STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245272	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	1401 East 100th Street Bloomington, MN 55425

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 33925 Based on observation, interview and document review, the facility failed to ensure timely assistance with elimination care was provided, when requested, to promote dignity and reduce the risk of complication (i.e., incontinence) for 1 of 2 residents (R182) reviewed for dignity with personal care. Findings include: R182's N Adv Brief Interview For Mental Status (BIMS) Evaluation (a screening tool used to determine cognition), dated 4/10/24, identified R182 had intact cognition. On 4/15/24 at 5:45 p.m., R182 was observed lying in bed while in her room. R182 was interviewed, and explained she had admitted to the care center about a week prior and was mostly bed-ridden due to a sustained injury adding she could only use a bed pan for various elimination needs due to the immobility. R182 stated the biggest complaint about the care center was staff who respond to her calls for assistance, and then express they will be right back but not then return timely, if at all. R182 stated this had happened many times since she admitted . On 4/17/24 at 8:46 a.m., medication administration was observed with registered nurse (RN)-D preparing medications for R182's roommate at a mobile cart in the hallway of the transitional care unit (TCU). RN-D then brought the prepared medications to R182's roommate who was in the shared room. As RN-D entered the room, with the surveyor present, the nursing assistant (NA)-D was inside and asked aloud, I need help turning her [R182]. NA-D then left the room while RN-D provided R182's roommate with medication. RN-D then left the room saying aloud, I am going to chart [the medications]. At 8:49 a.m., R182 was observed lying in bed with a pink-colored bed pan present sitting by her feet and her covered meal tray on her bedside table. R182 stated aloud, I won't be able to go [void/eliminate] by the time everybody gets here, that's the way that works. At 8:52 a.m., R182 remained lying in bed and no staff, including NA-D or RN-D had returned to provide assistance. R182 stated she wished the care center would adjust night shift staff's hours to better help with early morning cares. R182 looked at the wall-mounted clock in her room and explained she had first asked for help around five to ten after eight [a.m.], but added, I can't be sure. R182 stated staff then responded pretty quick but, again, then said they would be right back adding, Then I never saw her again. R182 stated she then used the call light to get help with the bed pan and this gal [NA-D] responded just before the surveyor entered the room with RN-D present. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 8:57 a.m., a physical therapist assistant (PTA)-A entered the room and stated they wanted to check on R182 for a morning therapy session. PTA-A stated aloud, How's it going? R182 responded with, My legs' really been hurting, adding, I am still waiting for the bed pan. PTA-A acknowledged R182 waiting and responded, I will check back later. PTA-A then left the room. At 8:59 a.m. (over 10 minutes later), R182 remained in bed with no assistance being provided yet. R182 stated having to wait for help caused her to feel, Frustrated. R182 stated situations like this, with having to wait for help to return, happened often and expressed aloud, This is awful, adding further, You're here for help and it just seems like they don't have it to give. R182 stated her meal tray had arrived just a few minutes before you came [surveyor entered the room], and expressed she ordered pancakes but, after waiting so long for help, added aloud, They won't be hot cakes any longer. At 9:09 a.m., R182 remained in bed with neither RN-D or NA-D having returned to assist her with the bed pan. R182 stated she no longer needed to use it though as the urge had passed due to waiting so long for help adding, That's not good, either. At 9:12 a.m. (over 20 minutes later), R182 remained without any return of staff to help assist her with elimination as she had requested. As a result, the surveyor alerted NA-B and registered nurse unit manager (RN)-E, whom were in the hallway outside R182's room, about R182's need for help. NA-B immediately donned a gown and entered to assist R182. At 9:15 a.m., NA-D, whom had originally said they needed help to turn R182 to provide the bed pan, was observed pushing another resident to their room from the dining room. Immediately following, RN-D was interviewed and explained they were still trying to find someone to help turn R182 when NA-D joined the conversation. NA-D stated they had got pulled to the other side to help and verified they had not yet returned to R182's room to either assist or provide an explanation for the delay in care. NA-D stated the delay, in part, was due to the morning meal tray pass adding, It's hard cause of the trays. NA-D stated staff typically always tried to respond to call lights and resident' requests timely. When interviewed on 4/17/24 at 9:18 a.m., RN-D verified they had not returned to assist R182 since themselves and the surveyor entered the room. RN-D stated they thought NA-D was going to help but then NA-D left the area and did not tell me adding there had been some confusion about the situation and who exactly was going to assist her. RN-D stated staff usually tried to respond right away, but again reiterated, We got confused. RN-D stated they felt call lights and requests were often addressed timely, however, the shift that day had someone show up late which also had caused some delays. Further, RN-D stated it was important to ensure resident' requests for assistance were met timely to promote quality of life adding, We don't want them to suffer. R182's provided Responder 500 Report, dated 4/17/24, identified R182's call light activation and response times for the period. This identified R182 activated her call light at 8:37 a.m. and staff responded seven minutes and 53 seconds later (approximately 8:45 a.m.). On 4/17/24 at 11:10 a.m., RN-E was interviewed. RN-E explained staff often times will be helping a resident with care when another needs assistance so, as a result, staff were told to check in with the resident and let them know when they could return to help them. However, that morning (on 4/17/24), a staff member had accidentally slept in which caused the NA(s) to be moved to other units and switched around which may have caused a miscommunication. RN-E stated a NA being pulled or moved happened on a weekly basis and expressed staff should ensure they're communicating with each other adding they needed to do some education with them. RN-E stated it was important to ensure resident' requests for help were addressed timely as, Customer service is number one. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A provided Dignity policy, dated 10/21, identified the care center promoted care for residents' in a manner and environment which maintained or enhanced their dignity and respect adding, This means staff must carry out activities which assists the resident to maintain and enhance his/her self-esteem and self-worth. A series of examples were provided under a section labeled, Procedure, however, timely response to a resident' request was not listed.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview and document review, the facility failed to ensure complaint investigations regarding the facility during the three preceding years, and any plan of correction in effect with respect to the facility and posting of notice of availability of such reports were posted in areas of the facility that were prominent and accessible to the public. This had the potential to affect all 132 residents, families and visitors who may have wished to review the information. Findings include: According to the Federal database Automated Survey Processing Environment (ASPEN) in 2023, facility had in-person complaint investigations on 4/3/23, 6/22/23,5/18/23, 6/8/23, 6/21/237/20/23, 8/2/23, 9/28/23. Per ASPEN deficiencies were issued for 5/18/23 and 8/2/23. During observation on 4/17/24 at 11:08 a.m., review of [NAME] Care Center Annual State Survey Results located in main lobby of facility on small table inside front door failed to include any complaint investigation results including the facility's plan of correction were present for the year 2023. Facility lobby also failed to have any posting of notice of availability of such reports. During interview with administrator on 4/17/24 at 12:47 p.m., administrator stated she was responsible for updating the [NAME] Care Center Annual State Survey Results binder in the lobby with survey and complaint results. Administrator stated, .I know I have put the complaint results in that binder. The binder should have complaint and survey results for the past 3 years. Also, the administrator stated there was no signage in the binder, lobby or elsewhere in the facility to indicated where the residents, family, and visitors could review complaint survey results. Facility policy titled Required Postings-State Survey Results with revision date of 6/1/23 directs, Survey results must be: 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. Also, DEFINITIONS: Results of the most recent survey means the Statement of Deficiencies and the Statement of Isolated Deficiencies generated by the most recent standard survey and any subsequent extended surveys, and any deficiencies resulting from any subsequent complaint investigation(s).

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 44656 Based on observation, interview and document review, the facility failed to ensure resident medical records which contained private, medical, and personal information were kept private and not accessible to unauthorized personnel for 2 of 2 residents (R230 and R6) reviewed for privacy. Findings include: During observation on 4/16/24 at 8:19 a.m., an unattended medication cart in the hallway in the west side of the Transitional Care Unit (TCU) with laptop open to R230's medication list was observed. During interview with registered nurse (RN)-A on 4/16/21 at 8:21 a.m., RN-A stated he was responsible for the unattended TCU medication cart with R230's medication list visible on the laptop screen. RN-A stated, when I leave med cart I should hide the resident info on the laptop and lock med cart. During observation and interview on 4/18/24 at 1:27 p.m., an unattended medication cart with a laptop open to R6's electronic medical record was observed in the 2nd floor east hallway of the long term care unit of facility. RN-G approached medication cart with a rolling vital sign equipment and stated she was responsible for the unattended medication cart and, yes this screen is visible to anyone who is near and I should not have left it open. I am so busy and forgot. It should be closed when I leave the cart for patient privacy and HIPAA (health insurance portability and accountability act). During interview with charge nurse, RN-C on 4/17/24 at 8:08 a.m., RN-C stated, When you leave [it], med cart is to be locked and screen locked for patient privacy. During interview with RN-F on 4/18/24 at 8:26 a.m., RN-F stated, any time I leave the med cart, I turn screen off of computer with any kind of patient information shown and lock the cart. [It is] important for patient privacy. During interview with director of nursing (DON) on 4/18/24 at 12:11 p.m., DON stated, [left open laptops] with patient identifying information should never be visible [to anyone but authorized staff] and the rationale as, patient privacy of records. Facility policy titled Medication Administration-General Guidelines with review date of 3/10/23, state, privacy is maintained at all times for all resident information (e.g., MAR) by blanking the computer screen when not in use.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene care (i.e., nail care) was provided for 1 of 1 resident (R64) reviewed for activities of daily living (ADLs) who was dependent on staff for their care. Findings include: R64's quarterly Minimum Data Set (MDS) dated [DATE], indicated R64 had moderate cognitive impairment, needed substantial/maximal assistance with personal hygiene, dressing, eating, oral hygiene and was dependent on toileting and showering. R64's MDS did not indicate behaviors or refusal of cares. R64's Clinical Diagnosis Report printed 4/18/24, indicated diagnoses of vascular dementia (problems with reasoning, planning, judgement, memory, and other thought processes caused by brain damage from impaired blood flow to the brain), type II diabetes mellitus with diabetic neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), major depressive disorder, peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), below left and right knee amputation, and hypertension. R64's Activities of daily living (ADL) care plan indicated R64 had a self-care performance deficit and required assistance with personal hygiene. R64's care plan, MDS and electronical medical record lacked documentation R36 refused personal cares. During observation on 4/15/24 at 6:13 p.m. R64's nails were about 0.4 centimeters (cm) long and had black debris underneath his fingernails. During observation on 4/16/24 at 1:14 p.m., R64 was in bed watching television, scratched his head and touched his face several times. R64 fingernails were about 0.4 cm long and had black debris underneath. R64 was able to answer some questions but did not talk about his fingernails. During interview on 4/16/24 at 1:45 p.m., nursing assistant (NA)-F stated during morning cares staff assisted residents with personal grooming, including shaving, brushing their teeth, combing their hair, washing their arms, and hands. NA-F stated nail care was done on shower day but if a resident was diabetic the nurse did both finger and toenail care. During interview on 4/16/24 at 1:49 p.m., NA-E stated this morning she provided morning cares for R64 including washing his hands and helping him eat breakfast, and later helped R64 eat lunch. NA-E didn't notice R64 had black debris underneath all his fingernails until it was brought to her attention. NA-E verified R64's fingernails were about 0.4 cm long and had black matter underneath his fingernails. During interview on 4/16/24 at 1:59 p.m. registered nurse (RN)-F stated the concern with long dirty nails could be a source of infection. RN-F added, if R64 touches his food with his hands he could get sick. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/16/24 at 2:01 p.m. nurse manager/registered nurse (RN)-I stated there were many concerns related to long dirty fingernails. Concerns included lack of cleanliness, potential for infections, and lack of dignity. RN-I stated, the interdisciplinary team needed to follow up and determine if there was a behavior pattern and revise R64's care plan. During interview on 4/17/24 at 11:39 a.m. director of nursing (DON) stated you eat with your hands, it is an infection control issue, consequently R64 can get sick. DON stated R64 care plan and interventions needed to be reviewed and updated to reflect his needs. Facility's policy titled Care of Nails dated 9/2022 indicated the purpose was to provide cleanliness, prevent spread of infection, comfort, and prevent skin problems.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48065 Based on observation, interview, and document review, the facility failed to ensure wound prevention treatment was implemented for 1of 1 resident (R36) who had a history of bilateral heel pressure areas and risk for skin breakdown. Findings include: R36's annual Minimum Data Set (MDS) dated [DATE], indicated R36 had moderate cognitive impairment, no delirium, or behaviors, and did not refuse cares. MDS indicated, R36 needed moderate assistance with upper body dressing, toileting, oral hygiene, and bathing. R36 needed maximal assistance with lower body dressing, putting on/taking off footwear, personal hygiene, and transfers. MDS also indicated, R36 was at risk to develop pressure areas. R36's Clinical Diagnosis Report printed 4/17/24, indicated diagnoses of type II diabetes mellitus (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), diabetes chronic kidney disease (a gradual loss of kidney function), vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath), morbid obesity (a disorder involving excessive body fat that increases the risk of health problems), history of transient ischemic attack (temporary period of symptoms similar to those of a stroke that usually lasts a few minutes and doesn't cause permanent damage), dysphagia (difficulty swallowing), bunion left and right foot (a bony bump that forms on the joint at the base of the big toe), hypertension, idiopathic peripheral autonomic neuropathy (damage of the peripheral nerves where a cause cannot be determined), and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). R36's Clinical Orders report printed 4/17/24, indicated an order dated 8/1/22 for a Prevalon boot (a therapuetic boot which helps reduce the risk of pressure wounds by keeping the heel floated and relieving pressure) for the left foot when on a recliner or in bed, every shift. R36's treatment administration record (TAR) between January and April 2024 included the order for the Prevalon boot. R36's care plan lacked documentation of the direction to use the Prevalon boot on the left foot. R36's medical record lacked documentation of refusal to use the boot. R36's nurse practitioner's visit report dated 3/18/24, indicated R36 had a history of peripheral artery disease with a left toe amputation and recurrent ulcers to bilateral heels. The provider also indicated R36 remained at a high risk for recurrent skin issues related to her diagnosis of peripheral vascular disease. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 4/16/24 at 9:50 a.m., R36 stated once I had pressure wounds on my heels, they were open and took a long while to heal. When R36 removed her socks, her heels showed dry, soft, scaly, pink skin. R36 used her thumb to pressure her heels and she exclaimed ouch. R36 stated her heels hurt if she puts pressure on them while in bed to reposition herself and when she stands up. R36 appeared confused when asked about the order to use a Prevalon boot on the left foot. R36 stated I haven't used boots for a long time. During observation on 4/17/24 at 8:51 a.m., R36 was sitting on recliner chair and was not wearing a pressure relief boot on her left foot. R36 treatment administration record (TAR) dated 4/17/24 documented R36 was wearing the Prevalon boot. During interview on 4/17/24 at 10:40 a.m., R36's spouse/family member (FM)-D stated R36 had not used a boot for at least four months, FM-D added I visited her almost daily, so I know. FM-D looked around the room in drawers, cabinets, bathroom, and found the Prevalon boot in the back of an armoire drawer. FM-D stated the armoire was rarely used. During interview on 4/17/24 at 2:05 p.m., licensed practical nurse (LPN)-B stated R36 used a Prevalon boot when she sat on the recliner and laid in bed to prevent pressure areas on her heels. LPN-B stated she put the boot on when she returned to her room from breakfast and lunch. During observation and interview on 4/17/24 at 2:07 p.m. R36 was sitting in her recliner chair with her feet elevated and was not wearing a boot on her left foot. LPN-B asked R36, why did you remove your boot?, R36, responded back, What boot? R36 firmly stated she had not removed a boot. LPN-B asked R36, where is the boot?, LPN-B looked around the room and was unable to find the boot. After a few minutes LPN-B stated, I probably confused R36 with another resident, you caught me, I did not put on the boot and signed for it (TAR). During interview on 4/18/24 at 9:37 a.m. director of nursing (DON) stated the nursing staff failed to implement the Prevalon boot order and incorrectly documented what they were not doing and the resident was at risk for injury due to her history of pressure areas. Facility's policy titled Prevention and Treatment of Pressure Injury dated 12/6/22, indicated it's their policy to properly identify and review residents whose clinical conditions increase the risk for development of skin issues and pressure injury, to implement preventative measures, and to provide appropriate treatment measures for pressure injury.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 48065 Based on observation, interview and document review, the facility failed to comprehensively reassess after repeated refusals of an ambulation program and, if needed, develop interventions to reduce the risk of mobility loss for 1 of 1 resident (R36) reviewed for mobility. Finding include: R36's annual Minimum Data Set, dated dated dated (MDS) 4/8/24, indicated R36 had moderate cognitive impairment, no delirium, or behaviors, and did not refuse cares. MDS indicated, R36 needed moderate assistance with upper body dressing, toileting, oral hygiene, and bathing. R36 needed maximal assistance with lower body dressing, putting on/taking off footwear, personal hygiene, and transfers. MDS also indicated, R36 was at risk to develop pressure areas. R36's Clinical Diagnosis Report printed 4/17/24 indicated diagnoses of type II diabetes mellitus (a condition in which the pancreas doesn't make enough insulin causing the body to have trouble controlling blood sugar and using it for energy), diabetes chronic kidney disease (means a gradual loss of kidney function), vascular dementia (problems with reasoning, planning, judgement, memory and other thought processes caused by brain damage from impaired blood flow to the brain), chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath), morbid obesity (a disorder involving excessive body fat that increases the risk of health problems), history of transient ischemic attack (temporary period of symptoms similar to those of a stroke that usually lasts a few minutes and doesn't cause permanent damage), dysphagia (difficulty swallowing), bunion left and right foot (a bony bump that forms on the joint at the base of the big toe) , hypertension, idiopathic peripheral autonomic neuropathy (damage of the peripheral nerves where cause cannot be determined), and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). R36's mobility care plan printed 4/17/24 indicated, Walking program #1: Walk with assist of 1 using a four wheeled walker daily. Can walk 100-200 feet. R36 can walk with her husband assisting and w/c [wheelchair] follow on the unit. Always use a transfer/chair belt when walking with R36. Intervention was initiated on 6/9/23, no revisions were docuemented to walking program since 6/2023. During observation and interview on 4/17/24 at 9:50 a.m., R36 stated that she can walk short distances in her room with her walker and assistance of one person. R36 stated staff have not offered to help her walk for a long time but she walked sometimes with the therapist, usually in the mornings. During interview on 4/18/24 at 8:23 a.m., nursing assistant (NA)-G stated he used to ask R36 if she wanted to walk after breakfast, R36 always responded she was tired or to try later. NA-G stated the nurses and manager knew R36 was not walking. During interview on 4/18/24 at 8:41 a.m., NA-H stated R36 was supposed to walk with the physical therapist before breakfast, but she wasn't sure why she was not walking to meals anymore. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/18/24 at 8:56 a.m., registered nurse (RN)-K stated she worked on-call for several years and she had never seen R36 doing her walking program. During interview and document review on 4/18/24 at 9:00 a.m., RN-J, verified R36 had a Restorative Walking Program based on a therapist recommendation and it needed to be done. RN-J reviewed R36's care plan and noted the Restorative Program was not linked to the nursing assistants Kardex (resident's care directions used by nursing assistants). Instead, it had been linked directly to R36's electronic record under tasks. RN-J reviewed the task documentation and noted the staff had documented R36 did not participate in the ambulation program in the months of January, February, March, or April 2024. The TAR for those months indicated R36 refused to ambulate or was not available. RN-J indicated this was very concerning because resident was supposed to be walking 100 to 200 feet and this could be an indication of decline and the walking program was no longer appropriate and needed to be re-evaluated. During interview on 4/18/24 at 9:26 a.m. director of nursing (DON) stated R36's husband had been through a lot and maybe R36 didn't want to walk. DON stated she would send a message to the nurse manager to follow up. DON stated the rehabilitation programs were reviewed quarterly by the MDS coordinator, unit managers, administrator, Medicare nurse and DON. Their last meeting was in February 2024. DON stated R36 will need to be re-evaluated if she had not participated in the walking program. During interview on 4/18/24 at 10:20 a.m. physical therapist (PT)-A stated R36 received physical therapy services in 2023. In June of 2023, R36 was discharged and was placed on a nursing restorative ambulation program. PT-A stated R36 was currently on a physical therapy skill maintenance program, three times a week. PT-A stated that a decline was expected due to her Parkinson's condition like symptoms. PT-A added R36's walking distance had decreased from 100-200 feet to 50-80 feet. Her strength had declined, and the shuffling incidences had increased. PT-A stated she was not informed R36 had not been participating in the restorative nursing program with the nursing staff. During interview on 4/18/24 at 12:25 p.m. PT-A stated she would expect to be informed if a resident had stopped participating in a restorative program and expected to see a referral to re-evaluate the resident and develop a new restorative nursing program. DON provided a copy of the February 15th, 2024, Walking Programs LTC [Long Term Care] minutes which indicated R36's program was reviewed and it was decided her program was appropriate. Facility's policy title Restorative Nursing Program dated 10/2021 indicated the purpose is that resident's ability in abilities in ADL's did not deteriorate and residents maintain their highest practicable well-being. This is a nursing program ordered by nurses with {physical; Occupational or Speech Therapy functioning as consultants.

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	245272	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview and document review, the facility failed to ensure the use of bilateral, bed-mounted grab bars was comprehensively reassessed and, if needed, develop interventions to ensure safety while in bed for 1 of 1 resident (R62) reviewed who developed seizures after admission to the care center. Findings include: R62's admission Minimum Data Set (MDS), dated [DATE], identified R62 had intact cognition, demonstrated no delusional thinking during the review period, and required supervision or touch-level assistance with mobility-related activities of daily living (ADLs; i.e., rolling left to right, lying to sitting). Further, the MDS outlined a section labeled, Section I - Active Diagnoses, with R62 being recorded as not having a seizure disorder or epilepsy. R62's most recent Device Assessment and Consent - V2, dated 3/26/24, identified an admission evaluation was being completed for two devices which included, 9. Grab Bars - Bilateral. The evaluation outlined R62 was not prevented from rising with them (i.e., restraint) but lacked any recorded alternatives attempted prior with the field to record such left blank and uncompleted. An intent of the device was listed to enhance positioning and/or independence with consideration being outlined as, 12. Recent trauma or surgery, and, 22. Wound, listed. A series of potential risks were identified and the evaluation concluded with a section labeled, B. Consent for Device(s), which outlined R62 consented to using them on 3/26/24. The evaluation included a checkmark placed next to, 1. Care Plan Current. The completed evaluation lacked evidence R62 was identified with any current or history of seizures. R62's ADL care plan, dated 3/27/24, identified R62 had an ADL self-care deficit and listed several interventions for R62 including, Bilateral grab bars. The care plan contained a section on the top labeled, Special Instructions, which identified, SEIZURE PRECAUTIONS; OK to administer oral medications in public places. On 4/8/24, the care plan was updated to include, [R62] has a seizure disorder, with several interventions including asking R62 about potential aura prior to events and giving medications. However, the care plan lacked any specific information on what, if any, interventions were considered or needed to promote safety while in bed despite use of bilateral grab bars and associated risk of injury. R62's progress notes, dated 3/26/24 to 4/15/24, were reviewed and identified: On 3/26/24, R62 admitted to the care center from the hospital after having a right shoulder dislocation. R62 was listed as, . alert [and] oriented X4. On 4/3/24, R62 was found to have had an emesis and complained of 'not feeling well.' R62's vital signs were within normal limits and she was brought to her bed to rest after bowel medication was given. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24, R62 continued with shoulder pain and was listed as alert and oriented. The note included a section labeled, Safety, which identified the call light was in reach and added, Resident is not on seizure precautions. On 4/5/24, R62 was with therapy when they reported, . patient having a seizure like activity during session . increase in tremors to UE [upper extremities] spacing/eye glaze, uncommunicative for approximately 15-20 seconds . she [R62] stated that she 'probably' had a seizure . explained that she has a PMH [past medical history] of epilepsy. The note outlined R62, Patient currently is in her room, sitting up in her bed . IDT [interdisciplinary team] and NP [medical provider] updated. On 4/8/24, R62 had a witnessed seizure while in the dining room. The note outlined, . [R62] reported to nurse in dining room that she wanted to get back to her room fast because she was going to have seizure . began to have tremorsand [sic] was sat back into chair . Seizure lasted approx. 2.5 mins; [R62] was able to track staff [with] eyes, but was unresponsive; upper bilateral extremities convulsing noted . began drooling during seizure . broughtto [sic] room following . also had x2 emesis in room following seizure . A subsequent note, also dated 4/8/24, identified R62 declined transfer to the hospital following the seizure. However, none of the completed progress notes identified any re-evaluation of R62's use of bilateral grab bars, including potential safety interventions to reduce the risk of injury within the bed environment, despite now having sustained multiple seizures at the care center. On 4/15/24 at 6:34 p.m., R62 was observed seated on her bed while in her room with a black-colored sling on her right arm. R62's bed was positioned against the far-wall of the room and had bilateral, white-colored metal u-shaped grab bars attached to the frame of the bed. There was no visible padding on the devices. R62 was interviewed, and stated she had admitted to the care center after being in the hospital due to a broken arm. When asked, R62 verified she had a history of seizures and expressed she had been born with them, but they stopped until recently while at the care center when she had more of them. R62 was questioned on the bilateral grab bars and stated she used them often to help her stand up. However, upon touching the bar attached to the left side (open side) of the bed, it moved side to side several inches and was unsecured with only light touch being needed to move it. R62 stated it had been loosened due to her seizures adding the resulted shaking was what loosened it. R62 stated it had been loose for two weeks or so and, to her recall, had not been inspected since the seizures started; nor had any staff discussed their ongoing use with her since, either. R62's entire medical record was reviewed and lacked evidence R62 was comprehensively reassessed for safety with use of bilateral, bed-mounted grab bars despite having multiple, witnessed seizures at the care center. There was no evidence what, if any, potential safety interventions were considered or evaluated (i.e., different type of bar, padding) to reduce the risk of injury should R62 sustain a seizure while in bed. (continued on next page)

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	245272	A. Building B. Wing	04/18/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 1:06 p.m., nursing assistant (NA)-B was interviewed. NA-B explained they had worked with R62 multiple times and described her as needing just minimum help with cares adding R62 was able to get up from her bed without physical assistance. NA-B verified R62 had metallic bilateral grab bars without any padding present and stated she used them to stand up on her own with no complaints of them being voiced from R62. NA-B then touched the left side bar, at the request of the surveyor, and verified it was loose adding, uh oh. NA-B stated R62 must have been using [it] too much. Further, NA-B stated they recalled hearing R62 had sustained seizures after she admitted to the care center and expressed, to their recall, the nurses' were aware of it. When interviewed on 4/16/24 at 1:13 p.m., licensed practical nurse (LPN)-A explained side rails and grab bars were evaluated upon admission to ensure safety by nursing and, if needed, physical therapy. LPN-A stated the results were documented using the Device Assessment and Consent form to their knowledge adding, I think so. LPN-A verified R62 had sustained multiple seizures after she admitted to the care center and expressed the charge nurse or the manager would be responsible to re-evaluate the use of physical devices, such as grab bars, if needed. LPN-A stated they had not been told or directed to do any special monitoring or interventions while R62 is in bed (i.e., padding, safety checks) with the bare metal bars attached adding they were not sure if the devices had been re-evaluated or not. On 4/16/24 at 2:10 p.m., the environmental services director (ESD) was interviewed. They explained the care center used two types of grab bars which mounted to the bed frames and were checked for fit on a monthly basis. ESD observed R62's bed and grab bars and verified they were a Invacare brand adding padding for them was available, if needed. However, application of such would only be done if initiated by nursing adding, We can't make that call. On 4/16/24 at 3:03 p.m., registered nurse unit manager (RN)-E was interviewed and verified they had reviewed R62's medical record. RN-E explained grab bar use' was evaluated upon admission and then via the MDS cycle thereafter (i.e., re-admit, quarterly). RN-E stated re-evaluation of the devices' would not typically be done after a resident, including R62, developed seizures. RN-E verified the care center was unaware R62 had a history of seizures upon admission as there was no mention of it within the hospital' paperwork. RN-E verified the medical record lacked evidence R62's use of bilateral metal grab bars, including for any potential safety interventions with them, had been re-evaluated since she had seizures and reiterated it would not be done until the next MDS was due for completion. However, RN-E stated it was important to ensure their use was periodically reviewed to make them safer and reduce the risk of injury to the resident. A facility' provided Seizure Precautions policy, dated 11/23, identified a purpose to prevent injury and implement emergency care to a resident with seizures. A procedure was listed which included how to address an active seizure, however, lacked any information or dictation on post-seizure physical device (i.e., side rails, grab bars) use re-evaluation. However, a provided Assessment and Use of Grab Bars/Side Rails policy, dated 3/24, identified a policy outline which read, Upon admission and ongoing the nurse/IDT will assess the need and safety of grab bars or side rails . The nurse will document these conversations and recommendations.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview, and document review the facility failed to ensure staff provided cares according to standard of practice for gastrostomy tube care for 1 of 1 residents (R230) reviewed for tube feedings. Findings include: R230's admission Minimum Data Set (MDS) dated [DATE], identified R230 dependent on helper (staff) for all effort of activity or requires assistance of 2 or more helpers for oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, personal hygiene and mobility. In addition, R230 diagnoses included stroke (cell death to portions of the brain causing loss of functioning), aphasia (inability to speak well), hemiplegia/hemiparesis (partial paralysis) of right dominant side, respiratory failure, dysphagia (inability to swallow), and had a gastrostomy tube (feeding tube to stomach) for all nutrition and medication administration. R230's care plan (CP) dated 2/23/24, documented R230 Dependent with tube feeding and water flushes. And Enteral feed: Water flushes via PEG tube [feeding tube inserted in abdomen] of 120 milliliters [mL] every [q] 4 hours [hrs] + 90 mL before and after feeds. Water flushes + free water from formula = 1964 mL free water daily. During observation on 4/15/24 at 1:37 p.m., R230 was lying in bed with eyes closed. A graduated cylinder with 400 mL of clear fluid and a piston syringe was resting inside was noted to be on a rolling bedside table next to R230. The graduated cylinder and piston syringe did not have a date or label. During observation on 4/16/24 at 8:19 a.m., an empty undated and unlabeled graduated cylinder and piston syringe resting inside, was observed to be on the rolling bed side table next to R230. During interview with registered nurse (RN)-A on 4/16/24 at 8:21 a.m., RN-A pointed to graduated cylinder and piston syringe in R230's room and stated, it is not labeled [and dated]. During observation on 5/17/24 at 8:05 a.m., an empty undated and unlabeled graduated cylinder and with piston syringe resting inside, was observed to be on R230's dresser near the foot of bed. During observation on 5/18/24 at 8:13 a.m., in R230's bathroom on the counter next to sink, an empty undated and unlabeled graduated cylinder and piston syringe were observed sitting on a paper towel with piston syringe laying next to the graduated cylinder. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with RN-F on 4/18/24 at 8:26 a.m., RN-F stated, Syringe and container is changed every 24 hours. Night shift does it. It must be dated and labeled. No, I do not see a date or label on the syringe or container. I used [graduated cylinder and piston syringe] this morning [for R230's medication administration and tube flushing]. And I should not use it because that is not a good professional practice to use a non-dated and labeled syringe and container. I honestly would not know when it was actually replaced. It could be one day or several days. RN-F stated the practice is a, concern for infection control in a immunosuppressed gentleman. RN-F pointed to R230's electronic medical record (EMR) and stated it lacked a care plan or treatment record of documenting when and if the equipment replacement was done. During interview with infection control (IP) on 4/18/24 at 11:50 a.m., IP stated, for medical equipment including the graduated cylinder and piston syringe for R230's gastrostomy care, they should be dated on a weekly schedule. Even if it were documented in the EMR we would expect [both containers to be dated and labeled]. During interview with director of nursing (DON) on 4/18/24 at 12:11 p.m., DON stated, for medical equipment including the graduated cylinder and piston syringe for R230's gastrostomy care, The graduated cylinder and syringe must be dated. If it is not dated then there is a concern with infection control because we don't really know when it was changed or replaced. Even if staff document in the electronic medical record (EMR) that it is changed, standard practice is to not use the syringe or container because we cannot be sure when it really was changed. DON stated facility did not have process to ensure the dating and labeling of tube feeding equipment was documented in the EMR or audited for compliance. Facility policy titled ENTERNAL [SIC] FEEDING TUBE-CARE OF revised 10/21 direct staff to, 8. Replace and date syringe every 24 hours.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44656 Based on observation and interview the facility failed to ensure two medication carts were kept locked or under direct observation of authorized staff in areas where residents, staff and guests could access medications. The deficient practice had the potential to affect twenty residents that resided on those units. Findings include: Facility map provided to surveyors immediately after entrance on 4/15/24 identified the Bridgeway unit of facility as the Transitional Care Unit (TCU) of the facility. This includes rooms 110-129. During observation on 4/16/24 at 8:19 a.m., an unattended medication cart in the west section of the TCU was observed to be unlocked with no staff visible. During interview with registered nurse (RN)-A on 4/16/21 at 8:21 a.m., RN-A stated he was responsible for the unlocked unattended medication cart. RN-A stated, when I leave med cart I should hide the resident info on the laptop and lock med cart. During interview with charge nurse, RN-C on 4/17/24 at 8:08 a.m., RN-C stated, When you leave [it], med cart is to be locked and screen locked for patient privacy. RN-C provided surveyor a list of residents the medication cart for RN-A was responsible for. This list titled Team 4 Nurses Census Sheet includes ten residents of the TCU. During observation and interview with licensed practical nurse (LPN)-A on 4/16/24 at 9:15 a.m., an unattended unlocked medication cart in the east section of the TCU and directly next to a resident lounge and nursing station, was observed near two residents who were in the lounge and a housekeeper with her cart passing by it. No nursing staff was observed in vicinity at the time. At 9:18 a.m., LPN-A approached the unattended unlocked medication cart and stated she was responsible for the medication cart. LPN-A stated, yes my cart is unlocked. [It] should be locked so the meds are not accessible to everybody. RN-F provided surveyor a list of residents the medication cart for LPN-A was responsible for. This list titled Team 2 Nurses Census Sheet includes ten residents of the TCU. During interview with RN-F on 4/18/24 at 8:26 a.m., RN-F stated, any time I leave the med cart, I turn screen off of [sic] computer with any kind of patient information shown and lock the cart. [It is] important for patient privacy. During interview with director of nursing (DON) on 4/18/24 at 12:11 p.m., DON stated, med carts should always be locked when leaving cart to secure medications. And, [unlocked med carts] are a,safety issue with unrestricted access to resident medications. Facility policy titled Medication Administration-General Guidelines with review date of 3/10/23, direct legally authorized persons, During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or trained medication aide.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review, the facility failed to ensure expired and visibly molding produce was disposed to prevent serving expired food. This had potential to affect all residents, visitors and staff who consumed food from the main kitchen. Findings include: During the initial kitchen tour with the dietary director (DD) on [DATE] at 12:10 p.m., the walk-in cooler was observed, which stored food served to all units of the facility and contained the following expired foods; an unopened bag of broccoli with a use-by date of [DATE], which was noticeably watery with brown spots, four unopened five-pound bags of brussels sprouts with a use-by date of [DATE], a cardboard box with approximately 25 cucumbers with noticeable denting open areas and white colored mold, a cardboard box , d+[DATE] full of wrinkled, drooping asparagus with a use-by date of [DATE], three unopened bags of pre-chopped zucchini with a use-by date of [DATE] which was noticeably watery and browning, and two undated bags of precut potatoes which appeared watery with white mold spots. During an interview on [DATE] at 1:09 p.m., the DD confirmed there was expired produce on the back shelf in the walk-in cooler and that it was disposed of after the initial kitchen tour. The DD stated all fresh produce is delivered on Tuesdays and Fridays and they would expect fresh produce to be disposed of seven days after delivery, when it was past the used by date or appeared old in anyway. The DD stated most of the produce was delivered with a use by date, but it would be expected for all produce to be dated when opened. During a follow up interview on [DATE] at 8:32 a.m., the DD stated they threw away enough produce to feed all the residents at the facility for at least one meal. The DD stated he would be concerned about the produce being served as it would put the residents at risk of getting sick. Review of the facilities Week 3 menu, dated [DATE], indicated chicken zucchini was on the lunch menu for Monday, [DATE] and broccoli was on the menu to be served for dinner on Monday, [DATE]. A facility policy titled Food Safety, revised ,d+[DATE], indicated the director of food and nutrition services would be responsible for providing safe foods to all residents and to ensure all refrigerated foods were stored and handled properly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview and record review the facility failed to ensure appropriate infection control measures were implemented for direct resident care for 1 of 1 residents (R230) who was placed on enhanced barrier precautions. In addition, the facility failed to ensure clean personal and facility laundry was protected during transport and storage outside resident rooms. This had the potential to affect all 132 residents who utilized facility provided laundry services. Findings include: PPE Use The Centers for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality/Quality, Safety and Oversight Group Ref: QSO-24-08-NH dated March 20, 2024, state Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact resident care activities. In addition, EBP are indicated for residents with any of the following: -Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or -Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Also, Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. Guidance also state, EBP is employed when performing the following high-contact resident care activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care: any skin opening requiring a dressing. R230's admissions Minimum Data Set (MDS) dated [DATE], documented R230 dependent on helper (staff) for all effort of activity or requires assistance of 2 or more helpers for oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, personal hygiene and mobility. In addition, R230 was listed with diagnoses which included stroke (cell death to portions of the brain causing loss of functioning), aphasia (inability to speak well), hemiplegia/hemiparesis (partial paralysis) of right dominant side, respiratory failure, dysphagia (inability to swallow), and had a gastrostomy tube (feeding tube) for all nutrition and medication administration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R230's care plan (CP) dated 2/23/24, directed staff to the following, PERSONAL HYGIENE/ORAL CARE: (1) staff assist with personal hygiene/oral care. Oral cares with oral sponge every 2-3 hours while awake. Oral Cares: Wet toothbrush with mouthwash and brush teeth. CP dated 2/23/24 documented, Requires tube feeding related to Dysphagia and on 3/29/24 Enhanced Barrier Precautions due to indwelling device. CP dated 4/8/24 indicated, Enhanced Barrier Precautions Indefinitely due to Indwelling device. Interventions/Tasks included: REQUIRED PPE: Gloves and gown prior to the high-contact care activity: High-contact resident care activities such as but not limited to: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and Wound care: any skin opening requiring a dressing. During observation on 4/15/24 at 12:39 p.m., door frame of R230's room had signage posted for enhanced barrier precautions with instructions for staff and visitors regarding when to wear PPE when caring for R230. Also, a personal protective equipment (PPE) cart was located outside the room. During observation on 4/16/24 at 8:19 a.m., registered nurse (RN)-A exited R230's room wearing gloves and walked to supply cabinet in the hallway and opened the cabinet (still wearing gloves) to obtain a toothette oral swab. Then RN-A closed the cabinet door (with gloved right hand) and walked back into R230's room without changing gloves, sanitizing hands, or putting on a PPE gown. RN-A again walked back out to the hallway and repeated actions (walking to the cabinet with gloved hands, opening the cabinet, obtaining oral toothette, closing the cabinet with gloved right hand, and re-entered R230's room without changing gloves, sanitizing hands, or putting on a PPE gown.) RN-A walked to resident who was lying in bed and provided oral care using toothettes moistenend with water (dipping toothette in water and inserting toothette into mouth and rubbing along the oral cavity, including teeth and gums). RN-A then disposed of the toothettes into the trash and removed gloves and exited room without sanitizing hands. During interview with RN-A on 4/16/24 at 8:21 a.m., RN-A stated R230 was on EBP because, he [R230] has tube feeding and RN-A stated he was providing oral cares for R230 using the oral toothettes and needed to get supplies which is why he left the room twice to obtain them in the supply cabinet. RN-A stated, I need to wear gown [PPE] when I am using toothettes with [R230]. I did not do that. Also, [I] should wear gown and gloves when providing direct personal care. And, RN-A stated he did not sanitize hands upon entering and exiting R230 room. During interview with RN-B on 4/16/24 at 1:35 p.m., RN-B stated residents on EBP require staff to wear gown and gloves when direct patient care: touching them. Also, RN-B stated, we must sanitize our hands [before and after resident care]. During interview with RN-G on 4/18/24 at 8:26 a.m., RN-G stated residents with rooms posted with EBP signage directed staff ,to protect them [residents] and using a toothette is considered direct patient care and we [staff] must wear gown and gloves [when providing direct patient care]. During interview with director of nursing (DON) on 4/18/24 at 12:11 p.m., DON stated, staff should always sanitize hands before and after being an a EBP room. Staff must wear PPE gown and gloves when providing direct care like using a toothettes to clean [R230] mouth. Clean linen transport (continued on next page)

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	245272	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Luther Care Center	1401 East 100th Street Bloomington, MN 55425

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation on 4/16/24 at 9:07 a.m., staff observed to be pushing a four wheeled laundry cart down the hall on the first floor of facility through the transitional care unit (TCU) with the top completely off. [NAME] linen was visible as cart was pushed past rooms 100-111. During observation on 4/16/24 at 9:15 a.m., a covered a four wheeled laundry cart was observed outside R37's room. Signage on door frame of R37's room indicated Contact Precautions and instructions for staff and visitors when to don and doff PPE's. A fabric gown was lying on top of the closed cart. During interview with licensed practical nurse (LPN)-A on 4/16/24 at 9:19 a.m., LPN-A stated the four wheeled laundry cart was for clean laundry in there. The fabric gown should not be on top of clean linen cart because of [concern for] infection control. During observation on 4/17/24 at 8:06 a.m., a four wheeled laundry cart outside R84 and R37's rooms with top of cart open and visible laundry inside of it was observed. During observation and interview on 4/17/24 at 8:08 a.m., a four wheeled laundry cart outside R77's room with top of cart open and visible laundry inside of it. RN-C stated the linen carts contained clean PPE fabric gowns and, for best practice they should be covered [at all times]. [And] nothing should be on top of them. During observation on 4/17/24 at 8:31 a.m., a four wheeled laundry cart with a fabric gown on top of it was observed in the long term care unit (LTC) of [NAME] Crossing hallway. During observation on 4/17/24 at 12:35 p.m., a four wheeled laundry cart with top of cart half-way open with visible laundry inside of it and a fabric gown placed on top of it was observed in the TCU, Bridgeway hallway. During observation on 4/17/24 at 12:39 p.m., a separate four wheeled laundry cart with top of cart open with visible laundry inside was observed in the TCU, Bridgeway hallway. During observation on 4/17/24 at 12:45 p.m., a four wheeled laundry cart with top of cart open with visible laundry inside was observed in the TCU, Bridgeway hallway. During observation on 4/17/24 at 1:44 p.m., a four wheeled laundry cart was observed outside R77's room with top of cart open and visible laundry inside of it. During observation on 4/18/24 at 1:26 p.m., a four wheeled laundry cart was observed with top of cart open and visible laundry inside of it in the LTC of Eagle Crest hallway for rooms 200-211. During observation on 4/18/24 at 1:26 p.m., a four wheeled laundry cart was observed with top of cart open and visible laundry inside of it in the LTC of Eagle Crest hallway for rooms 212-223. During observation on 4/18/24 at 1:33 p.m., a four wheeled laundry cart was observed with top of cart open and visible laundry inside of it in the locked memory care unit of facility, Prairie Spirit hallway. During observation on 4/18/24 at 1:27 p.m., a four wheeled laundry cart was observed with top of cart open and visible laundry inside of it in the LTC [NAME] Crossing hallway. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview with IP on 4/18/24 at 11:50 a.m., IP stated clean linen carts located outside resident rooms contain fabric washable PPE gowns that are used for staff who enter resident rooms that are on precautions (EBP, Standard, Contact, Isolation). IP stated, I don't want them open [clean linen carts] to protect them. They should be covered. 49339 Personal Linen During observation on 4/16/24 08:27 a.m., an uncovered metal laundry cart delivering personal laundry items was observed on 1st floor in [NAME] Crossing. The cart had residents clean personal items on it (both hanging on the metal bar from hangers and on the shelves where folded items sit). It was observed as the cart was pushed down the hallway, the clean personal laundry items were touching/rubbing again the walls and handrails. During interview at this time, laundry aid (LA)-E stated, we don't have covers for these carts, only for the linen carts. On 4/16/24 at 8:47 a.m., a four-tiered metal open and uncovered laundry cart was observed on second floor that appeared to be used for personal laundry items. The cart was empty, had 2 metal bars with hangers on it with white circle separators with room numbers written on them. The other half of the cart had 4 shelves, some of the shelves had slots. There was no cover on or around the cart. On 4/17/24 at 7:36 a.m., LA-E verified they have worked in laundry for over [AGE] years. They verified they have 3 metal carts that deliver personal laundry to the facility. Each of the laundry carts have a place to hang personal items on hangers, separated by white circle rings with rooms numbers on them. The other half of the carts have shelves on them for personal items that are folded for resident drawers. LA-E verified the 3 carts used to deliver the personal laundry items for residents are not covered. LA-E stated, personal clothing has never been covered. LA-E stated, clean linen is covered so it doesn't get dusty and dirty. LA-E stated they do pretty much everyone's laundry in the facility. On 4/17/24 at 7:43 a.m., LA-D verified they have worked in laundry for over [AGE] years. LA-D stated that we have never covered the personal laundry and added maybe it is because we bring it up right away and deliver it. LA-D verified they cover the clean linen and not personal laundry. On 4/17/24 at 11:01 a.m., infection preventionist (IP) verified that she oversees the infection prevention program for the facility. IP verified clean linen carts are covered to to keep residents from throwing stuff in there and keep them clean as so many things can come in contact with it. When IP was asked about keeping personal linen covered, she stated, I don't know that if I can answer that one specifically and would direct you to their department head. On 4/18/24 at 9:30 a.m., director of environmental services (ESD)-A verified that he oversees the laundry. ESD-A verified clean linen carts are covered for multiple purposes including dignity, and infection control purposes. ESD-A verified clean personal laundry carts are not covered when delivered to the floors to residents. ESD-A verified historically they have never been covered. ESD-A stated that he will get some covers ordered now that he is aware that they need to be covered. On 4/18/24 at 12:22 p.m. director of nursing (DON) stated I don't know the policy on that when asked about how should clean personal laundry be transported to resident rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy titled STANDARD PRECAUTIONS FOR INFECTION CONTROL/ENHANCED BARRIER PRECAUTIONS revised 4/1/24 directed health care workers to perform hand hygiene according to the Hand Hygiene (Hand Washing) policy and Enhance Barrier Precautions (EBP) are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Also, policy stated, When to use Enhance Barrier Precautions include, Feeding tubes and Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: -Dressing -Bathing/showering -Transferring -Providing hygiene -Changing linens -Changing briefs or assisting with toileting -Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator -Wound care: any skin opening requiring a dressing. Facility policy titled Hand Hygiene revised 4/24 directed staff to, Perform hand hygiene upon room entry and exit has been suggested as best practice to facilitate hand hygiene compliance. Additionally, Do not wear gloves in hallway. Perform hand hygiene after doffing gloves and donning a new pair. Facility policy titled Linen Handling, dated 11/21, was provided. The policy lacks identification on transporting clean laundry. The policy identifies clean linen is covered when in storage .

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 47495 Based on observation, interview and document review, the facility failed to ensure the kitchen floors and mats were routinely and properly cleaned to ensure a sanitary kitchen environment. This had the ability to affect all 132 residents residing at the facility. Findings include: During the initial kitchen tour on 4/15/24 at 12:10 p.m., the kitchen floors including the food preparation area, the walk-in cooler, the dry storage room, and the clean dishware storage room were noticeably soiled. The floors were covered sporadically with a white/brown coating, various old dried food particles filling the crevices of floor mats and sporadically covering the floor in all rooms including underneath food and clean dish storage racks, various used food wrappers such as used Cafe Delight and brown sugar topping packets, broken and scattered dishware pieces in the clean dishware room, as well as noticeably darkened and soiled mop heads found underneath food storage racks and in the food preparation area. During an interview on 4/17/24 at 1:09 p.m., the dietary director (DD) confirmed the dirty kitchen floors and mats during the initial kitchen tour, stating, it was pretty bad. The DD stated they pulled up the mats the previous night and had the night custodian deep clean the floors. The DD stated they did not have a cleaning schedule established and would work with maintenance to get a schedule for cleaning the kitchen floors. The DD stated they were working on creating a formal cleaning schedule to include areas that were frequently missed including the floors and mats stating there was not a good cleaning process prior. During a follow up interview on 4/18/24 at 8:32 a.m., the DD stated they would be concerned about the dirty floors potentially causing food borne illness stating it was, best to have things clean. A facility policy titled Food Safety, revised 3/2019, indicated the director of food and nutrition services would ensure sanitary conditions were maintained in storage, preparation and food serving areas and that cleaning schedules would be posted and followed.