

|   |  |  |  |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245272 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>06/21/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Martin Luther Care Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1401 East 100th Street<br>Bloomington, MN 55425 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

|  |   |
|--|---|
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649</b></p> <p>Based on interview and record review the facility failed to report an allegation neglect to the State Agency (SA) within 24 hours for 1 of 1 resident (R1). R1 was given the incorrect medications at the facility, which required R1 to be sent to the hospital for bradycardia (low heart rate), pain and anxiety.</p> <p>Findings include:</p> <p>R1's care plan dated 6/12/24 indicated R1's diagnoses included pneumonia, shortness of breath, saddle embolus of the pulmonary artery with acute cor pulmonale (a large blood clot that lodges in the pulmonary artery obstructing blood flow to both lungs), chronic pain, stage 3 kidney disease, hypertension (high blood pressure), cerebral infarction (stroke), hemiplegia and hemiparesis affecting the left side (weakness), osteoarthritis, and depression.</p> <p>R1's medication/treatment error report dated 6/15/24 at 9:15 a.m. indicated R1 was given Keppra (an anticonvulsant), metoprolol (a beta blocker to treat high blood pressure), and clopidogrel (a blood thinner). The description of the error indicated the nurse on the cart pulled out a patient's medications and did not check the right room. She entered the room and gave the medications to R1 not knowing she was in the wrong room. The provider was notified and gave orders to monitor R1's blood pressure, pulse, and respirations every 30 minutes, monitor for sedations and bleeding. R1 was to be hydrated and hold his morning Gabapentin (indicated for nerve pain, apixaban (blood thinner), methocarbamol (a muscle relaxant) and assess before the next dose.</p> <p>R1's progress note dated 6/15/24 at 1:17 p.m. indicated R1 had taken the wrong medications. His vital signs were within normal range expect his heart rate. The on-call provider was notified and R1 was sent to the hospital for close evaluation.</p> <p>R1's Hospital Emergency Department after visit summary dated 6/15/24 indicated R1 was seem for 1. drug overdose: multidrug. 2. Metoprolol organ tablet. The reason for R1's visit was he was given the wrong medications. His diagnosis was medication reaction. Labs taken were a complete blood culture (CBC) with platelets and differential and a complete metabolic panel. Imaging Tests included a 12-lead electrocardiography (EKG). R1 was given Tylenol, Lidocaine (for irregular heart rate), and Oxycodone was given twice for pain.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245272   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>06/21/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Martin Luther Care Center  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1401 East 100th Street<br>Bloomington, MN 55425 |  |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |  |  |  |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory for Mental Status (BIMs) score was 15 indicating R1 was cognitively intact. R1's MDS did not indicate his diagnoses.</p> <p>Upon interview on 6/20/24 R1 stated he was given the wrong medications at the facility. He stated his stomach began to hurt and he left like he was going throw-up. He stated he had never been so terrified in his life, stating he felt like his chest was going to collapse. R1 stated he did not know if the feeling in his chest was due to the incorrect medications being administered or if the medications were hurting him.</p> <p>Upon interview on 6/20/24 at 3:05 p.m. registered nurse RN-A, the unit manager stated R1 was given another resident's medications on 6/15/24 which was a Saturday. She stated she was not aware of the incident until 6/17/24 the following Monday upon reporting to work. She stated she was not certain why the incident was not reported to the SA over the weekend when R1 required hospitalization .</p> <p>Upon interview on 6/20/24 at 4:12 p.m. family member (FM)-A stated she was visiting R1 shortly after the medication error occurred. She stated the medication error caused him great anxiety, which was still lingering as R1 does not trust the staff at the facility anymore. She stated she felt like she could not trust the facility as well since the medication error caused his heart rate to drop 46 beat per minute. She stated the medication error keeps her awake at night.</p> <p>Upon interview on 6/21/24 at 1:15 p.m. RN-B, the nursing educator stated the medication error should have been reported. She stated her rationale was R1 was exhibiting a low heart rate of 46 and a change in sedation. RN-B stated, if anything prompts them to be sent out it would be a VA (vulnerable adult report).</p> <p>Upon interview on 6/21/24 at 1:37 p.m. the Administrator stated she chose not to report the medication error incident at the time because R1 did not have serious bodily harm.</p> <p>A facility policy titled Vulnerable Adult - Adult Prohibition Plan dated 10/6/22 indicated Mandated reporters in skilled nursing facilities ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported, and a report made immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials in accordance with State law through established procedures. The report will be made to the Minnesota Department of Health (MDH)/OHFC. To identify and meet this VAA reporting obligation, follow these procedures: Neglect Is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm pain, mental anguish, or emotional distress.</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245272  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>06/21/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Martin Luther Care Center  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1401 East 100th Street<br>Bloomington, MN 55425 |  |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |   |  |  |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649</b></p> <p>Based on observation, interview, and record review the facility failed to provide pharmaceutical services to meet the needs for 1 of 4 residents (R4) reviewed for medication administration. R4 had an over-the-counter medication on his tray table that he had been taking for approximately two weeks, the facility failed to monitor his intake of the medication. This medication had an interaction with a prescription medication R4 was taking.</p> <p>Finding include:</p> <p>R4's self-administration of medication assessment dated [DATE] indicated:</p> <ul style="list-style-type: none"> <li>-Required assistance for storing medications in a secure location.</li> <li>-Required assistance for opening and closing medication containers.</li> <li>-Could count not accurately tell time to know when medications need to be taken.</li> <li>-R4 did understand that skipping a medication dose is a refusal and staff will be notified when refusal has occurred.</li> <li>-Required assistance administering eye drops/ointments, topical lotions, ear drops, suppositories, subcutaneous injections, nasal sprays, and oral medications.</li> <li>-Required assistance naming his medications and their prescribed use.</li> <li>-Fully capable of reading the labels for medications.</li> <li>-Required assistance to identify common side effects of medications.</li> <li>-Required assistance with time of medications, dosage, proper amount, and documentation of self-administration of medications.</li> <li>-Required assistance with being able to identify when needing a prn (as needed) medication.</li> </ul> <p>R4 was not approved for self-administration of medications or to keep medications at bedside.</p> <p>R4's care plan dated 6/12/24 did not indicate R4 was able to self-administer any medications.</p> <p>R4's admission Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory for Mental Status (BIMs) score of 15 indicating R1 was cognitively intact. R1's diagnoses were Rhabdomyolysis (breakdown of muscle tissue that releases damaging protein into the blood), unspecified fall, unspecified symptoms and signs of cognitive functions and awareness, abnormalities with gait and mobility, and Type 2 Diabetes Mellitus.</p> <p>(continued on next page)</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245272  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>06/21/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Martin Luther Care Center  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1401 East 100th Street<br>Bloomington, MN 55425 |  |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |   |  |  |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Upon observation and medication review on 6/21/24 at 8:57 a.m. R4's medication Rosuvastatin 20 mg (a statin to treat high cholesterol) card indicated to not take aluminum, magnesium, or antacids within two hours of the medication. Registered nurse (RN)-C administered all R4's morning medications including the Rosuvastatin. On R4's table was a bottle of over-the-counter Roloids. RN-C asked R4 if the facility knew he had the Roloids. R4 stated that the facility was aware. RN-C did not question R4 when he had taken the Roloids last or how often he takes them. RN-C did not remove the Roloids from R4's room.</p> <p>Upon interview on 6/21/24 at 9:10 a.m. RN-C stated it was fine for R4 to have the Roloids in his room since the facility knew about them. He stated they should not cause any adverse effects.</p> <p>Upon interview on 6/21/24 at 9:14 a.m. R4 stated his family member (FM)-B brought in the bottle of Roloids after he had been admitted . R4 stated he FM-B her to bring him some antacids because when he had daily heartburn, he would not have wait for staff to give him a medication due to long wait times. R4 stated he did not think he was on any other medications for heartburn. R4 stated the Rolaid had been on his tray table for a few weeks.</p> <p>Upon interview on 6/21/24 at 10:34 a.m. FM-B stated she brought R4 a bottle of antacids due to his frequent heartburn and it takes the staff so long to answer his call light, she thought it was a good idea that he keeps his own bottle. She stated she brought the medications in about 6/12/24 or 6/13/24.</p> <p>Upon interview on 6/21/24 at 11:38 a.m. the pharmacist stated that R4 having the Roloids at his bedside was a concern because it did interact with R4's Rosuvastatin and the facility was not monitoring the use so the pharmacy could not address how much and how often R4 was taking the medication. R4 stated their pharmacy consultant would be doing a full assessment as soon as possible to assure R4 is taking the correct medication for his heartburn.</p> <p>Upon observation and interview RN-A the nurse manager stated she was unaware that R4 had the Roloids in the room. She stated the bottle should have been removed and the provider and pharmacy should have been notified. She stated she was not aware of any contraindications of the Roloids with any other medications R4 was taking.</p> <p>Upon interview on 6/21/24 at 1:37 p.m. the Administrator stated if a resident is not allowed to self-administer their own medications, then the nurse staff would remove the medication from the room. If the nurse sees it, we don't rifle through their things.</p> <p>A facility policy titled Medication Administration - General Guidelines dated 3/10/23 indicated Residents are not allowed to self-administer any medication unless specifically authorized to do so by their attending physician/nurse practitioner and then only in accordance with the procedure for Self-Administration of Medications. Medications in a resident's room must be secured or maintained in the medication's cart/room. A physician's order is to be obtained when a resident is involved with self-administration of his/her medications in any way:</p> <p>If a resident keeps his/her medications at the bedside, an order similar to the following is to be obtained:<br/>resident self-administer medications- medications kept at bedside (this would include prescription medications and over-the-counter medications). The Resident is instructed to report use of PRN.</p> |  |  |