

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/30/2026
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)		
F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. Based on interview and document review, the facility failed to ensure resident personal fund accounts were insured with adequate surety bond coverage (a contract or promise by a surety or guarantor to pay a certain amount if a second party fails to meet the obligation) to cover the total account balance. This had the potential to affect 33 residents identified with a positive account balance. Findings include: A Bond Execution Report dated 5/10/19, indicated the facility had a surety bond in place for up to \$25,000.00. The facility resident fund account record dated 7/29/26, identified 33 residents who had current fund accounts with a positive balance. The total amount of these accounts was recorded as \$38,563.85. During an interview on 7/30/26 at 8:26 a.m., the administrator acknowledged the surety bond would not fully cover the resident's personal fund. The administrator stated that corporate oversaw the surety bond. The administrator stated that when she reached out to corporate about the surety bond, they stated the bank for the resident funds was FDIC (Federal Deposit Insurance Corporation, protects the depositor if the bank fails) insured. When a facility surety bond policy was requested, policies titled Trust Fund Accounting & Records dated 11/2017 and Trust Fund Authorization dated 9/2019 were received. Neither policy included information regarding a surety bond.		

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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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to honor resident rights to make choices about food preferences at meals for 1 of 1 resident (R12) reviewed for food choices. Findings include: R12's quarterly Minimum Data Set (MDS) dated [DATE], indicated R12 had moderate cognitive impairment, required substantial/maximal assistance with personal and oral hygiene and set up/clean up assistance with eating. R12's diagnoses include type 2 diabetes, acute cystitis (bladder infection), muscle weakness, history of transient ischemic attack and cerebral infarction, dysphasia (difficulty swallowing) and protein-calorie malnutrition. R12's care plan dated 7/9/26, indicated potential alteration in nutrition and instructed staff to Cater to food preference as much as possible: Likes: EGGS [pureed]. R12's nutrition assessment dated [DATE], indicated, Cater to food preference as much as possible: NO EGGS During observation on 7/29/26 at 8:27 a.m., unidentified staff delivered R12's breakfast tray. The breakfast tray included a plate of scrambled eggs, milk and water. R12's meal ticket indicated, Cheese Omelet > Minced and Moist.Add-On Salsa.Water.Milk. In addition, the meal ticket indicated a preference for PUREED EGGS OK. During observation and interview on 7/29/26 at 12:09 p.m., R12's lunch tray was delivered and breakfast tray removed by nursing assistant (NA)-B. NA-B verified and R12's breakfast included scrambled eggs and it appeared she had only eaten a bite or two. NA-B further verified R12's breakfast meal ticket indicated cheese omelet and stated the provided meal did not match the ticket. During interview on 7/29/26 at 12:10 p.m., resident friend (RF)-A stated she visited R12 at least three times a week and assisted with meals when she at times. RF-A stated R12 did not really like eggs, but if she did get them, they had to be mashed up pretty well in order for R12 to swallow them. RF-A stated scrambled eggs were not mashed enough. During observation and interview on 7/30/26 at 8:28 a.m., R12 sitting up in bed with a breakfast tray in front of her. The breakfast consisted of scrambled eggs, cream of wheat, water and apple juice. R12 stated she did not really like eggs and had previously requested not to have them. R12 stated lately, all she seemed to get for breakfast was scrambled eggs. R12's breakfast meal ticket indicated, Water.Sausage Breakfast Casserole > Minced and Moist .Pureed Bread.Oatmeal >Add-On [NAME] Sugar.Apple Juice. During observation and interview on 7/30/26 at 8:28 a.m., nursing assistant (NA)-A in to assist R12 with breakfast NA-A placed a clothing protector on R12 and proceeded to provide spoonful after spoonful of cereal to R12 without offering sips of beverage in between. After about one quarter of the cream of wheat, NA-A provided a spoonful of scrambled egg. R12 chewed the one bite of eggs for approximately five minutes with several attempts at swallowing. NA-A attempted to offer additional bites of egg but R12 declined stating she was done with breakfast. When directed to the meal ticket, NA-A confirmed R12's breakfast meal did not match the meal indicated on the ticket and could not explain why. NA-A stated it was the kitchen staff responsibility to assemble the meal as indicated on the ticket. During interview on 7/30/26 at 8:57 a.m., registered nurse (RN)-E stated would expect meals provided to residents would match what was ordered and listed on the meal ticket. During interview on 7/30/26 at 9:09 a.m., registered dietician (RD) stated the food services process recently changed and now the NAs rounded on residents approximately two hours prior to each meal would offered food choices for the upcoming meal. The NA would then enter the order into the iPad, which went into the system and print the meal ticket. RD stated resident choices should be honored and that when R12 was provided eggs, they should be pureed. During interview on 7/30/26 at 12:18 p.m., director of nursing (DON) stated that resident preferences should (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be honored. DON further stated would expect the meals provided would match the meal ticket and kitchen staff should be checking for accuracy while NAs provided a second check as well. During interview on 7/30/26 at 1:06 p.m., corporate culinary director (CCD) stated kitchen staff should set up trays according to the meal ticket. Facility policy Food and Nutrition Services/Nursing dated 5/24, indicated, Staff will check individual name and diet on each meal ticket/card to verify the meal is served to the appropriate person, check items on the plate/tray to assure accuracy for therapeutic diets, texture, adaptive equipment and consistency modifications as needed. The policy further indicated, Staff will offer alternative choices for refused food/meals or any resident dislikes. Facility policy Resident Rights dated 6/25, indicated the facility was committed to honoring and protecting each resident's individuality, preferences, autonomy, and equal access to care. In addition, the facility indicated the resident had The right to make choices and exercise self-determination.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure staff was familiar with and provided care according to the residents plan of care for 1 of 1 residents (R12) reviewed for meal assistance. Findings include: R12's quarterly Minimum Data Set (MDS) dated [DATE], indicated R12 had moderate cognitive impairment, required substantial/maximal assistance with personal and oral hygiene and set up/clean up assistance with eating. R12's diagnoses include type 2 diabetes, acute cystitis (bladder infection), muscle weakness, history of transient ischemic attack and cerebral infarction, dysphasia (difficulty swallowing) and protein-calorie malnutrition. R12's care plan dated 7/9/26, indicated activities of daily living (ADL) self-care deficit and potential alteration in nutrition. The care plan indicated R12 required adaptive feeding equipment to include weighted utensils and two handled cups and to instruct staff to encourage R12 to work on self-feeding at all meals. The care plan further indicated R12 had potential for alteration in nutrition and instructed staff, upright at 90 degrees for all intake, upright for 30 minutes after meals, reflux precautions, use of safe swallowing strategies during intake, feeding assistance. R12's Nutritional assessment dated [DATE], indicated, R12 was admitted from hospital after possible aspiration pneumonia and had complaints of difficulty or pain when swallowing. The care plan further indicated, adaptive equipment required. R12's Kardex printed 7/29/26, indicated, EATING: Partial/moderate assistance. Encourage [R12] to work on self-feeding at all meals. Requires adaptive feeding equipment: weighted utensils and 2-handled cups w/lids at each meal. Upright 90 degrees during intake/meals. Stay upright 30 minutes following meals. Use safe swallowing strategies during meals. R12's Rehab Communication dated 3/24/26, indicated, Please provide pt w-handled cup w/lid and weighted utensils for all meals. Assist pt in cutting up food PRN [as needed]. R12's breakfast meal ticket dated 7/29/26, indicated, Feeding assist during meals but encourage self-feeding as able. Equipment: Weighted Utensils [Grey], Two Handled Cups with Lid. R12's lunch meal ticket dated 7/29/26, indicated, Feeding assist during meals but encourage self-feeding as able. Equipment: Weighted Utensils [Grey], Two Handled Cups with Lid. R12's breakfast meal ticket dated 7/30/26, indicated, Feeding assist during meals but encourage self-feeding as able. Equipment: Weighted Utensils [Grey], Two Handled Cups with Lid. During interview on 7/27/26 at 12:30 p.m., resident friend (RF)-A stated she visited R12 frequently and did not think R12 was getting enough to eat. RF-A stated R12 required assistance with meals and did not think anyone ever helped her since she often found her meals untouched. During observation on 7/29/26 at 8:27 a.m., unidentified staff delivered R12's breakfast tray, set on bedside table and did not provide any set up or attempt to wake R12. The breakfast tray included a plate of scrambled eggs, milk and water-both in regular cups. The tray had regular utensils and did not include any weighted utensils. R12's bed was flat and staff did not provide any set up assistance with the meal tray. During observation and interview on 7/29/26 at 12:09 p.m., R12's lunch tray was delivered and her breakfast tray was removed. R12's lunch tray included minced meatloaf, mashed potatoes, minced broccoli, milk and water in regular cups and no weighted utensils. RF-A stated she had arrived at 11:10 a.m., and that R12's breakfast tray was untouched. RF-A further stated that she visited R12 at least three times a week and felt that staff did not provide the assistance R12 required. Staff should not just drop it [the tray] off and wake her up and encourage her to eat. RF-A further stated that the head of bed was supposed to be fully up during meals to prevent choking. During observation and interview on 7/30/26 at 8:28 a.m., nursing assistant (NA)-A in to assist R12 with breakfast. R12's breakfast tray (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contained scrambled eggs, cream of wheat, water and apple juice. The beverages were in regular cups and no weighted utensils on tray. NA-A placed a clothing protector on R12 and proceeded to provide spoonful after spoonful of cereal to R12 without offering sips of beverage in between. After about one quarter of the cream of wheat, NA-A provided a spoonful of scrambled egg. R12 chewed the one bite of eggs for approximately five minutes with several attempts at swallowing. NA-A attempted to offer additional bites of egg before R12 had finished the first one. NA-A did not offer R12 to hold the utensils or the cups and did not encourage R12 to self-feed. After approximately a quarter of the breakfast was consumed, R12 stated she was done. NA-A picked up the tray and started to lower R12's head of bed to a flat position. R12 started yelling for him to stop and stated she had to stay up after meals and did not want to choke. NA-A confirmed that R12 was not provided with adaptive equipment and stated was not aware she was supposed to be receiving them. NA-A further stated was not aware staff were supposed to be encouraging self-feeding or that R12 required to remain upright for 30 minutes after every meal. When NA-A was directed to the meal ticket, he confirmed the meal ticket indicated weighted utensils, two-handed cups, and to encourage self-feeding. NA-A stated did not know those items were part of R12's plan of care. NA-A could not define safe swallowing strategies. During interview on 7/30/26 at 8:57 a.m., registered nurse (RN)- E stated R12 required assistance with meals but staff should encourage self-feeding. RN-E stated would expect staff to know and follow the plan of care and Kardex and confirmed R12 should receive adaptive equipment with meals to promote independence and should remain upright after meals. RN-E stated safe swallowing strategies meant upright during meals, slow small bites, and be supervised. During interview on 7/30/26 at 9:09 a.m., registered dietician (RD) stated trays should be set up according to the meal ticket. RD stated R12 should be supplied with weighted utensils and two-handed cups. During interview on 7/30/26 at 10:20 a.m., speech therapist (ST) stated R12 was currently maximum assistance with meals but could self-feed at times and that staff should be encouraging self-feeding. ST further stated that R12's goal was to eat independently and therefore, should have adaptive equipment to assist in reaching that goal. ST stated R12 should have someone with her during all meals and would expect her to remain upright for 30 minutes after each meal. During interview on 7/30/26 at 12:18 p.m., director of nursing (DON) stated would expect staff to know and follow the residents care plan and Kardex. DON stated would expect residents would receive adaptive equipment as recommended and as indicated on the meal ticket and staff to follow safe swallowing strategies as indicated in their plan of care. Facility policy Food and Nutrition Services/Nursing dated 5/24, indicated, Resident's ordered or recommended type and consistency by IDT [interdisciplinary team] team members will determine and care planed for supervision, assistive devices and monitoring of intake will be care planned for the appropriate interventions.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure pain medication was administered timely for 1 of 1 resident (R12) reviewed for pain management. Findings include: R12's quarterly Minimum Data Set (MDS) dated [DATE], indicated R12 had moderate cognitive impairment, had lower extremity impairment on both sides, was fully dependent or required substantial/maximal assistance with many activities of daily living (ADLs), and was fully dependent with transfers and bed mobility. R12's MDS further identified R12 had almost constant pain and received scheduled and as needed pain (PRN) medication. R12's diagnoses included muscle weakness, history of transient ischemic attack and cerebral infarction, and dysphasia (difficulty swallowing). R12's care plan dated 4/8/26, indicated R12 was on opioid/pain medication due to chronic pain and instructed staff to, Administer ANALGESIC medications as ordered by physician. R12's care plan further identified R12 had pain related to ankle fracture repair and neuropathy and instructed staff to Give pain medications per schedule to maintain therapeutic levels. R12's Pain Interview and Evaluation dated 7/9/26, identified R12 had a condition or diagnosis that usually caused pain or had potential to cause pain and that pain was typically worse in the morning. R12's medication administration record (MAR) July 2026, reviewed on 7/29/26 at 8:58 a.m., identified the following scheduled and PRN pain medications had not been administered yet: -Acetaminophen ER (extended release) 650mg, give two times a day at 8:00 a.m. and 2:00 p.m.-Gabapentin 40mg, give two times a day at 8:00 a.m. and 2:00 p.m.-Hydromorphone 2mg, give as needed for severe pain, last administration 7/25/26 at 3:51 p.m.-Hydromorphone 2mg, give four times a day for chronic pain at 7:00 a.m., 12:00 p.m., 6:00 p.m., and 10:00 p.m.-Lidocaine External patch 4%, apply to bilateral shoulders one time a day at 8:00 a.m. for pain (apply two patches) During observation and interview on 7/29/26 at 8:48 a.m. physical therapist (PT) in to initiate a PT session. R12 declined and stated that she was in too much pain for a therapy session and had not received any pain medication yet this morning. During observation on 7/29/26 at 9:17 a.m., registered nurse (RN)-D in to assess R12's pain and administer pain medications. R12 stated she was in a lot of pain and yelled, please help, please help! R12 stated she had pain in her stomach, arms and legs and stated again, Oh God, please help. RN-D attempted to administer each pill one at a time with a spoon, and R12 had a very hard time swallowing them. RN-D left the room to get some applesauce to assist R12 in swallowing the pills. R12 continued to yell, Oh please God help! At 9:31 a.m., RN-D returned and continued to administer the pain medications. At 9:41 a.m., all the scheduled oral pain medications were administered. During observation on 7/29/26 at 9:43 a.m., RN-E in to assist RN-D to reposition and perform incontinent care. R12 was assisted from side to side and verbalized increased pain with every turn. During observation on 7/29/26 at 10:05 a.m., RN-D back in R12's room and applied one lidocaine patch on each of R12's shoulders. R12 stated, just make the pain go away! During interview on 7/29/26 at 10:11 a.m., RN-D stated he was tied up with wound care on two other residents this morning and confirmed R12's morning medications, including her pain medication was given very late. RN-D further stated that had R12 received her pain medications timely, she may not have been in as much pain during morning cares and may have been able to participate in her PT session. During interview on 7/29/26 at 1:28 p.m., RN-E stated she can verbalize her pain and displayed quite a bit of non-verbal pain cues during repositioning. RN-E stated R12 did have scheduled and PRN pain medications ordered. RN-E further stated if R12 had received her pain medication on time this morning, she may have participated in PT and may have experienced a lot less pain during morning cares. RN-E stated medications should be administered on time as (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scheduled. During interview on 7/30/26 at 10:36 a.m., PT stated they try to coordinate PT sessions so they were approximately 30 minutes or so after pain medication administration so the resident would not be in pain and more successful with therapy. PT stated if R12 had received her morning pain medication as scheduled, she would have been more likely to participate in the PT session. During interview on 7/30/26 at 12:18 p.m., director of nursing (DON) expectation was that residents received pain medications per physician order and on time with a maximum of one hour before and one hour after they were scheduled. DON further stated when resident's pain was managed appropriately, they would be more willing to participate in therapy. Facility policy Pain Management dated 8/8/25, indicated, All residents have the right for appropriate pain evaluation and pain management. The interdisciplinary team is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain, such as during a treatment.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to ensure that antihypertensive medications (used to treat high blood pressure) were given according to provider-ordered parameters to reduce the risk of adverse effects for 1 of 5 residents (R15) reviewed for unnecessary medication use. In addition, the facility failed to ensure active, duplicate medication orders were prevented with the potential for excessive medication use and correlating adverse effects for 1 of 5 residents (R3) reviewed for unnecessary medication use. Findings include: Antihypertensive Medications R15's annual Minimum Data Set (MDS) dated [DATE], indicated R15 had intact cognition and was diagnosed with heart failure and diabetes. R15's Medication Administration Record (MAR) dated 7/1/26 to 7/30/26 at 10:33 a.m., indicated R15 had an order dated 6/11/26 for 50 milligrams (mg) of metoprolol (antihypertensive medication) to be given twice a day for high blood pressure. The order had provider-set parameters to hold the metoprolol if R15's systolic blood pressure (SBP) was lower than 120 or the heart rate was lower than 60. In the a.m. on 7/13/26, R15's SBP was 116, and the medication was documented as given. In the a.m. on 7/16/26, R15's SBP was 115, and the medication was documented as given. In the a.m. on 7/20/26, R15's SBP was 112, and the medication was documented as given. In the a.m. on 7/30/26, R15's SBP was 106, and the medication was documented as given. R15's care plan dated 7/20/26, indicated R15 had hypertension and received antihypertensive medications. The care plan indicated R15 was to receive blood pressure checks per the provider order and staff were to monitor for side effects such as orthostatic hypotension and increased heart rate. R15's medical record was reviewed, and consent from the provider to give the metoprolol against the written ordered parameters was not found. During an interview on 7/30/26 at 12 p.m., registered nurse (RN)-A stated she was the nurse overseeing R15's care for the shift. RN-A stated staff administering medications should review the pulse and blood pressure before administering antihypertensive medications to ensure they were not below the parameters. RN-A confirmed she had reviewed R15's medication and stated that R15's metoprolol should have been held today because the blood pressure was lower than ordered parameters, but it was not. RN-A stated she would worry about potential adverse effects to R15 as the metoprolol was administered when R15's SBP was lower than 120. During an interview on 7/30/26 at 12:12 p.m., RN-C, the nurse manager for the unit, confirmed she had reviewed R15's medical record and stated that R15's metoprolol should not be given if R15's SBP is lower than 120. RN-C confirmed the metoprolol had been administered on multiple occasions, including today (7/30/26) when it was outside of the parameters. RN-C stated this was a medication error and she would need to follow up with the staff who administered the medication and notify the provider. The facility's Medication Administration policy dated 2/2026, indicated nursing staff should obtain and record any vital signs or other monitoring parameters ordered, and if a dose is held, the staff member administering the medication would document this in the space provided in the EHR. Duplicate Medication Order R3's quarterly MDS dated [DATE], indicated R3 had intact cognition and was diagnosed with kidney disease, diabetes, and dementia. The MDS indicated R3 did not have vomiting during the look back period. R3's MAR dated 7/1/26 to 7/29 at 12:14 p.m., indicated R3 had an active order dated 4/8/26 for four mg of ondansetron (anti-nausea medication) every eight hours as needed for nausea and vomiting. Ondansetron was given to R3 under this order twice during the period (7/11/26 and 7/16/26). The MAR had an additional order dated 7/10/26 for four mg of ondansetron every six hours as needed. Ondansetron was given to R3 under this order three times during the period (7/22/26, 7/25/26, and (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/26/26). R3's progress note dated 7/10/26, indicated R3 signed onto hospice on this date.R3's Certification and Plan of Care dated 7/10/26, included an order summary with one Ondansetron order (four mg of ondansetron every six hours as needed).During an interview on 7/30/26 at 12:07 p.m., RN-B confirmed he was the nurse overseeing R3's care for the day. After RN-B confirmed he had reviewed R3's record, he stated R3 had two as-needed orders for ondansetron, and both were available to be administered through the facility's electronic administration software. RN-B stated that the health unit coordinator entered orders in the electronic health record (EHR), and then nursing staff was responsible for reviewing and confirming the resident's orders, so the order became active in the EHR. RN-B stated he would have to call the provider to see which ondansetron order should be kept as active.During an interview on 7/30/26 at 12:19 p.m., RN-C, the nurse manager for the unit, stated R3 had recently signed on to hospice, and it was possible that hospice had ordered a duplicate of the ondansetron. RN-C stated that the health unit coordinator transcribed the order into the EHR and then the nurse reviewed all medications currently ordered to ensure the medication was not a duplicate before confirming the medication.During interview on 7/30/26 at 9:19 p.m., consulting pharmacy manager (PM) stated blood pressure and heart rate should be taken before each dose and held based upon prescribed parameters and if staff gave metoprolol to the resident when their blood pressure was below prescribed parameters it could further lower their blood pressure and increase the potential for lightheadedness, dizziness, lethargy, and falls. Regarding duplicate orders, PM stated it was important to ensure there were no duplicate orders to prevent a resident from receiving more medication than was ordered.During an interview on 7/30/26 at 12:27 p.m., the director of nursing (DON) stated she expected her nursing staff to follow provider orders regarding antihypertensive medication parameters. The DON stated she would have expected nursing staff to review all medications when the medications were entered into the EHR to ensure R3's Zofran was not a duplicate prior to confirming the medication.The facility's Order Transcription policy dated 10/2024, indicated the health unit coordinator/nurse should review the chart after the provider visit to check for any new orders, and the orders should then be transcribed into the EHR. The policy indicated a second licensed staff member must confirm the order placed in the EHR.		

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 07/30/2026
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)		
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure adaptive equipment was provided for 1 of 1 resident (R12) who required weighted utensils and two-handed cups to encourage and promote self-feeding. Findings include: R12's quarterly Minimum Data Set (MDS) dated [DATE], indicated R12 had moderate cognitive impairment, required substantial/maximal assistance with personal and oral hygiene and set up/clean up assistance with eating. R12's diagnoses include type 2 diabetes, acute cystitis (bladder infection), muscle weakness, history of transient ischemic attack and cerebral infarction, dysphasia (difficulty swallowing) and protein-calorie malnutrition. R12's care plan dated 7/9/26, indicated activities of daily living (ADL) self-care deficit and potential alteration in nutrition. The care plan indicated R12 required adaptive feeding equipment to include weighted utensils and two handled cups and to instructed staff to encourage R12 to work on self-feeding at all meals. R12's Nutritional assessment dated [DATE], indicated, Adaptive equipment required. R12's Kardex printed 7/29/26, indicated, EATING: Partial/moderate assistance. Encourage [R12] to work on self-feeding at all meals. Requires adaptive feeding equipment: weighted utensils and 2-handed cups w/lids at each meal. R12's Rehab Communication dated 3/24/26, indicated, Please provide pt w/handled cup w/lid and weighted utensils for all meals. Assist pt in cutting up food PRN [as needed]. R12's breakfast meal ticket dated 7/29/26, indicated, Equipment: Weighted Utensils [Grey], Two Handled Cups with Lid. R12's lunch meal ticket dated 7/29/26, indicated, Equipment: Weighted Utensils [Grey], Two Handled Cups with Lid. R12's breakfast meal ticket dated 7/30/26, indicated, Equipment: Weighted Utensils [Grey], Two Handled Cups with Lid. During interview on 7/27/26 at 12:30 p.m., resident friend (RF)-A stated she visited R12 frequently and did not think R12 was getting enough to eat. RF-A stated R12 required assistance with meals and did not think anyone ever helped her since she often found her meals untouched. During observation on 7/29/26 at 8:27 a.m., unidentified staff delivered R12's breakfast tray, set on bedside table and did not provide any set up or attempt to wake R12. The breakfast tray included a plate of scrambled eggs, milk and water-both in regular cups. The tray had regular utensils and did not include any weighted utensils. During observation on 7/29/26 at 12:09 p.m., R12's lunch tray was delivered and her breakfast tray was removed. R12's lunch tray included minced meatloaf, mashed potatoes, minced broccoli, milk and water in regular cups and no weighted utensils. During interview on 7/29/26 at 12:28 p.m., R12 stated she used to receive weighted utensils and two-handed cups with her meals, but had not received them for quite some time. R12 stated adaptive equipment made it much easier for her to eat independently since she had a difficult time grasping and handling the regular utensils and cups. During observation and interview on 7/30/26 at 8:28 a.m., nursing assistant (NA)-A in to assist R12 with breakfast. R12's breakfast tray contained scrambled eggs, cream of wheat, water and apple juice. The beverages were in regular cups and no weighted utensils on tray. NA-A confirmed that R12 was not provided with adaptive equipment and stated was not aware she was supposed to be receiving them. When NA-A was directed to the meal ticket, he confirmed the meal ticket indicated weighted utensils and two-handed cups. NA-A stated it was the kitchen's responsibility to ensure the trays were set up correctly. During interview on 7/30/26 at 8:57 a.m., registered nurse (RN)-E stated R12 should be assisted with meals but also should be encouraged to self-feed as much as she could. RN-E stated R12 was supposed to get weighted utensils and two-handed cups to help promote independence during meals. During interview on 7/30/26 at 9:09 a.m., registered dietician (RD) stated (continued on next page)		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trays should be set up according to the meal ticket. RD stated R12 should be supplied with weighted utensils and two-handled cups. During interview on 7/30/26 at 10:20 a.m., speech therapist (ST) stated R12 was currently maximum assistance with meals but could self-feed at times and that staff should be encouraging self-feeding. ST further stated that R12's goal was to eat independently and therefore, should have adaptive equipment to assist in reaching that goal. During interview on 7/30/26 at 12:18 p.m., director of nursing (DON) stated would expect residents to receive adaptive equipment as recommended and as indicated on the meal ticket. DON stated that weighted utensils and 2-handled cups would help promote independence for R12 during meals. DON further stated the kitchen staff were responsible for tray set up, but the NAs who deliver the tray, should also check the tray for accuracy. During interview on 7/30/26 at 1:06 p.m., corporate culinary director (CCD) stated kitchen staff should set up trays according to the meal ticket and if adaptive equipment was listed on the meal ticket, they should be included on the tray. Facility policy Food and Nutrition Services/Nursing dated 5/24, indicated, Staff will check individual name and diet on each meal ticket/card to verify the meal is served to the appropriate person, check items on the plate/tray to assure accuracy for therapeutic diets, texture, adaptive equipment and consistency modifications as needed.		