**DEPARTMENT OF HEALTH AND HUMAN SERVICES** **CENTERS FOR MEDICARE & MEDICAID SERVICES**

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E6HF

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00047

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245024**
2.STATE VENDOR OR MEDICAID NO.
(L2) **516740000**

3. NAME AND ADDRESS OF FACILITY
(L3) **INTERFAITH CARE CENTER**
(L4) **811 THIRD STREET**
(L5) **CARLTON, MN** (L6) **55718**

4. TYPE OF ACTION: **7** (L8)
**1. Initial** **2. Recertification**
**3. Termination** **4. CHOW**
**5. Validation** **6. Complaint**
**7. On-Site Visit** **9. Other**
**8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/27/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| **01 Hospital** | **05 HHA** | **09 ESRD** | **13 PTIP** | **22 CLIA** |
| **02 SNF/NF/Dual** | **06 PRTF** | **10 NF** | **14 CORF** | |
| **03 SNF/NF/Distinct** | **07 X-Ray** | **11 ICF/IID** | **15 ASC** | |
| **04 SNF** | **08 OPT/SP** | **12 RHC** | **16 HOSPICE** | |

FISCAL YEAR ENDING DATE: (L35)
**12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
**X** A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 96 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 8/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/29/2014 (L20)

## PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
**01/01/1969**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

***Protecting, Maintaining and Improving the Health of Minnesotans***

Medicare Provider # 245024

August 29, 2014

Ms. Constance Anderson, Administrator
Interfaith Care Center
811 Third Street
Carlton, Minnesota 55718

Dear Ms. Anderson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 6, 2014 the above facility is certified for or recommended for:

96 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

***Protecting, Maintaining and Improving the Health of Minnesotans***

Electronically delivered
August 13, 2014

Ms. Constance Anderson, Administrator
Interfaith Care Center
811 Third Street
Carlton, Minnesota 55718

RE: Project Number S5024024

Dear Ms. Anderson:

On July 15, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 27, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On August 11, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 27, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 6, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 27, 2014, effective August 6, 2014 and therefore remedies outlined in our letter to you dated July 15, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245024 | A. Building<br>B. Wing | 8/11/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| INTERFAITH CARE CENTER | 811 THIRD STREET<br>CARLTON, MN 55718 |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **F0248**<br>Reg. # **483.15(f)(1)**<br>LSC | Correction Completed **08/06/2014** | ID Prefix **F0285**<br>Reg. # **483.20(m), 483.20(e)**<br>LSC | Correction Completed **08/06/2014** | ID Prefix **F0309**<br>Reg. # **483.25**<br>LSC | Correction Completed **08/06/2014** |
| ID Prefix **F0311**<br>Reg. # **483.25(a)(2)**<br>LSC | Correction Completed **08/06/2014** | ID Prefix **F0327**<br>Reg. # **483.25(j)**<br>LSC | Correction Completed **08/06/2014** | ID Prefix **F0328**<br>Reg. # **483.25(k)**<br>LSC | Correction Completed **08/06/2014** |
| ID Prefix **F0329**<br>Reg. # **483.25(l)**<br>LSC | Correction Completed **08/06/2014** | ID Prefix **F0411**<br>Reg. # **483.55(a)**<br>LSC | Correction Completed **08/06/2014** | ID Prefix **F0431**<br>Reg. # **483.60(b), (d), (e)**<br>LSC | Correction Completed **08/06/2014** |
| ID Prefix **F0441**<br>Reg. # **483.65**<br>LSC | Correction Completed **08/06/2014** | ID Prefix **F0465**<br>Reg. # **483.70(h)**<br>LSC | Correction Completed **08/06/2014** | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | GN/KFD | 08/13/2014 | 10160 | 08/11/2014 |
| Reviewed By<br>CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 6/27/2014 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

# SURVEY TEAM COMPOSITION AND WORKLOAD REPORT



| Provider/Supplier Number | Provider/Supplier Name |
|---|---|
| 245024 | INTERFAITH CARE CENTER |

Type of Survey (select all that apply):

| | | | | | |
|---|---|---|---|---|---|
| A | D | | | | |

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

| | | | | | |
|---|---|---|---|---|---|
| D | | | | | |

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

| Surveyor Id Number (A) | First Date Arrived (B) | Last Date Departed (C) | Pre-Survey Preparation Hours (D) | On-Site Hours 12am-8am (E) | On-Site Hours 8am-6pm (F) | On-Site Hours 6pm-12am (G) | Travel Hours (H) | Off-Site Report Preparation Hours (I) |
|---|---|---|---|---|---|---|---|---|
| 1. Team Leader 10160 | 8/11/2014 | 8/11/2014 | 0.25 | 0.00 | 0.00 | 0.00 | 0.00 | 0.25 |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |
| 7. | | | | | | | | |
| 8. | | | | | | | | |
| 9. | | | | | | | | |
| 10. | | | | | | | | |

| | |
|---|---|
| Total Supervisory Review Hours ..... | 0.25 |
| Total Clerical/Data Entry Hours..... | 2 |
| Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... | Y |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

# SURVEY TEAM COMPOSITION AND WORKLOAD REPORT



| Provider/Supplier Number | Provider/Supplier Name |
|---|---|
| 245024 | INTERFAITH CARE CENTER |

Type of Survey (select all that apply):

| | | | | | |
|---|---|---|---|---|---|
| D | | | | | |

A Complaint Investigation  E Initial Certification  I Recertification
B Dumping Investigation  F Inspection of Care  J Sanction/Hearing
C Federal Monitoring  G Validation  K State License
D Follow-up Visit  H Life safety Code  L Chow

Extent of Survey (Select all that apply):

| | | | | | |
|---|---|---|---|---|---|
| D | | | | | |

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

| Surveyor Id Number (A) | First Date Arrived (B) | Last Date Departed (C) | Pre-Survey Preparation Hours (D) | On-Site Hours 12am-8am (E) | On-Site Hours 8am-6pm (F) | On-Site Hours 6pm-12am (G) | Travel Hours (H) | Off-Site Report Preparation Hours (I) |
|---|---|---|---|---|---|---|---|---|
| 1. Team Leader 10160 | 8/11/2014 | 8/11/2014 | 0.25 | 0.00 | 0.00 | 0.00 | 0.00 | 0.25 |
| 2. | | | | | | | | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| 5. | | | | | | | | |
| 6. | | | | | | | | |
| 7. | | | | | | | | |
| 8. | | | | | | | | |
| 9. | | | | | | | | |
| 10. | | | | | | | | |

Total Supervisory Review Hours ..... 0.25

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

**DEPARTMENT OF HEALTH AND HUMAN SERVICES** **CENTERS FOR MEDICARE & MEDICAID SERVICES**

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E6HF

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00047

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245024**

2.STATE VENDOR OR MEDICAID NO.
(L2) **516740000**

3. NAME AND ADDRESS OF FACILITY
(L3) **INTERFAITH CARE CENTER**
(L4) **811 THIRD STREET**
(L5) **CARLTON, MN** (L6) **55718**

4. TYPE OF ACTION: **2** (L8)
**1. Initial** **2. Recertification**
**3. Termination** **4. CHOW**
**5. Validation** **6. Complaint**
**7. On-Site Visit** **9. Other**
**8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/27/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| **01 Hospital** | **05 HHA** | **09 ESRD** | **13 PTIP** | **22 CLIA** |
| **02 SNF/NF/Dual** | **06 PRTF** | **10 NF** | **14 CORF** | |
| **03 SNF/NF/Distinct** | **07 X-Ray** | **11 ICF/IID** | **15 ASC** | |
| **04 SNF** | **08 OPT/SP** | **12 RHC** | **16 HOSPICE** | |

FISCAL YEAR ENDING DATE: (L35)
**12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 96 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 07/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/13/2014 (L20)

## PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
**01/01/1969**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7013 2250 0001 6356 5422

July 15, 2014

Ms. Constance Anderson, Administrator
Interfaith Care Center
811 Third Street
Carlton, Minnesota 55718

RE: Project Numbers S5024024, H5024009 and H5024007

Dear Ms. Anderson:

On June 27, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the June 27, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5024009. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 27, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5024007 that was found to be unsubstantiated.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

**<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**

**<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**

**Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

**Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

**Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.**

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

**DEPARTMENT CONTACT**

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731
Fax: (507) 206-2711

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 6, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

**PLAN OF CORRECTION (PoC)**

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected

by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

## FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 27, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 27, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**INFORMAL DISPUTE RESOLUTION**

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245024 | A. BUILDING _____ B. WING _____ JUL 28 2014 | 06/27/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| INTERFAITH CARE CENTER | 811 THIRD STREET CARLTON, MN 55718 |

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| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.<br><br>Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.<br><br>A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey for as follows:<br><br>Investigations of complaints H5024009 and H5024007 were completed. The complaint was substantiated related to H5024009. Deficiency issued at F309, F327, and F328.<br><br>The complaint related to H5024007 were not substantiated. | F 000 | | |
| F 248 SS=D | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, document review and | F 248 | 7/29/14 SPM | |

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

Constance A Andersen | Administrator | 7-25-14

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.

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| F 248 | Continued From page 1<br>staff interview, the facility failed to provide a resident specific activity program based on the resident ' s assessment for 1 of 3 residents (R128) reviewed for activities.<br><br>Findings include:<br><br>R128 was not provided with an individualized activity program based on the comprehensive assessment.<br><br>R128 admission Minimum Data Set (MDS) dated 4/10/14, indicated R128 was diagnosed with diabetes, dementia, and depression. The MDS also indicated R128 required extensive assistance of one to two staff for all activities of daily living. The Activity Profile Interest Assessment completed on 4/10/14, indicated R128 preferred to have leisure activities in her room, has a strong history of religious affiliation and had interests in Christian television (TV) programs and Christian music. The assessment also noted R128 had a new diagnosis of depression and indicated R128 would benefit from one to one visit and small groups. The plan of care dated 4/16/14, directed staff to assist with in room leisure interests, TV and radio with appropriate music and to provide one to one (1:1) visits with R128 two times a week.<br><br>On 6/24/14, during evening observations and 6/25/14, during morning observations R128 was observed to be in her room, sleeping in her chair or in her bed. There was no TV on or radio playing and R128 was not observed to participate in any activity program.<br><br>The activity log from April 2014 indicated R128 participated in sing along four times, Bingo one | F 248 | **F248 (D)**<br>**1. Corrective Action:**<br>a) Resident R128 had a comprehensive Activity assessment and POC reviewed and updated if needed.<br>b) Resident 128 is receiving scheduled 1:1 visits.<br>**2. Corrective Action as it applies to other residents:**<br>a) Audit of all residents who are identified at risk for isolation in Section E of the MDS to ensure the care plan is appropriate and the resident is receiving services.<br>b) 100% Audit of all residents currently assessed as needing 1:1 programming to ensure the services are being provided. | |

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| F 248 | Continued From page 2<br>time baking one time and one worship service.<br><br>The activity log from May 2014 indicated R128 participated in bingo, one time, reading circle one time, special music and sing along two times and Sunday worship two times.<br><br>The activity log from June 1 to June 26, 2014 indicated R128 participated in Bingo two times, sing along and sing praises four times, Jingo one time and weekday music one times.<br><br>However, none of the logs included participation in one to one visits.<br><br>On 6/27/14, at 9:16 a.m. the activity director verified R128's POC directed staff to provide 1:1 visits, however for some reason it was missed and was never initiated. The activity director added they can start those forms right now and begin the 1:1 visits.<br><br>On 6/27/14, at 9:45 a.m. activity aid-A stated she was not aware R128 was to have scheduled 1:1 activities. | F 248 | **3. Reoccurrence will be prevented by:**<br>a) All Interfaith Care Center staff were in-serviced on capturing individual resident preferences – with emphasis on improving quality of resident time spent alone, in room, etc.<br>b) Activity preferences will be added to the Nursing Assistant Direct Care Guides<br>c) The activity director will conduct scheduled and random visual audits of resident activities including 1:1's and group activities for 90 days. Audit results will be reported to QA for further recommendations.<br>**4. The Correction will be monitored by:**<br>Activity Director, Administrator<br>**5. Date of Completion: 8/6/2014** | |
| F 285 SS=D | 483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR<br><br>A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.<br><br>A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health | F 285 | | |

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| F 285 | Continued From page 3<br>authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.<br>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.<br><br>For purposes of this section:<br>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).<br>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation and staff interview, the facility failed to provide an assessment for specialized rehabilitation services for 1 of 1 resident (R56) reviewed for preadmission | F 285 | **F285 (D)**<br>**1. Corrective Action:**<br>a) Resident R had a Level 2 Screening.<br>**2. Corrective Action as it applies to other residents:**<br>**a)** 100% Audit of all facility residents for documentation of PASRR Level 1 screening and a Level 2 screening if indicated.<br>**3. Reoccurrence will be prevented by:**<br>a) The facility policy on PASRR was updated to reflect the new procedure at the State level.<br>b) Social service will document evidence of PASRR screening and follow up for a Level 2 screening (if indicated) in each resident's medical record.<br>c) The admissions team, social service, and licensed staff were in-serviced on the PASRR process.<br>**4. The Correction will be monitored by:**<br>Director of Social Services, Administrator<br>**5. Date of Completion: 8/6 /2014** | |

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| F 285 | Continued From page 4<br>screening.<br><br>Findings include:<br>R56 was admitted on 3/18/14, with a diagnosis that included bipolar disorder and depression The medical record lacked documentation indicating a Preadmission Screening and Resident Review (PASRR) was completed to ensure R56 received specialized rehabilitation services related to the mental illness.<br><br>On 6/27/14, at 11:44 a.m. licensed practical nurse (LPN)-B stated R56 was admitted for physical rehabilitation and stays in her room. LPN-B stated the resident sleeps a lot and is depressed and had recently received some devastating news. At that time R56 was observed to walk out of the bathroom and go back to her bed. LPN-B stated R56 had " stomach flu " type symptoms and would not be available to interview.<br><br>On 6/27/14 at 11:49 the licensed social worker (LSW)-A stated another social worker had been assigned to R56 and LSW-A was not familiar with her case. The LSW-A stated there should have been a Level II PASRR in the medical record but could not find one. LSW-A did have a facsimile cover sheet page dated 6/23/14, to Carlton County Public Health and Human Services requesting a Level II PASRR screening. LSW-A stated sometimes the county workers will complete these screenings and forget to send a form to the facility. LSW-A stated at this time the facility could not provide specialized rehabilitative services if the screening was not completed and LSW-A could not locate one. | F 285 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING | F 309 | | |

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| F 309 | Continued From page 5<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to notify the physician as ordered for weight changes and failed to monitor fluid restriction with intake and output consistently for 1 of 1 resident (R130) reviewed for dialysis.<br><br>Findings include:<br><br>R130 had a physician orders related to monitoring of weight, fluid intake, and fluid output. The facility had not monitored consistently or notified the physician as ordered.<br><br>R130 was admitted to the facility 4/9/14. The admission Minimum data Set (MDS) dated 4/9/14 noted the resident had no cognitive impairment, the resident required extensive assistance with activities of daily living, and the resident could independently eat and drink. The 4/9/14 hospital discharge orders noted diagnoses that included acutely decompensated systolic heart failure, cardio renal syndrome, and urinary retention. The physician notes of 4/27/14 identified chronic kidney disease stage 4 (severe) as an additional diagnosis. Nursing notes indicated R130 had expired 5/13/14. | F 309 | **F309 (D)**<br>**1. Corrective Action:**<br>a) Resident R 130 discharged from the facility<br>**2. Corrective Action as it applies to other residents:**<br>a) 100% Audit of all residents with fluid restrictions for monitoring fluids, intake and output, weights, and parameters for physician notification.<br>**3. Reoccurrence will be prevented by:**<br>a) Facility policy on Intake and Output was reviewed and revised to include documentation of 24 hour totals, data collection and measurements.<br>b) Facility policy on Fluid Restriction was revised to include identification of departmental responsibilities and a guideline for liquid allotments for each department, shift and meal.<br>c) All Interfaith Licensed and Direct Care staff will be in-serviced on the I & O policy, Fluid Restriction policy and the Change of Condition policy. | |

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| F 309 | Continued From page 6<br>The 4/9/14 Fairview Hospital discharge orders directed cardiac diet with less than 2 gm sodium restriction, low carbohydrates. The discharge orders also directed intake and output every shift and daily weights. The facility computer generated orders dated 4/9/14 directed a heart healthy diet, intake and output 3 times day, weekly weights.<br><br>Physician orders of 4/27/14 directed fluid 1500 ml per 24 hour day. The facility computer generated orders dated 4/28/14 directed daily weight and notify physician if weight is up 3 pounds (lbs.) in 1 day or 5 lbs. in 1 week from dry weight one time a day.<br><br>On 5/9/14 the physician ordered 1500 ml fluid restriction. The nursing notes dated 5/9/14 indicated dialysis had been contacted and had given a fluid restriction of 1500 cc and identified the dry weight of 211 lbs. On 5/12/14 the nurse ' s notes and medication administration record (MAR) indicated a 1200 cc fluid restriction.<br><br>An eating evaluation was completed on 4/15/14. The evaluation did not mention an estimated fluid intake requirements or the fluid restriction. No additional nutritional assessment was found or provided when asked.<br><br>The care plan dated 4/9/14 identified diet heart healthy. The care plan did not identify directions of the 1500 cc fluid restrictions, intake/output monitoring, or weight monitoring and notification of physician.<br><br>The April 2014 medication administration record identified an order of daily weights and to notify medical doctor if weight is up 3 lbs. in 1 day or 5 | F 309 | d) Inter-departmental team members involved in care planning for residents with Fluid Restrictions were in-serviced on the Fluid Restriction policy, establishing departmental allotments, monitoring, and physician notification.<br>e) Residents on Fluid Restrictions will be added to daily Inter-Disciplinary Team QA review for evaluation with compliance with restrictions, weights and physician notification.<br>**4. The Correction will be monitored by:**<br>Nurse Managers, DON, Dietary Manager<br>**5. Date of Completion: 8/6/2014** | |

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| F 309 | Continued From page 7<br>lbs. in 1 week from 'dry weight' (meaning first weight in day without having had fluids consumed) had a start dated of 4/10/14. Also noted 19 of 21 opportunities of weight were documented according in the MAR in April. April 10: R130's weight was 203.8 lbs.; April 12: 206/lbs. up 3 lbs.; April 16: 210 lbs. an increase which was more than 5 lbs. in one week; April 18: 212 lbs. again more than 5 lbs. gain in the week; April 23: 214.2 lbs. and again more than 5 lbs. gain in the week. R130 had an admission weight per nursing notes of 203 lbs. and none of the weights over three pounds per day or five pounds per week had been reported to the physician as ordered and none were provided to support that the weights were sent to the physician.<br><br>The May 2014 MAR identified record intake and output however, there was several days the shift documentation of fluid intake was missing so 24 hour totals were not available to review for weight gain. On 4/24/14 nursing note documentation noted the placement of the dialysis catheter. Review of dialysis weight 5/2/14 to 5/8/14 showed a 7 lbs. to 10 lbs. weight difference between pre and post dialysis run. During an interview on 6/26/14 at 7:59 a.m. the director of nursing verified R130's intake and output had not been tallied for a 24 hour period.<br><br>The May MAR continued the physician order daily weights: notify MD if weight is up 3 lbs. in 1 day or 5 lbs. in 1 week from 'dry weight.' The resident's weight on April 24, 2014 (at time of the dialysis catheter placement) was 212 lbs. On May 10 the weight was 215.6 lbs. and on May 12 was up to 217.6 pounds or up 8 lbs. in a six day period of time. Review of the physician faxes, physician documentation and nursing notes of this time | F 309 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 309 | Continued From page 8<br>again did not reveal the physician had been notified nor was information in regards to physician notification of weight gain provided by the director of nursing when requested.<br><br>During an interview on 6/26/14 at 7:58 a.m. the director of nursing indicated that she had reviewed R130's medical record in the past, but not the intake and output component. Stated would need to do the totals for intake and output yet. Also stated there was no known check to see if there was any balance between the intake and output. She verified that there had not been and intake and output balance completed for R130.<br><br>During an interview on 6/26/14 at 9:35 a.m. the director of nursing stated the facility had not identified a planned amount of fluid to be provided by nursing and by dietary to stay in compliance with the 24 hour total of 1500 cc per day. During an interview on 6/27/14 at 11:00 a.m. the director of nursing stated the fluid restriction order was received on 5/9/14. The original order had been since to Spirit Mountain Clinic instead of the facility. The facility needed to ask for it to be faxed. Dialysis began on 5/1/14 but the facility request was not made until 5/9/14. On 5/1/14 the dry weight was considered to be 211#. The DON stated the admission weight was 203 and the primary physician had assumed care at admission, and had requested daily weights and notification. DON verified the physician had not been notified of elevated weights noted 4/14/14 through 4/30/13. DON verified the daily fluid restrictions were not monitored after identified as ordered and the resident weights were not discussed with the physician as ordered. | F 309 | | |
| F 311 | 483.25(a)(2) TREATMENT/SERVICES TO | F 311 | | |

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| F 311 SS=D | Continued From page 9<br>IMPROVE/MAINTAIN ADLS<br><br>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide ambulation services to maintain or improve ambulation ability for 1 of 1 resident (R95) who required assistance with ambulation.<br><br>Findings include:<br><br>R95 received ambulation services by nursing assistants but there was no documentation as to how far R95 ambulated to determine if there was deterioration in ambulating. Also twice daily ambulation was not consistently completed for R95.<br><br>R95's quarterly Minimum Data Set (MDS) dated 5/27/14 indicated R95 required extensive assistance of 1 staff for ambulation. R95's Fall Care Area Assessment (CAA) dated 12/16/14 indicated R95 had a fall at home and was to receive therapy to improve balance and decrease fall risk.<br><br>R95's care plan (CP) revised 5/28/14, indicated R95 required extensive assist with all transfers and ambulation related recent hip fracture. Interventions listed were therapy services as ordered and extensive assist of 1-2 staff for ambulation. The CP also indicated R95 was forgetful, would not always use the call light and | F 311 | **F311 (D)**<br>**1. Corrective Action:**<br>a) Resident 95 had a comprehensive assessment of her mobility and care plan updated to include measurable distance goals.<br>**2. Corrective Action as it applies to other residents:**<br>a) 100% audit of all residents receiving ambulation services to ensure measurable distance goals and compliance with programming.<br>**3. Reoccurrence will be prevented by:**<br>a) The facility policy on documentation of ambulation services was reviewed and updated to include distance and goals.<br>b) Facility Ambulation Program Documentation forms were updated to include goals, distance, and reason for any refusals.<br>c) Ambulation goals were added to the Direct Care Guides for communication to the Direct Caregivers.<br>d) All Nursing staff will be educated on ambulation services, documentation expectations including distance goals.<br>e) Ambulation services will be monitored daily by the Licensed Staff for 90 days and reviewed weekly at IDT. Findings will be reported to the Quality Assurance Committee for recommendations.<br>**4. The Correction will be monitored by:**<br>Nurse Managers, DON<br>**5. Date of Completion: 8/6/2014** | |

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| F 311 | Continued From page 10<br>would attempt to transfer herself. The record indicated R95 had a sensor alarm in the bed and wheelchair.<br><br>The Walk and Transfer CP initiated on 2/27/14, directed staff to walk R95 using a 2 wheeled walker (WW) with limited assistance of 1 staff to pull wheelchair behind resident for 100 feet to 150 feet. A progress note from the physical therapist dated 4/30/14 indicated R95's skilled physical therapy program would be discontinued but would continue to be on a functional maintenance program with the assistance of nursing staff and a two wheeled walker. R95's Walk and Transfer POC were reviewed which indicated the following:<br><br>March 2014, out of 62 opportunities to ambulate, 41 opportunities were blank and the record lacked the distance R95 ambulated.<br><br>April 2014, was not available for review.<br><br>May 2014, out of 62 opportunities to ambulate, 51 opportunities were blank and the record lacked the distance R95 ambulated.<br><br>June 2014, out of 60 opportunities to ambulate, 43 opportunities were blank and the record lacked the distance R95 had ambulated.<br><br>On 6/26/14 at 7:32 a.m. R 95 was observed to be sitting in a wheel chair at the dining room table and remained there until 8:12 a.m. when she wheeled herself out of the dining room and into her room. At approximately 8:20 a.m. R95 observed to be wheeled out of her bathroom with the assistance of nursing assistant. R95 was not observed to walk in the hallway or in the bedroom | F 311 | | |

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| F 311 | Continued From page 11<br>during these observation times.<br><br>On 6/26/14, at 2:30 p.m. registered nurse (RN)-A verified R 95 was to be walked twice a day. RN-A stated she has seen staff walk with R95 but they were not documenting residents ambulation times or distances she walked. The RN stated nurse managers reviewed the forms monthly and they had identified problems with the ambulation program.<br><br>The physical therapist (PT) stated on 6/26/14, at approximately 4:00 p.m. that if it was not being signed off it was not being done. She stated it is a nursing task not part of the therapy program. The PT added the therapy department does not look at their programs again unless they are referred back to them which R95 had not been referred back.<br><br>On 6/27/14, at approximately 11:05 a.m. the director of nursing verified R95 was not being offered ambulation services according to the plan of care. | F 311 | | |
| F 327 SS=D | 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION<br><br>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure physician fluid restriction orders were implemented for 1 of 1 resident (R91) reviewed with fluid restrictions. | F 327 | | |

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| F 327 | Continued From page 12<br><br>Findings include:<br><br>R91 was observed on 6/24/14 at 12:35 p.m. R91's lunch tray was on the bedside table and had a glass of water and 2 glasses of juice. R91's daughter stated the resident was on a fluid restriction of 2000 cc related to a low sodium level. R91 was again observed in the room on 6/25/14 at 4:00 p.m. and had a cup of coffee (180 cc of fluid) and a 10 ounce (oz) and 300 cc of fluid pitcher of water on the bedside table. Only sips of coffee and water were left in the containers at this time. On the morning of 6/26/14 at 7:35 a.m. a 10 oz. pitcher of water was on the bedside table with most of the fluid from the pitcher consumed. During an interview on 6/26/14 at 9:20 a.m. nursing assistant (NA)-A stated she had filled the pitcher with 10 oz. of water and currently only 6 oz. remained in the pitcher and most of the cup of coffee on the bedside table had been consumed. On 6/26/14 at 11:45 a.m. R91 was observed sitting in a wheelchair. The daughter, also in the room who had brought R91 a 12 oz. cup (360 cc) of "real coffee."<br><br>The facility diagnosis list of 5/9/14 for R91 included congestive heart failure and cardiac disease. A laboratory report dated 6/13/14 indicated sodium level was at 125 but normal was 136 to 145. The admission Minimum Data Set dated 5/15/14 indicated R91 had no cognitive impairment, required limited assistance with activities of daily living, and could eat and drink independently.<br>Registered nurse (RN)-B stated R91 had been discharged home and then was readmitted from the hospital on 6/9/14. | F 327 | **F327 (D)**<br>**1. Corrective Action:**<br>a) Resident R 91's care plan was reviewed and revised to include monitoring fluid restriction with intake and output, weights and parameters for physician notification.<br>b) Resident R 91 had a nutritional assessment completed that included information related to estimated fluid intake requirements<br>**2. Corrective Action as it applies to other residents:**<br>a) 100% Audit of all residents with fluid restrictions for monitoring fluid restriction with intake and output, weights and parameters for physician notification. | |

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| F 327 | Continued From page 13<br><br>Physician orders dated 5/4/14 included an order to monitor intake and output, daily weight, low sodium diet. On 5/13/14 the physician documented "slow down on fluid intake" and to notify physician for changes in weights. On 6/18/14 the physician ordered water and liquid intake limited to 2 liters daily (total of 2000 cubic centimeters (CC) per day.) On 6/20/14 the physician documented decrease fluid to 1500 cc per day. Physician orders dated 6/24/14 the physician again noted decrease fluid to 1500 cc daily.<br><br>The medication administration record (MAR) was reviewed. The MAR noted on 6/19/14 to monitor intake and output. The MAR indicated on 6/24/14 the fluid intake restriction of 1500 cc daily. The MAR showed inconsistent monitoring of intake for 6/19, 6/20, 6/211, 6/22, 6/23, 6/24, and 6/25. There was no daily total of fluids consumed by R91. No plan to identify who (nursing or dietary) was to give what amount during the day so total fluid intake did not go over the 1500 cc per day. On 6/25/14 at 3:40 p.m. registered nurse (RN)-B stated the recorded intake was what was given by nursing with medications and not sure how much dietary is responsible to give.<br><br>The care plan printed 6/25/14 identified a problem of respiratory status. The problem had an intervention that directed fluid restriction as established at 1500 cc/d initiated on 6/25/14. The care plan did not identify who (nursing or dietary) was to give what amount fluid during the day and did not direct the monitoring of the intake.<br><br>No nutritional assessment was found or provided | F 327 | **3. Reoccurrence will be prevented by:**<br>a) Facility policy on Intake and Output was reviewed and revised to include documentation of 24 hour totals, data collection and measurements.<br>b) Facility policy on Fluid Restriction was revised to include identification of departmental responsibilities and a guideline for liquid allotments for each department, shift and meal.<br>c) All Interfaith Licensed and Direct Care staff will be in-serviced on the I & O policy, Fluid Restriction policy and the Change of Condition policy.<br>d) Inter-departmental team members involved in care planning for residents with Fluid Restrictions were in-serviced on the Fluid Restriction policy, establishing departmental allotments, monitoring, and physician notification.<br>e) Residents on Fluid Restrictions will be added to daily Inter-Disciplinary Team QA review for evaluation with compliance with restrictions, weights and physician notification.<br>**4. The Correction will be monitored by:**<br>Nurse Managers, DON, Dietitian<br>**5. Date of Completion: 8/6/2014**<br>**4. The Correction will be monitored by:**<br>Nurse Managers, DON, Dietary Manager<br>**5. Date of Completion: 8/6/2014** | |

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| F 327 | Continued From page 14<br>for R91. A nutritional CAA (care area assessment) undated but printed on 6/26/14 did not contained information related to estimated fluid intake requirements.<br><br>On 6/25/14 at 3:50 p.m. NA-C was interviewed. NA-C stated she would set up the trays and would usually give R91 240 cc coffee for supper and 120 cc apple juices. NA-C stated she would document this in the " Point of Care " kiosk. RN-B stated during the evening shift R91 would drink about 120 cc water with each medication administration and would get 4 medication passes a day but not sure how many fluids were given at other medication pass times. RN-B stated daily intake was not tracked and that the amount was not totaled daily.<br><br>During an interview on 6/26/14 at 7:58 a.m. director of nursing (DON) stated she thought that the shift total in the MAR did include what the nursing assistants gave the resident during the shift. She added there was no direction of who was to give what and when or how much was to be given with the medication. DON stated she did not know if fluid in the room counted towards the total fluids per day amount. At 9:35 a.m. on 6/26/14 DON stated there had not been a definitive amount of fluid to be provided by nursing or dietary, but that dietary was aware of the total amount to be given, just not how much dietary could give.<br><br>During an interview on 6/26/14 at 1:45 p.m. the director of nursing (DON) stated dietary did not have a definite amount of fluids to provide the resident. DON stated she had not found a policy related to fluid restriction/s or fluid intake monitoring. | F 327 | | |

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| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interview, and record review, the facility failed to ensure residents that received enteral feedings received the correct amount of fluid for 1 of 1 resident (R35) reviewed who received enteral feedings.<br><br>Findings include:<br><br>R35 was observed 6/25/14 at 9:03 a.m. and she stated that she received a tube feeding. R35 was noted to have lower extremity edema. On 6/26/14 at 12:28 p.m. licensed practical nurse (LPN)-A was observed to administer an enteral feeding to R35.<br><br>The resident care plan dated 6/25/14 indicated R35 was admitted to the facility in 2010 and had diagnoses that included but not limited to stroke, congestive heart failure and hypertension. The physician orders of 4/16/14 indicated R35 received Lasix (diuretic) and Lopressor ( | F 328 | **F328 (D)**<br>**1. Corrective Action:**<br>a) Resident 35 had her fluid, enteral feeding & medication intake re-evaluated by the Nurse Manager, Dietitian and Consultant Pharmacist and her care plan was updated to reflect the amount of water to administer with the feedings: with the medications and the flushes.<br>b) Resident 35's physician was updated and orders were obtained for mixing the crushed medications.<br>**2. Corrective Action as it applies to other residents:**<br>c) 100% audit of all residents receiving enteral feedings or medications via enteral tube to insure that the amount of water to administer with the feedings, the medications and the flushes are appropriately calculated. | |

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| F 328 | Continued From page 16<br>hypertensive), . The quarterly Minimum Data Set (MDS) dated 4/8/14 indicated R35 had a BIMS (brief interview of mental status) of 13 or no impairment and required extensive assistance with activities of daily living.<br><br>Physician orders of 4/16/14 directed Prosource liquid 30 ml and 30 ml water flush before and after administration; enteral feed four times a day of 250 ml and flush with 80 ml o water before and after feeding. Water flush 180 ml free water three times a day. The resident received oral medications via tube four times a day, but the physician orders did not include amount of water to be used with the medication administration. The total amount of water the physician prescribed was 1240 ml. This did not include water within the formula.<br><br>The care plan dated 6/25/14 noted R35 had the G-tube placement on 10/30/13. The care plan of 6/25/14 identified a problem of nutrition/hydration that identified the use of a G-tube for feeding and refers the reader to " Eating Care Plan. TF [tube feeding] and H20 [water] flush per MD order. Check residuals with every feeding. " The eating problem identified " 11/11/13: Returned from hospital with G-tube. Also refer to Nutrition/Hydration Care Plan. " Neither of the identified problems identified the amount of water R35 was to receive with the feedings, before or after administration with the enteral formula, before and after medications, or amount of fluids to be mixed with the medications.<br><br>The June 2014 medication administration record (MAR) indicated R35 was to receive 30 ml Prosource with 30 ml water before and after administration once a day, 240 ml feeding | F 328 | **3. Reoccurrence will be prevented by:**<br>a) The facility policy on Medication Administration via Enteral Tubes was updated.<br>d) IDT team members involved in care planning will be in-serviced on enteral feedings and medications via enteral tube to insure that the amount of water to administer with the feedings, the medications and the flushes is appropriately addressed in the care plan.<br>b) All facility licensed staff will be in-serviced to the Medication Administration via Enteral Tube policy.<br>**4. The Correction will be monitored by:**<br>Nurse Managers, DON, Dietitian<br>**5. Date of Completion: 8/6/2014** | |

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| F 328 | Continued From page 17<br>Osmolite 1.5 cal with 80 ml water before and after administration of feeding four times a day and 180 ml free water every shift. The MAR did not indicate the amount of water to be mixed with the medication, the amount of water before and after administration of the medications, the amount of water to be instilled between each medication.<br><br>During an interview on 6/26/15 at 8:35 a.m. LPN-A stated she would instill 30 ml water before and after each individual medication but this was not noted on the MAR. During an observation on 6/26/14 at 12:20 a.m. LPN-A was observed to place each crushed medication (2 individual medications) in 30 ml water or a total of 60 ml water mixed with the medication. LPN-A was observed to flush the syringe with 30 ml water before and after instilling the medications. R35 received 120 ml fluid with this medication administration.<br><br>Review of the Abbott Nutrition Osmolite 1.5 cal [calorie] information indicated the 240 cc of formula contained 181 ml water or R35 received 724 ml water with the four cans given each day.<br><br>The nutritional status CAA (care area assessment) undated, printed 6/26/14 did not indicate the estimated fluids required. The Nutrition Assessment Reference Tool dated 11/11/13 indicated a fluid requirement of 1890 ml. On 4/8/14 the registered dietician noted R35 received 180 ml free water three times a day, 80 ml water before and after feeding. RD did not note any additional water consumed.<br><br>The director of nursing and registered nurse (RN)-A were interviewed on 6/26/14 at 2:04 p.m. The director of nursing indicated the facility did | F 328 | | |

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| F 328 | Continued From page 18<br>not have a policy/procedure to direct staff related to tube feedings and medication administration through a G-Tube. It was her understanding that the medications were to be individually crushed and diluted with 30 ml water and that the G-tube was to be flushed with 30 ml of water before and after the medication administration and with 5 ml water between each medication. The director of nursing verified the documentation did not indicate the amount of fluid the resident would receive in a 24 hour period.<br><br>RN-A was interviewed on 6/27/14 at 9:05 a.m. and stated she tallied the amount of water R35 should be provided during medication administration and water flush as 1630cc. RN-A added this amount did not include the amount of fluid received with the enteral feeding.<br><br>Using the amount of water flush provided by RN-A and adding the 724 ml of water in the formula the resident received 2354 ml water daily. This amount was 464 ml more that the maximum recommended by the dietician. The 2354 ml water received daily was 390 ml more than what the doctor ordered plus the water within the formula.<br><br>During an interview on 6/27/14 at 8:40 a.m. the director of nursing stated the amount of fluid tallied was the using a 30 cc amount with medications and flushes. The director of nursing verified R35 would receive greater than dietician recommendations, and that R35 received Lasix and had lower extremity edema. The director of nursing stated she would need to speak with the pharmacist related to recommendations of mixing the medications with water and the physician for total amount of fluid to be received. | F 328 | | |

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| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to complete a sleep assessment and develop non-pharmacological interventions before starting a hypnotic for 1 of 1 resident (R36) who received daily dose of Remeron for a sleep disturbance; failed to ensure adequate indications for use were identified for antipsychotic medications and an attempted gradual dose reduction or justification for not | F 329 | **F 329 (D)**<br>**1. Corrective Action:**<br>a) Residents R36, R14 and R26 will have a comprehensive psychotropic medication reviews, physician's justification for continued use or GDRs if indicated.<br>**2. Corrective Action as it applies to other residents:**<br>a) 100% audit of all psychotropic medications for appropriate non-pharmacological interventions, usage parameters, GDR or physician's clinical justification for continued use. | |

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| F 329 | Continued From page 20<br>doing a gradual dose reduction documented for 1 of 5 residents (R14) who used and antipsychotic medication; the facility failed to ensure a physicians clinical justification from the ongoing use of three psychotropic medications that have significant adverse consequences of causing falls identifies risk vs. benefits for 1 of 5 residents (R26) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R36 on 2/20/14 received a physician order for Remeron (antidepressant) 30 mg daily for sleep disorder.<br><br>On 6/26/14 at 7:29 a.m. R36 was observed at the breakfast table. She was noted to be awake and vocalizing. R36 was observed on 6/27/14 at 12:09 p.m. sitting at the dining room table, being fed and said, "I don't like doing his hair daddy" even though her father was not living.<br><br>On 6/27/14 at 12:09 p.m. nursing assistant (NA)-E stated R36 would " tense up " but did not fight or hit when taking care of her. She stated R36 was mostly confused. Licensed practical nurse (LPN)-C stated R36 would become weepy and repeat phrases and had quick mood changes. LPN-C stated R36 would nap during the day and would sleep throughout the night.<br><br>R36 was admitted to the facility on 8/28/13. The care plan dated 5/28/14 identified diagnoses that included, but not limited to, memory loss, unspecified sleep disturbance, depression and advanced dementia. The significant change Minimum Data Set (MDS) dated 4/20/14 noted a BIMS (brief interview for mental status) of 3 or severe cognitive impairment and noted R36 | F 329 | **3. Reoccurrence will be prevented by:**<br>a) The facility policy on psychotropic medication will be reviewed and updated as needed.<br>b) Facility Nursing Management will be re-inserviced on the psychotropic medication policy.<br>c) Facility Staff will be inserviced on psychotropic medication usage and unnecessary drugs.<br>d) Psychotropic medications will be discussed and monitored weekly at IDT meeting.<br>e) Interfaith will participate in a QIIP project on reducing psychotropic medication which includes identification appropriate non-pharmacological interventions, monitoring psychotropic use and reporting findings monthly at QA meeting.<br>**4. The Correction will be monitored by:**<br>Nurse Managers, DON, Consultant Pharmacist<br>**5. Date of Completion: 8/6/2014** | |

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| F 329 | Continued From page 21<br>required limited assistance with activities of daily living.<br><br>R36's clinical record was reviewed. A sleep assessment was not found nor had the care plan dated 4/22/14 did not have a problem of sleep/insomnia identified. The care plan dated 4/16/14 identified antidepressant related to depression. Listed Remeron with behaviors including disrupted sleep, but did not provide any non-pharmacological interventions.<br><br>On 4/21/14 the nurse ' notes noted R36 had been on Zoloft (antidepressant) that was discontinued on 2/20/14 and the Remeron was increased from 7.5 mg to 30 mg daily "Resident is stable. She is sleeping through the night and is awake and alert during the day." Weekly nursing charting dated 6/25/14 noted the resident had Remeron 30 mg every bedtime prescribed for unspecified sleep disturbance. An interdisciplinary team (IDT) notes dated 6/12 noted an overall decline.<br><br>Nurses ' notes were reviewed 2/1/14 through 2/27/14. No documentation noted related to poor sleep was found. On 2/22/14 the nursing notes documented that R36 slept well during the night.<br><br>The medication administration record (MAR) for June was reviewed. The MAR had identified target behaviors of insomnia to be documented 3 times a day with a monitoring start date of 8/29/13. There were no incidents in June 2014. The MAR also identified target behaviors for Zoloft to be documented 3 times a day starting 9/5/14. These behaviors were weepiness, restlessness, yelling out. The Zoloft was identified as given for memory loss, unspecified | F 329 | | |

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| F 329 | Continued From page 22<br>sleep disturbance and other mental problems. The behaviors were noted on 10 shifts out of 81 documented in June 2014.<br><br>Registered Nurse (RN) - C nurse manager verified R36 did not have interventions for insomnia. RN-C stated the facility had not completed a comprehensive sleep assessment and that no care plan had been developed before starting the Remeron. RN-C stated she would need to contact the physician to re-evaluate the use of Remeron for sleep.<br>R14 did not have adequate indications identified for the use of antipsychotic medications, and an attempted gradual dose reduction had not been initiated.<br><br>Review of the physician orders for R14 revealed that the medication Risperdal (antipsychotic) 1 mg by mouth every day was first initiated on 9/18/12, for the diagnosis of dementia with paranoia.<br><br>R14 was observed on 6/26/14 from 7:20-9:00 a.m. and again on 6/27/14, from 8:15 a.m. to 9:09 a.m. and it was noted that R14 was non-verbal and did not respond to questions during attempted conversation.<br><br>Licensed Practical Nurse (LPN)-C was interviewed 6/27/14, at 8:49 a.m. and stated that R14 verbalized very little and had not expressed behavior/s including hallucinations or delusions, and stated that the behavior R14 exhibited included hitting, kicking, spitting, scratching, and yelling out.<br><br>Review of the annual Minimum Data Set (MDS) a resident assessment dated 5/20/14, identified that | F 329 | | |

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| F 329 | Continued From page 23<br>R14 was rarely/never understood, had significant long and short term memory impairment, cognitive skills for daily decision making was severely impaired, and the only mood symptom identified included inattention (difficulty focusing attention).<br><br>The care area assessment (CAA) dated 5/28/2014, identified the following: "CAAs triggered mood due to PHQ-9 score of 14/30 on staff assessment due to little interest in doing things, feeling down, having little energy, and poor appetite. [R14] has been spending more time in her room and needing increased encouragement to participate in activities. [R14] has a DX [diagnosis] of dementia and is becoming more short-tempered and easily agitated.<br><br>The care plan dated 5/22/14 identified the following: "BEHAVIOR: I become angry at times without understanding why. I have been aggressive toward others and will need redirection at times due to my inability to discern my moods or motives for my aggression." The following interventions were identified: "I will act appropriately around others and will refrain from aggressive acts toward other vulnerable adults. Staff will intervene to protect [R14] and other vulnerable adults when she becomes agitated or acts aggressively around or toward others. Social services will be notified if resident becomes aggressive. Give one to one time with resident when she appears upset emotionally to deflect her anger or aggressive actions." "MOOD: I have been suffering from dementia cognitive loss and my mood has declined. I do not understand where nor why I am in this facility. My most recent PHQ-9 score was 0." The following mood | F 329 | | |

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| F 329 | Continued From page 24<br>interventions were identified: "I will express to social services that I have adapted to my new settings. Listen to what resident says about her concerns. Encourage resident to share problems/worries/concerns with family when they visit. Social services will greet [R14] and will ask her to express how she is feeling (emotionally). Actively listen to what resident chooses to express. Physician will be apprised of [R14's] mood condition and her behaviors so appropriate medication can be considered. Social worker will allow resident to express herself verbally, as best she can.<br>Psychoactive medication r/t dementia with paranoia." The interventions were identified as the following: "Medications as ordered by MD [medical doctor]-see MAR. MD to review regularly and order labs as needed. Nurse to monitor regularly for side effects of use. See MAR. "<br><br>The physician notes from 9/18/13-6/27/14, were reviewed and had not addressed the ongoing use of Risperdal in the absence of identified psychotic symptoms, and had not identified when a gradual dose reduction would be attempted.<br><br>The monthly pharmacist drug regimen reviews were reviewed and it was noted that on 5//22/13, the pharmacist identified that R14 had taken Risperdal 1 mg by mouth every morning since 9/18/12, and questioned if R14 should have an attempted gradual dose reduction. The physician identified the following related to the pharmacist recommendation "Still lots of paranoia. Not now. Will document. " On 2/12/14, the pharmacist again requested a consideration for an attempted dose of Risperdal 1 mg by mouth every morning. The physician identified the following related to the pharmacist recommendation "Keep | F 329 | | |

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| F 329 | Continued From page 25<br>Risperdal." The physician had not identified sufficient documentation according to the requirement at this tag read, "For any individual who is receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia, bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated, if:<br>o The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; &<br>o The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder."<br><br>During interview with registered nurse (RN)-C on 6/27/14, at 10:21 a.m. she stated that she does not know when the last time a gradual dose reduction of Risperdal had been attempted for R14. RN-C confirmed that R14 had not exhibited psychotic features that would warrant the use of antipsychotic medication. RN-C confirmed that the physician had not identified a written justification for ongoing use of the antipsychotic medication without a dose reduction.<br><br>R26 was admitted to the facility 7/14/2010 with diagnoses addressed on the CAA summary that included: non Alzheimer's dementia, seizures, dementia with depression, delusions, paranoid/psychosis, and anxiety problems. According to the admission sheet.<br><br>Review of the medical record indicated that R26 had physician orders for Seroquel (antipsychotic) | F 329 | | |

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| F 329 | Continued From page 26<br>100 milligrams (mg) twice a day, 50 mg twice a day related to vascular dementia with depressed mood, Remeron (antidepressant) 15 mg daily for vascular dementia with depressed mood, and Clonazepam (Klonopin) (anti-seizure & antianxiety) 0.5 mg daily for unspecified psychosis.<br><br>A Pharmacy review dated 4/4/2014 was reviewed and identified R26 on Klonopin, Remeron, and Seroquel medications. Resident currently getting 3 sedating medication at bedtime. The use of multiple sedating medication at once increases risk for falls/confusion; this is especially true in the elderly (resident is 86 years old) periodic risk vs benefit analysis is recommended to ensure the medication are indeed indicated still and to prevent an unnecessary medication. Please reassess the current doses of the medications. Consider reducing the Klonopin and continue other medications for now. If reduction not appropriate, please document risk vs. benefit. The physician's response was "Recommendation is rejected" "Needs these meds due to her medical hx." However, the physician response was not sufficient to determine the justification for the continued use of three psychotropic medications that have known side effects of increasing falls especially in the geriatric population.<br><br>On 6/27/2014 at 12:30 p.m. a registered nurse/nurse manager (RN)-C was interviewed. She verified she could not find a clinical justification from physician for continued use of antipsychotic medications for this resident. | F 329 | | |
| F 411 SS=D | 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS | F 411 | | |

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| F 411 | Continued From page 27<br><br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure routine dental services were provided for 1 of 1 resident (R5) identified as requiring dental services.<br><br>Findings include:<br><br>R5 had missing, decayed and/or broken teeth and had not been offered dental services or a dental evaluation.<br><br>R5's initial Minimum Data Set (MDS) dated 3/3/14 indicated R5 required extensive assistance of one for personal hygiene and other activities of daily living. The MDS assessment indicated R5 had no identified dental problems. R5 ' s care plan (CP) dated 11/8/13, indicated R5 had an upper partial with own teeth on the bottom and some missing teeth on the bottom. The CP also indicated R5 had a history of weight loss and required | F 411 | **F411 (D)**<br>**1. Corrective Action:**<br>a) Resident R5 had a comprehensive dental assessment and dental services were re-offered.<br>**2. Corrective Action as it applies to other residents:**<br>a) 100% Audit of resident's dental status VS assessment by visually resident comparing oral status to resident assessment, dental services offered if needed and POC updated.<br>**3. Reoccurrence will be prevented by:**<br>a) Inter-departmental team members involved in assessing and care planning for residents will be in-serviced on oral assessment and dental services<br>**4. The Correction will be monitored by:**<br>RAI Coordinators, Nurse Managers<br>**5. Date of Completion: 8/6/2014** | |

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| F 411 | Continued From page 28<br>increased calories. The CP directed staff to offer dental referral and assist with appointment as necessary.<br><br>On 6/24/14, at 6:30 p.m. R5 was observed to have missing and decayed bottom tooth. The front bottom tooth was observed to be decayed to the gum line and the gum appeared to be red and inflamed.<br><br>On 6/25/14, at 1:00 p.m. after this surveyor informed registered nurse (RN)-A concerning observation of R5 ' s teeth, RN-A evaluated R5's teeth and verified R5 had decayed bottom teeth and stated the teeth appeared to have been decayed for some time. RN-A stated R5 had not been referred to the dentist or offered dental services since she had been admitted in February 2014. RN-A added the decayed teeth should have been addressed in the initial assessment and stated that initial assessment was incorrect and there should have been a plan in place upon admission. | F 411 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the | F 431 | | |

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| F 431 | Continued From page 29<br>appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure narcotic medications were accurately reconciled and a system was developed and implemented to track discrepancies in narcotic counts for 3 of 3 residents (R108, R11, and R14) in the Birch unit (dementia unit) who used liquid morphine.<br><br>Findings include:<br><br>The medication storage area of the Birch unit was reviewed/observed on 6/27/14, at 9:10 a.m. during which liquid morphine (narcotic) was stored and reconciled. It was noted that the narcotic book identified that R108 was supposed | F 431 | **F431 (D**<br>**1. Corrective Action:**<br>a) The discrepancies on the controlled substance records for R108, R11 and R14 were reconciled with the DON and Consultant Pharmacist.<br>**2. Corrective Action as it applies to other residents:**<br>a) The facility policy on Narcotic Count was updated during the survey to include how to reconcile liquids by the DON and Consultant Pharmacist.<br>b) 100% facility wide Narcotic Audit was conducted to check for any other discrepancies.<br>**3. Reoccurrence will be prevented by:**<br>a) All facility staff licensed staff will be in-serviced on the facility narcotic policy.<br>b) Random (stop in time) Narcotic count audits will be conducted by nurse managers and nursing supervisors at least weekly on rotating shifts and units for 90 days. Findings will be reported to the QA committee for recommendations.<br>**4. The Correction will be monitored by:**<br>Nurse Managers, Nursing Supervisors, DON<br>**5. Date of Completion: 8/6/2014** | |

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| F 431 | Continued From page 30<br>to have 22.8 ml of liquid morphine sulfate with a concentration of 2 mg/0.1 ml. When checked licensed practical nurse (LPN)-C verified that the bottle only contained 16 ml ( and should have been 22.8 ml a discrepancy of 6.8 ml missing).<br><br>The narcotic book identified that R14 was supposed to have 11.8 ml of liquid morphine sulfate with a concentration of 2 mg/0.1 ml. When checked LPN-C verified that the bottle only contained 8 ml (and should have been 11.8 ml a discrepancy of 3.8 ml missing).<br><br>The narcotic book identified that R11 was supposed to have 8.5 ml of liquid morphine sulfate with a concentration of 2 mg/0.1 ml. When checked LPN-C verified that the bottle contained 12 ml (and should have been 7.5 ml a discrepancy of 4.5 ml to much). When interviewed LPN-C stated that she had completed the narcotic reconciliation count with the nurse that worked the night shift, however the only discrepancy identified was with R108 who was supposed to have 22.8 ml of liquid morphine sulfate and when checked licensed practical nurse (LPN)-C verified that the bottle only contained 16 ml with a loss of 6.8 ml missing and unaccounted for. LPN-C stated that she only gets worried when the liquid narcotics are off by 5 ml or more. LPN-C stated that she had planned to report the narcotic discrepancy to the Registered Nurse (RN)-C the Unit Manager when she came into the unit so that RN-C count make a note in the narcotic book and change the amount remaining to match what was in the bottles.<br><br>RN-C was interviewed on 6/27/14, at 9:27 a.m. during which she stated that she had not received a report from LPN-C stating that the narcotic | F 431 | | |

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| F 431 | Continued From page 31<br>count had been off. RN-C stated that normally to fix the discrepancy she would make a notation in the narcotic book and change the amount remaining so the count was back on track. RN-C stated that she did not have a system to identify how often the count was off or when the narcotic count was off to see when where and by whom the narcotic count became off. She stated that she did not know if the facility had a policy which identified when an internal investigation would be completed for missing narcotic medications.<br>RN-C then provided a policy identified as "Narcotic- Counting Of" dated June 2014, and identified the following "HOW TO RECONCILE LIQUIDS: (New June 2014)<br>Set the bottle on a firm surface.<br>Use a flashlight if needed to reconcile amount if the amount is incorrect-put the accurate amount in the Controlled Substance sheet AND notify the nurse manager or nursing supervisor.<br>Complete a Medication Error Report for the discrepancy.<br><br>RN-C verified that LPN-C had not followed the policy which included reporting to the RN manager the discrepancy, identifying the accurate amount in the controlled substance sheet, and completing a med error report for the discrepancies identified for R108, R14, and R11. | F 431 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. | F 441 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245024 | A. BUILDING _____ B. WING _____ | 06/27/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| INTERFAITH CARE CENTER | 811 THIRD STREET CARLTON, MN 55718 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 32<br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation interview and document review, the facility failed to ensure clean technique was used during enteral feedings for 1 of 1 resident (R35) observed during enteral feedings. | F 441 | **F441 (D)**<br>**1. Corrective Action:**<br>a) Staff member LPN-A was in-serviced on enteral feeding and concepts of infection control: clean technique.<br>**2. Corrective Action as it applies to other residents:**<br>a) Licensed staff working with enteral feedings will be in-serviced and competency checked on enteral feeding techniques, concepts of infection control, hand sanitizing and gloving.<br>**3. Reoccurrence will be prevented by:**<br>a) The facility policy on enteral feeding was reviewed and updated to include concepts of infection control and a skill competency check component.<br>b) All facility licensed staff will be in-serviced to the new Enteral Tube Feeding and Medication Administration Policy<br>c) ALL facility staff will be in-serviced on Concepts of Infection Control: hand washing and gloving via inservice and competency skill check.<br>**4. The Correction will be monitored by:**<br>Nurse Managers, DON<br>**5. Date of Completion: 8/6/2014** | |

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| | 245024 | A. BUILDING _____ B. WING _____ | 06/27/2014 |

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| F 441 | Continued From page 33<br>Findings include:<br><br>R35 was observed during enteral feeding administration on 6/26/14 at 12:28 p.m. by licensed practical nurse (LPN)-A.<br><br>At 12:38 p.m. on 6/26/14 LPN-A was observed looking R35 ' s incontinent briefs and bra. LPN-A said she was looking for R35 ' s feeding tube. LPN-A had on a pair of exam gloves as she touched the lower abdomen, brief, and breast area and without changing gloves LPN-A held the feeding tube with her soiled gloves. This surveyor asked the LPN why she had not changed her soiled gloves before continuing to manipulate the feeding tube and check for placement. LPN-A responded to the question by stating she did not know why she was asked to change her gloves before continuing to manipulate the feeding tube and port.<br><br>R35 ' s care plan dated 6/25/14 indicated R35 was admitted to the facility in 2010 and had diagnoses that included but not limited to stroke. The physician orders of 4/16/14 indicated R35 received enteral feedings and medication via a G-Tube. The quarterly Minimum Data Set (MDS) dated 4/8/14 indicated R35 had a BIMS (brief interview of mental status) of 13 or no impairment and required extensive assistance with activities of daily living.<br><br>The director of nursing was interviewed on 6/26/14 at 2:04 p.m. The director of nursing stated the facility had not written a policy/procedure related to the tube feedings. The director of nursing added the LPN should have changed the soiled gloves for infection control reasons. | F 441 | | |

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| F 465 SS=B | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure the carpet was maintained in a clean and sanitary manner for 2 of 4 wings (Oak Lane and Birch Lane) which had the potential to affect 43 of 88 residents who live on these two units and also includes family and staff who frequent these two wings.<br><br>Findings include:<br><br>During the facility initial tour on 6/23/14 at 2:15 p.m., the Oak Lane and Birch Lane carpet in the hallways was observed to have multiple dark stains which varied in size throughout the entire hallway and had many worn areas of carpet.<br><br>On 6/26/14, at 12:05 p.m. the director of maintenance verified the carpet was stained and " worn out " and needs to be replaced. The maintenance director stated they thoroughly clean the carpet in the winter and then in the spring the spots appear again. The facility had an estimate and plan in place to replace the carpet in the nurse ' s desk area and have currently contacted a company to give them an estimate to replace the worn out flooring.<br><br>On 6/17/14, at 9:00 a.m. the administrator stated they have identified the problem of the stained | F 465 | **F465**<br>1. Corrective Action:<br>a) The facility flooring replacement plan has been implemented including meeting with flooring company, discussing options, and receiving a quote for Shaw Carpet.<br>b) July 1st the Board of Directors approved the expenditure to replace worn and stained carpet with the goal date for the final flooring selections made by August 15th.<br>c) A goal date of October 1st, 2014 has been targeted for completion of the flooring project.<br>d) While the facility selects, orders, and waits for installation of the new flooring, all units have been put on a weekly cleaning schedule with spotting in-between.<br>**The Correction will be monitored by:**<br>Director of Environmental Services, Administrator<br>8/6/14 sapn | |

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| | 245024 | A. BUILDING _____ B. WING _____ | 06/27/2014 |

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| F 465 | Continued From page 35<br>carpet and will present the proposal of replacing the carpet in the hallways at the next board meeting. | F 465 | | |

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|---|---|---|---|
| | 245024 | A. BUILDING **01 - MAIN BUILDING** B. WING _____ | **06/24/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **INTERFAITH CARE CENTER** | **811 THIRD STREET CARLTON, MN 55718** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Inter-Faith Care center was found to in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>Inter-Faith Care Center is a 2-story building with no basement. The building was constructed in 2000, and determined to be of Type II (222) constriction. The skilled nursing home has two assisted living facilities attached that are both of Type II (000) construction. They are both properly separated by a 2 hour fire rated barrier, with 1&1/2 hour fire rated self closing doors.<br><br>The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all resident rooms, that is monitored for automatic fire department notification. The facility has a licensed capacity of 84 beds and had a census of 82 at the time of the survey.<br><br>The requirement at 42 CFR Subpart 483.70(a) is met. | K 000 | | |

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

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.