Hospital) After Discharge Orders, dated 4/30/25, identified R50's physician orders upon discharge back to the care center. This included, "Treatment Options: Full Resuscitation." R50's subsequent POLST, completed upon her return to the care center and dated 4/30/25, identified R50's name and had visible markings (i.e., selected) next to the options which read, "Do Not Attempt Resuscitation / DNR (Allow Natural Death)," and, "Selective Treatment ... Treatment Plan: provide basic medical treatments aimed at treating new or reversible illness." The POLST was signed by R50 and care center staff on 4/30/25, and the nurse practitioner (NP)-A on 5/1/25. R50's Care Conference Summary - V8, dated 5/16/25, identified a care conference was held with R50, their representative, social services, and nursing on 5/16/25. The summary contained a section labeled, "2. Nursing," which asked a question to be completed by staff which read, "1. POLST and Code Status match[?]," which was answered, "1. Yes." The summary outlined R50's advanced directives were reviewed and accurately reflected their wishes with a corresponding answer, "1. Yes." However, R50's facility' electronic medical record (EMR) was reviewed on 6/9/25 as part of the routine survey process. This EMR contained R50's assessments, progress notes, and other pertinent clinical information used by the staff to provide care for R50 while at the campus. The EMR included a banner along the top of the system which contained medical information such as the patient name, date of birth (DOB), allergies, and included a section labeled, "Code Status:," which had adjacent text reading, "(Advance Directives [link; click-able]) Full Code." The link included in the banner response labeled, "Advanced Directives," brought the user to R50's scanned POLST(s) within the medical record; both of which outlined R50's DNR/DNI wishes. The EMR banner information did not reflect or identify R50's wishes from the POLST, dated 4/30/25, to be a DNR.	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21840	Continued from page 42 On 6/9/25 at 6:05 p.m., R50 was observed seated in a recliner chair while in her room on the transitional care unit (TCU). R50 had visible, white-colored bandages on both legs along with visible reddened skin on her right thigh and hip which had black-colored marker circling it's perimeter which R50 stated was a "skin infection." R50 was interviewed about her current wishes for resuscitation should she be found without a pulse or not breathing. R50 replied, "I'm a don't revive [DNR]." R50 stated she didn't want a situation to happen where her family member would have to make decisions about whether to stop life-extending measures after CPR (i.e., potential ventilation, tube feeding) adding, "I don't want my [family] to have to unplug me." R50 stated the care center had asked her about these wishes "several times" and she was frustrated there was potential confusion about it adding aloud, "I don't know why it's [DNR] not listed!" R50 stated she would be very upset if she underwent CPR against her wishes adding, "I wouldn't like it!" R50 reiterated she didn't want her family member placed in a situation of whether to end her life if she was hospitalized and on a ventilator after CPR adding, "I don't want to put [them] through all that." When interviewed on 6/9/25 at 6:10 p.m., registered nurse (RN)-B stated they were working on R50's unit and explained if a resident was found without a pulse or not breathing the first step would be "check their code status." RN-B stated this was done using the Medication Administration Record (MAR; used to pass medications from mobile laptop on carts), and pointed to an open MAR which listed a resident' name and other various clinical information including a section labeled, "Code Status," with corresponding directions (i.e., Full Code, DNR). RN-B verified the MAR is where they'd check for a code status and respond accordingly adding aloud, "We go here [MAR]." RN-B stated the health unit coordinator (HUC) was responsible to enter resident' POLST information into the EMR and nurses were not routinely auditing it to their recall adding, "The HUC [does]." RN-B stated it was important to ensure the code status matched the POLST adding if they were mis-matched then someone could get the wrong resuscitation efforts performed. RN-B added, "Chances are [they would]." When interviewed on 6/9/25 at 6:14 p.m., RN-C verified they were working on R50's unit, and stated if a resident, including R50, were found without a pulse or not breathing then staff would immediately assess them	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21840	Continued from page 43 adding if it was "a 911 issue" then they would ask the charge nurse(s) for help to get them transferred to the hospital. RN-C stated they would "immediately" start CPR on the resident if their code status directed. RN-C stated they checked for a code status using the MAR and pointed to an open example on their computer screen adding, "This [pointing] is where you find it [status]." RN-C stated the code status was not kept anywhere else to their knowledge, and expressed they were unsure whom or how the code status information on the MAR gets updated with changes adding aloud, "I don't know." RN-C explained a POLST was obtained for every resident upon admission or re-admission from the hospital if they were absent over 24 hours; and the physician typically would sign it the next time they're onsite. RN-C stated the HUC was responsible to check the accuracy for the information within the EMR and MAR, and RN-C verified the POLST and EMR should match. On 6/9/25 at 6:18 p.m., RN-D was interviewed, and verified they were currently assigned to care for R50. RN-D stated if R50 was found without a pulse or not breathing then they'd check her code status using the MAR and, if needed, begin CPR adding aloud, "We do the CPR." RN-D reviewed R50's MAR screen with the surveyor and verified it directed to perform CPR on R50 with text reading, "Full Code." The MAR lacked the click-able hyper-link to R50's POLST(s) as is present within the actual EMR system. RN-D stated since 'Full Code' was outlined, then staff "do everything" to try to resuscitate her including CPR with chest compressions. RN-D stated the HUC was responsible to enter the POLST information into the EMR and expressed, at least to their knowledge, the nurses were not auditing this adding, "They [management] have never told us to." RN-D stated they were unsure who, if anyone, double checks entered resuscitation wishes once entered into the EMR system either adding aloud, "For that one, umm, not sure." RN-D then left R50's MAR and entered into the EMR system which had the POLST(s) scanned into it. RN-D reviewed R50's most recent POLST (dated 4/30/25) and verified it was signed with wishes for DNR/DNI. RN-D stated it was likely not updated in the EMR/MAR when it was signed and should have been; however, RN-D verified they would have performed CPR on R50 as directed by the MAR until seeing the signed POLST as pointed out by the surveyor. When interviewed on 6/9/25 at 6:29 p.m., the clinical services coordinator (CSC)-A verified they were responsible to manage the HUC staff. CSC-A explained the HUC would typically be the person to enter the	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21840	Continued from page 44 POLST information into the EMR, however, if on a weekend then a nurse could do it, too. CSC-A stated when a POLST is obtained, then a corresponding order gets entered and it was important for every place with the information to match so "there's no misunderstanding or what not." CSC-A stated the nurses should be checking the entered information about code status after the HUC to ensure it is accurate adding, "Well, they're supposed to." CSC-A stated they had just recently started a "check off sheet" to audit code status within the EMR to ensure it matched the POLST for new admissions. CSC-A provided this orange-colored sheet and verified it started on 5/30/25, adding they had not been directed to go back and include residents who admitted prior to 5/30/25 (such as R50). CSC-A verified all POLST(s) were scanned into the EMR system, and none were kept within the hard chart or any other locations to their knowledge. CSC-A reviewed R50's medical record, including POLST(s) and EMR/MAR, and verified they didn't match. CSC-A expressed, "That is not good." CSC-A stated when the POLST was signed on 4/30/25, the nurses should have obtained a corresponding telephone order from the provider which would be kept within the hard chart. CSC-A then retrieved and examined the hard chart but was unable to locate this telephone order expressing the nurses "should have had it written in." CSC-A reiterated the nurses should be double-checking to ensure POLST(s) and the EMR match when POLST information is entered by the HUC. CSC-A acknowledged the potential for R50 to receive CPR against her wishes due to the mis-matched information adding aloud, "She would be revived when she doesn't want to be, which is not good." CSC-A stated the mis-matched code status information could also cause confusion about treatment as the nurses "wouldn't know which one [instructions] to follow." CSC-A stated they would immediately send an email to the medical provider to get this resolved adding, "Thank you for catching that." On 6/9/25 at 7:14 p.m., the director of nursing (DON) and unit nurse manager (RN)-E were interviewed. DON explained R50 admitted in March 2025 for wound care and was hospitalized in April 2025 before returning to the campus on 4/30/25. DON verified a new POLST was then obtained, and a corresponding telephone order was received from the NP on 5/2/25. RN-E then provided it for review. R50's sheet which was labeled, "Physician's Orders," and had three handwritten orders on it. This included, "5/2/25 [space] DNR/DNI," and was recorded as a	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21840	Continued from page 45 telephone order from NP-A. The order had two separate sets of hand-written initials next to the order. DON and RN-E both verified the DNR wishes were not updated in the EMR when this POLST was obtained. DON stated if a resident was found without a pulse or not breathing, then staff should be clicking the 'Advanced Directives' link in the EMR to review the POLST for instructions. However, when questioned on the lack of that link on the MAR system, DON and RN-E pulled up the MAR to observe. They both verified it lacked the click-able link to take nurses to the POLST(s) in the EMR and just had immediate directions listed (i.e., Full Code) adding, "It just says code status." DON verified the two staff initials present on the signed order (dated 5/2/25) was supposed to mean it was checked for accuracy within the EMR system. DON acknowledged the likelihood of R50 getting CPR against her wishes based on the error adding, "You're not wrong." DON explained a similar situation happened several months prior where a resident received CPR against their wishes at the campus and, as a result of that, they changed their process to check code status and POLST(s) for matching information around the end of May 2025; however, the DON verified they had never directed staff to go to admissions prior to that and check for accuracy. DON stated they were unsure if anyone else had, either, adding aloud, "I have no idea." DON stated it was important to ensure the POLST and EMR system matched adding, "We don't want people to not get their choices honored." DON and RN-E both verified they would have started CPR on R50 if she had been found without pulse or not breathing based on the MAR instructions directing such, and the DON expressed they felt the error was due to the nurses not checking the code status orders in the EMR after they were obtained. DON expressed, "That's the point of the two-check system," adding further, "It's unfortunate [this happened]." On 6/10/25 at 11:52 a.m., NP-A was interviewed, and verified they were involved with R50's care at the campus. NP-A stated R50 had a history of cellulitis, history of cardiac disease, and stasis ulcers adding the wounds on her legs were unlikely to ever heal. NP-A described R50 as having "several co-morbidities" with her care and medical conditions. NP-A stated R50's wounds could deteriorate "quite quickly" and cause the need for hospitalization. NP-A stated they had been involved with R50's care since she admitted back in March 2025, and expressed she was a DNR/DNI the entire time to their knowledge adding aloud, "I don't think	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21840	Continued from page 46 she's changed her mind [about that]." NP-A stated the care center nurses obtain a POLST upon admission and then the providers would address it "when here [onsite] next" adding often times the staff would wait for it to be signed before it was accepted (i.e., implemented). NP-A stated they felt R50's chances of successful resuscitation if she was found without pulse were "pretty limited," however, expressed R50 was older in age and, as a result, was at higher risk for any post-CPR issues such as fluid in the lungs or broken ribs. NP-A reiterated R50 as being unlikely to survive CPR but then added, "I've been wrong before too." A facility provided Cardiopulmonary Resuscitation (CPR) (Code Blue) policy, dated 6/2024, identified licensed staff would be certified in CPR so they could respond appropriately to victims of cardiac arrest. A procedure was outlined which directed, "All residents, upon admission, will have their code status (CPR or DNR) reviewed and placed as a Physicians Code order ... CPR or DNR (Do Not Resuscitate) stipulations will be recorded on the POLST form and after completion of Section B and signature by MD/GNP [medical provider] will be filed under the advance directive tab in the chart." The policy continued, "Code status physicians orders will be verified prior to initiating CPR. Verification of full code status should not significantly delay initiation of CPR." The policy directed CPR should be performed on a resident unless they have clinically irreversible signs of death (i.e., decapitation) or, "The patient has a Do Not Resuscitate (DNR) order is in place." However, the policy lacked any further information on where staff should go to obtain the most recent code status order (i.e., MAR, EMR, POLST) in an emergency situation. R321 R321's entry MDS was 6/6/25. An admission MDS had not been completed at this time. R321's face sheet indicated R321 admitted to the facility on 6/6/25. R321's diagnosis sheet included the following diagnosis: parkinsonism (a clinical syndrome characterized by tremors, rigidity and postural instability), restless legs syndrome, bipolar disorder (a disorder associated with episodes of mood swings	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21840	Continued from page 47 ranging from depressive lows to manic highs) and unspecified symptoms and signs involving cognitive functions and awareness. R321's Provider Orders for Life-Sustaining Treatment (POLST), signed by R321 on 6/6/25, identified R321 wishes where "Do Not Attempt Resuscitation/DNR (Allow Natural Death)" which was indicated by a check mark in a box in section A. Section B indicated R321's wishes were selective treatment which would not include intubation, advanced airway interventions or mechanical ventilation. The provider signed the document on 6/9/25 (three days after resident's wishes were known). During an interview on 6/09/25 at 6:30 p.m., registered nurse (RN)-B verified that they were responsible for R321's care as they were the nurse responsible for R321's this shift. RN-B reviewed R321's electronic medical record (EMR) and stated R321 was a full code. RN-B stated that if R321 was found unresponsive "we would call 911 and do everything possible," including CPR. RN-B stated they were trained to look at the banner in the EMR for a resident code status in an emergency. RN-B stated R321 should have a POLST in the chart but was unsure where to find it and re-iterated, "we go by the banner in the chart in an emergency." RN-B stated again, "we would start CPR on her since she is full code." During an interview on 6/09/25 at 7:02 p.m., R321 stated that if her heart were to stop, she has made it clear to staff to "just let me go" and stated "I don't want them to do anything." R321 stated she had signed a document that indicated this. R321 stated she would be very upset if CPR was performed on her in an emergency and she wouldn't feel very good about it. R321 stated, "I have stated my wishes clearly." During an interview on 6/9/25 at 7:31 p.m., registered nurse manager (RN)-E stated R321 was listed as a full code as the provider signed the POLST today (6/9/25). RN-E stated even if a resident signed a POLST, it would not be active until the provider signed it, even if it was days later. RN-E verified R321 signed the POLST on 6/6/25, indicating her wishes were to be DNR, however she continued to be listed as FULL code until 6/9/25 when the provider signed the POLST. RN-E again stated, "it is not an active order until the provider signs it."	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21840	Continued from page 48 On 6/10/25 at 11:52 a.m., NP-A was interviewed, and verified they rounded on the transitional care unit (TCU) often. NP-A stated the care center nurses obtained a POLST upon admission and then the providers would address it "when here [onsite] next" adding often the staff would wait for it to be signed before it was accepted (i.e., implemented). NP-A stated they were aware the nurses also called and obtained a telephone order for code status despite the POLST, and expressed in "my opinion" a signed POLST would be an order. NP-A acknowledged with the current process a POLST "could sit for a little bit" before getting a provider signature, and expressed the nurses could send it to triage for a signature, too. NP-A stated they were unaware of the triage providers being unwilling to sign POLST(s). During an interview on 6/12/25 at 12:48 p.m., director of nursing (DON) verified that she had not talked to the medical director about the triage providers not wanting to sign POLSTs without seeing the residents which caused the lapse in POLSTs being signed prior to the immediate jeopardy. DON stated it had now been addressed. A facility provided Cardiopulmonary Resuscitation (CPR) (Code Blue) policy, dated 6/2024, identified licensed staff would be certified in CPR so they could respond appropriately to victims of cardiac arrest. A procedure was outlined which directed, "All residents, upon admission, will have their code status (CPR or DNR) reviewed and placed as a Physicians Code order ... CPR or DNR (Do Not Resuscitate) stipulations will be recorded on the POLST form and after completion of Section B and signature by MD/GNP [medical provider] will be filed under the advance directive tab in the chart." Furthermore, the document lacked identification to obtain a provider order (i.e., verbal order) in a timely fashion to ensure the resident's wishes are honored after their wishes have been identified. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review the facility policy related to advanced directives and provide education to all staff. The administrator, director of nursing (DON), or designee could monitor for records for ongoing compliance. The facility could report those finings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance.	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21840	Continued from page 49 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21840		
21860	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 16 Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This LICENSURE REQUIREMENT is NOT MET as evidenced by: During observation and interview, the facility failed to implement interventions to ensure resident's personal care information was kept secured and out of public view when stored on 2 of 4 facility units with mobile medication carts. This had the potential to affect 9 of 9 residents (R8, R106, R110, R173, R174, R177, R325, R326, and R330) on the transitional care unit, and 3 residents (R70, R88, and R99) on the long-term care unit whose private and personal information was left unattended on medication carts left out in the hallway corridor. Findings include: During continuous observation and interview on 6/9/25 at 12:29 p.m. to 12:37 p.m., on the transitional care unit of facility, an unattended medication cart with visible care sheet exposing "TEAM 4 NURSES CENSUS SHEET" including columns with resident name, room number, diagnoses, bath days, diet orders, nursing care notes, skin impairment and labs. This included 9 residents. Housekeeper (HK)-A walked past the unattended care sheet and stated, "I know the patient information should not be showing." In addition, there were thirteen instances of staff walking past the unattended care sheet and one instance where a resident	21860	corrected	07/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21860	Continued from page 50 was being transported in a wheelchair past the unattended cart. At 12:37 p.m., licensed practical nurse (LPN)-A approached the unattended med cart and stated, "[care sheet] should not have been left like that. People can see the names and information for these people [pointing to the care sheet] and it is a HIPAA issue." During continuous observation and interview on 6/9/25 at 5:36 p.m., on the long-term care unit, registered nurse (RN)-A walked away from medication cart with visible care sheet titled "Fox Crossing Group 3 Nurse Report Sheet" left unattended and exposing R70, R88, and R99 personal information. RN-A had medications in a medication cup and walked into another residents' room. During this time two staff walked past the medication cart. At 5:42 p.m., RN-A returned to the medication cart and stated, "It is not my info sheet. I don't know whose sheet that is. It should be covered." In addition, RN-A stated, "[patient information] not supposed to be visible because of HIPAA law and private information". During interview with RN-B on 6/9/25 at 6:26 p.m., RN-B stated expectation of staff to ensure resident care sheets are covered at all times, "for privacy and HIPAA purposes. Resident information is there." During interview on 6/10/25 at 8:59 a.m., trained medication aide (TMA)-A stated expectation of nursing staff, "to lock cart and lock [computer] screen for HIPAA. Care sheets should not be left unattended due to HIPAA privacy". Facility policy titled Confidentiality and HIPAA Compliance effective date of 10/24, identified "all resident information remains confidential and protected from unauthorized access or disclosure". SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for maintaining confidentiality of records. All staff could be educated as necessary to the importance of complaince with handling and securing medical records. The DON or designee, could perform observational audits to ensure staff are locking access to medical records when not physically present. The DON or designee could take that information to QAPI to determine the need for further monitoring or	21860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/12/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	**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
21860	Continued from page 51 compliance. TIME PERIOD FOR CORRECTION: (21) days.	21860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET** **BLOOMINGTON, MN 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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/10/2025. 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/08/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET** **BLOOMINGTON, MN 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
K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET** **BLOOMINGTON, MN 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
K 000	Continued From page 2 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 120 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is	K 222		7/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET** **BLOOMINGTON, MN 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
K 222	Continued From page 3 protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.5.1 and 19.2.2.2.6. These deficient	K 222	Egress doors have been modified so that there is an electronic keypad to use for emergency exit. All staff have been educated on the passcode to exit and are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET** **BLOOMINGTON, MN 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
K 222	Continued From page 4 findings could have a patterned impact on the residents within the facility. Findings include: 1. On 06/10/2025 at 11:48 AM, it was revealed by observation that the gate that is used to exit the Bridgeway court yard has a keyed lock to exit, and the Director of Environmental Services informed me that only supervisors have the key to unlock the gate at night. 2. On 06/10/2025 at 11:56 AM, it was revealed by observation that the gate that is used to exit the Fox Cross courtyard has a keyed lock to exit, and the Director of Environmental Services informed me that only supervisors have the key to unlock the gate at night. An interview with the Director of Environmental Service and the Administrator Intern verified these deficient findings at the time of discovery.	K 222	able to use it for emergency exit only. Work order task entered and checked monthly by maintenance. Audits will be monitored by the MLCC Safety Committee monthly to determine if further action is necessary. The Director of Environmental Services or designee is responsible for compliance.	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement	K 346	Policy was reviewed and revised to state facility must contact the Fire Marshal if the	7/8/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET** **BLOOMINGTON, MN 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
K 346	Continued From page 5 a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/10/2025 between 09:30 AM and 12:15 PM, it was revealed by a review of available documentation that the fire alarm out of service policy that was provided at the time of the survey stated to contact the Deputy State Fire Marshal when the system was down longer than 10 hours which is longer than the required 4 hours. An interview with the Director of Environmental Services and the Administrator Intern verified these deficient findings at the time of discovery.	K 346	fire panel is down for more than 4 hours or if the sprinkler system is down for more than 10 hours. Administrator and EVS Director were educated on new policy. System for sprinkler system and fire panel are checked daily by environmental services. Language in policy has been reviewed and revised. Audits will be monitored by the MLCC Safety Committee monthly to determine if further action is necessary. The Director of Environmental Services or designee is responsible for compliance.	
K 363 SS=D	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	K 363		7/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET BLOOMINGTON, MN 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
K 363	Continued From page 6 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 REQUIREMENT 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 and 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/10/2025 at 12:01 PM, it was revealed by observation that the door to resident room 143 was propped open with a trash can. An interview with the Director of Environmental Services and the Administrator Intern verified these deficient findings at the time of discovery.	K 363	Garbage can was removed from resident door. Education was provided to all staff that nothing should remain in residents doorway or assist in propping door open. All staff educated on how to enter a work order if repairs need to be made. Audits will be completed by 3 times per week for 3 weeks to ensure doorways are clear of any items. Audits will be monitored by the MLCC Safety Committee monthly to determine if further action is necessary. The Director of Environmental Services or designee is responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET** **BLOOMINGTON, MN 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
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install emergency lighting in Emergency Power systems (EPS) equipment locations per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 7.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/10/2025 at 10:18 AM, it was revealed by observation that the facility did not have emergency lighting installed in the electrical room that contained the emergency generator transfer switch. An interview with the Director of Environmental Services and the Administrator Intern verified these deficient findings at the time of discovery.	K 911	Emergency lighting was installed in room on 6/17/25. The Director of Environmental Services has been educated on the policy. Audits have been added to the preventative maintenance log and will be completed once per month to ensure emergency lighting is adequately working. Audits will be monitored by the MLCC Safety Committee monthly to determine if further action is necessary. The Director of Environmental Services or designee is responsible for compliance.	6/17/25
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords	K 920		6/11/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET** **BLOOMINGTON, MN 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
K 920	Continued From page 8 Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, and NFPA 70, (2011 edition), National Electrical Code, sections 400.8. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 06/10/2025 at 11:52 AM, it was revealed by observation that an extension cord was being used in the TCU dining room to power plant	K 920	Extension cord was removed on 6/11/2025. Education for all staff that use of extension cords for permanent use are not permitted. This has been added to environmental services rounding sheet done monthly to ensure extension cords are not being utilized within the building. Audits will be completed daily during environmental services rounding. Audits will be monitored by the MLCC Safety Committee monthly. The Director of Environmental Services or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET** **BLOOMINGTON, MN 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
K 920	Continued From page 9 lighting. An interview with the Director of Environmental Services and the Administrator Intern verified these deficient findings at the time of discovery.	K 920	designee is responsible for compliance.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full	K 923		7/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET** **BLOOMINGTON, MN 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
K 923	Continued From page 10 cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.6 and 11.6.2.3 (11). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/10/2025 at 11:59 AM, it was revealed by observation that two oxygen cylinders that were stored in the oxygen room FC9 were not on a stand or cart. An interview with the Director of Environmental Services and the Administrator Intern verified these deficient findings at the time of discovery.	K 923	The oxygen canisters were placed in an appropriate cart immediately. Education was provided to all staff on the proper storage of oxygen canisters. This has been added to the work order system for weekly auditing to ensure proper storage of oxygen tanks throughout the building. Audits will be completed twice weekly for 6 weeks. Audits will be monitored by the MLCC Safety Committee monthly to determine if further action is necessary. The Director of Environmental Services or designee is responsible for compliance.	
K 930 SS=D	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to safely store liquid oxygen per	K 930	The unused liquid oxygen container was removed from resident room 143.	7/14/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTIN LUTHER CARE CENTER	**1401 EAST 100TH STREET** **BLOOMINGTON, MN 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
K 930	Continued From page 11 NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/10/2025 at 12:01 PM, it was revealed by observation that one liquid oxygen container was being stored not connected or in use in resident room 143. An interview with the Director of Environmental Services and the Administrator Intern verified these deficient findings at the time of discovery.	K 930	Education provided to nursing staff and housekeeping on use and procedures of liquid oxygen canisters. The oxygen storage policy was reviewed and does not require revisions. Audits will be completed 3 times weekly for 3 weeks liquid oxygen tanks is removed from resident room. Audits will be monitored by the MLCC Safety Committee monthly to determine if further action is necessary. The Director of Environmental Services or designee is responsible for compliance.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 22, 2025

Administrator
Martin Luther Care Center
1401 EAST 100TH STREET
BLOOMINGTON, MN 55425

RE: CCN: 245272
Cycle Start Date: June 12, 2025

Dear Administrator:

On June 30, 2025, we notified you a remedy was imposed. On August 28, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 14, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 15, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 30, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 15, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 14, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 22, 2025

Administrator
Martin Luther Care Center
1401 EAST 100TH STREET
BLOOMINGTON, MN 55425

Re: Reinspection Results
Event ID: U3C3-H2

Dear Administrator:

On July 30, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 12, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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