

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Martin Luther Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 East 100th Street 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.</p> <p>Findings include:</p> <p>Shower Rooms:</p> <p>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 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.</p> <p>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.</p> <p>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.</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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Walls:</p> <p>R4</p> <p>R4's quarterly Minimum Data Set (MDS) dated [DATE] identified R4 with intact cognition and admission date to facility on 2/24/22.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>R28</p> <p>R28's quarterly MDS dated [DATE] identified R28 with intact cognition and admission to facility on 2/8/21.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>During observation and interview with RN-I on 6/11/25 at 8:16 a.m., RN-I stated, this should be addressed.</p> <p>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.</p> <p>R77</p> <p>R77's quarterly MDS dated [DATE], identified R77 with intact cognition and facility admission to facility on 11/22/24.</p> <p>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 than 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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>Handrail:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.</p> <p>Findings include:</p> <p>During survey entrance on 6/9/25 at 11:00 a.m., the facility provided a document titled Mealtimes for [NAME], TCU, Eagle Crest, Prairie Spirit:</p> <p>Breakfast-7:45 am</p> <p>Lunch-11:45 am</p> <p>Dinner-4:45 pm.</p> <p>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.</p> <p>Review of resident council (RC) meeting minutes for:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>11/11/24: residents reported that meals are being served late</p> <p>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.</p> <p>3/10/25: Residents reported staff and residents are still struggling at times to use the new ordering system.</p> <p>4/7/25: residents turned in a petition for returning to the old menu system (paper)</p> <p>6/9/25: Residents reported that service is still slow at times and food is cold at times;</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>R1</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], 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.</p> <p>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.</p> <p>R3</p> <p>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.</p> <p>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 an issue for awhile.</p> <p>R40</p> <p>R40's quarterly MDS, dated [DATE], indicated R40 had intact cognition with no hallucinations or delusions and was independent with eating.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>R113</p> <p>R113's admission MDS, dated [DATE], indicated R113 had intact cognition with no hallucinations or delusions and was independent with eating.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Facility policy on food temperatures and timing of serving food was requested but not received.</p>