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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PR5T

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 **10/22/2018** (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:

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

* Code: **A** (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 :
Teresa Ament, Unit Supervisor 10/26/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/26/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_X_ 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
10/02/2018
(L33)

DETERMINATION APPROVAL

Electronically delivered CMS Certification Number (CCN): 245024

October 26, 2018

Administrator
Interfaith Care Center
811 Third Street
Carlton, MN 55718

Dear Administrator:

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 October 1, 2018 the above facility is certified 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
October 26, 2018

Administrator
Interfaith Care Center
811 Third Street
Carlton, MN 55718

RE: Project Number S5024028

Dear Administrator:

On September 10, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on August 30, 2018. 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 October 22, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 1, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 30, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 1, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 30, 2018, effective October 1, 2018 and therefore remedies outlined in our letter to you dated September 10, 2018, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PR5T
Facility ID: 00047

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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 **08/30/2018** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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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
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* 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 :
Kimberly Settergren, HFE - NE II 09/24/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/02/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
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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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 10, 2018

Administrator
Interfaith Care Center
811 Third Street
Carlton, MN 55718

RE: Project Number S5024028

Dear Administrator:

On August 30, 2018, 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. 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 electronically attached CMS-2567 whereby corrections are required.

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:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 October 9, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 November 30, 2018 (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 March 1, 2019 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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 ______	08/30/2018

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
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/27/18, through 8/30/18, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document, review the facility failed to ensure the emergency preparedness plan included directives for use of	E 024	E024 Policies/Procedures – Volunteers and Staffing	9/30/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/18/2018

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.

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 ______	08/30/2018

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
E 024	Continued From page 1 volunteers during an emergency. This had the potential to affect all 92 residents residing in the facility. Findings include: A review of the facility emergency preparedness plan indicated the plan lacked directives for use of volunteers during an emergency. On 8/30/18, at 1:25 p.m. the administrator verified the emergency preparedness plan lacked directives for use of volunteers.	E 024	Corrective Action: A policy entitled “Guidelines on the Deployment of Healthcare Disaster Volunteers at InterFaith Care Center” (IFCC) has been written. In-services/education on the policy for all IFCC staff will be completed by September 30, 2018. Reoccurrence Will Be Prevented By: Annual review/update of IFCC’s Disaster Preparedness Plan by the IFCC Safety Committee prior to the regularly scheduled April in-service (part of IFCC’s annual education plan) on IFCC’s Emergency and Natural Disaster Plan.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	E 026		9/30/18

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 ______	08/30/2018

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
E 026	Continued From page 2 *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their policies and procedures addressed the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. This had the potential to affect all 92 residents residing in the facility. Findings include: The facility emergency preparedness plan and binder failed to include a policy or to address the role of the facility under a waiver by the Secretary in a difference facility or evacuation site. On 8/30/18, at 1:25 p.m. the administrator verified the emergency preparedness plan failed to address the role of the facility under a waiver by the Secretary during an evacuation.	E 026	E026 Roles Under a Waiver Declared by the Secretary of HHS Corrective Action: A policy entitled "InterFaith Care Center's (IFCC) Request to Operate Under a CMS 1135 Waiver Procedure" has been written. In-services/education on the policy for all IFCC staff will be completed by September 30, 2018. Reoccurrence Will Be Prevented By: Annual review/update of IFCC's Disaster Preparedness Plan by the IFCC Safety Committee prior to the regularly scheduled April in-service (part of IFCC's annual education plan) on IFCC's Emergency and Natural Disaster Plan which includes the policy InterFaith Care Center's (IFCC) Request to Operate Under a CMS 1135 Waiver Procedure.	
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include	E 032		9/30/18

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	245024	A. BUILDING ______ B. WING ______	08/30/2018

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E 032	Continued From page 3 all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the emergency preparedness plan included alternate means of communication with emergency management agencies during an emergency. This had the potential to affect all 92 residents residing in the facility. Findings include: A review of the emergency preparedness plan indicated the facility had not identified or obtained alternate means of communicating with Federal, State, tribal, regional and local emergency management agencies during an emergency, in the event phone lines and cell phones are not able to be used. On 8/30/18, at 1:25 p.m. the administrator verified the facility had not identified alternate means of communication during an emergency.	E 032	E032 Primary/Alternate Means for Communication Corrective Action: A policy/procedure entitled “InterFaith Care Center Emergency Preparedness Primary and Secondary Communication Plan” has been written. In-services/education on the policy for all IFCC staff will be completed by September 30, 2018. Reoccurrence Will Be Prevented By: Annual review/update of IFCC’s Disaster Preparedness Plan by the IFCC Safety Committee prior to the regularly scheduled April in-service (part of IFCC’s annual education plan) on IFCC’s Emergency and Natural Disaster Plan which includes the policy InterFaith Care Center Emergency Preparedness Primary and Secondary Communication Plan.	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 4 On 8/27/18, through 8/30/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this	F 582		10/1/18

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F 582	Continued From page 5 section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Skilled Nursing Facility	F 582	Corrective Action a) A Notice of Medicare Non-Coverage	

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F 582	Continued From page 6 Advanced Beneficiary Notice was given to 3 of 3 residents (R42, R59, R198) whose Medicare A services ended, and they remained living in the facility. Findings include: R42's Skilled Nursing Facility Beneficiary Protection Notification Review (Form CMS-20052)completed by the facility, revealed R42's Medicare Part A services started 1/13/18, and the last covered day of services was 3/16/18. R42 remained in the facility following the end of Medicare Part A services. The facility provided the Skilled Nursing Facility Advance Beneficiary Notice of Non- Coverage (Form CMS-10055) which was signed by the authorized representative and dated 3/14/18. The facility failed to provide Notice of Medicare Non-Coverage (Form CMS-10123) to the resident or authorized representative. R59's Skilled Nursing Facility Beneficiary Protection Notification Review (Form CMS-20052) completed by the facility, revealed R59's Medicare Part A services started 4/20/18, and the last covered day of services was 5/11/18. R59 remained in the facility following the end of Medicare Part A services. The facility provided the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (Form CMS-10055) which was acknowledged via phone by authorized representative 3/9/18. The facility failed to provide Notice of Medicare Non-Coverage (Form CMS-10123) to the resident or authorized representative. R198's Skilled Nursing Facility Beneficiary Protection Notification Review (Form	F 582	(Form CMS-10123) was issued and reviewed with Resident R42 and R59 and signed by each resident or authorized representative. b) A Notice of Medicare Non-Coverage (Form CMS-10123) was issued to Resident R198 via U.S. Mail as she no longer resides in the facility. Corrective Action As It Applies To Other Residents: a) A Notice of Medicare Non-Coverage (Form CMS-10123) will be issued to any resident/authorized representative who had Medicare Part A services stay that ended within the last 6 months and did not receive one. Reoccurrence Will Be Prevented By: a) The IFCC policy on Medicare Part A Denial Notices was reviewed and updated. b) The IFCC Medicare Interdisciplinary Team was re-educated to the new Medicare Part A Denial Notice policy including the appropriate timing and instructions for each necessary form. c) Billing Office will keep an Audit Log of Medicare denials that will be reviewed weekly at Medicare Interdisciplinary Team for 3 months then monthly for 3 months by the QA committee to ensure appropriate notices were issued for residents ending a Medicare Part A services stay. Correction will be monitored by: Administrator, Business Office and QA committee	

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F 582	Continued From page 7 CMS-20052) completed by the facility, revealed R198's Medicare Part A services started 5/7/18, and the last day of covered services was 5/14/18. R198 was discharged home or to lesser care following the end of Medicare Part A services. The facility provided the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (Form CMS-10055) which was signed by the resident 5/10/18. The facility failed to provide Notice of Medicare Non-Coverage (form CMS-10123) to the resident. On 8/30/18, at 10:37 a.m. facility social worker (SW)-A stated she received notice of liability paperwork already filled out by a staff member in the business office. SW-A stated she is responsible to get the document(s) to the resident or resident representative for signature prior to the end of Medicare Part A coverage. SW-A stated did not choose which forms to use, and did not fill out the forms. On 8/30/18, at 10:42 a.m. business office employee (BO)-A stated she filled out the beneficiary notification paperwork when was informed a resident's approved Medicare Part A skilled services were ending. B)-A stated it was her understanding the CMS-10055 form was the only form needed, and she had not been issuing CMS-10123. A policy on Skilled Nursing Facility Advanced Beneficiary Notice was requested but not received.	F 582		
F 608 SS=E	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and	F 608		10/1/18

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F 608	Continued From page 8 implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately to the State Agency (SA) for 4 of 6 residents (R195, R19, R196, R61, R197, and R94) with potential allegations who were reviewed for abuse. Findings include:	F 608	Corrective Action a) Vulnerability and Behavior Care Plans were reviewed and updated as needed for Residents R19 and R61. b) Residents R195, R196, R197 and R94 no longer reside in the facility. Corrective Action As It Applies To Other Residents:	

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F 608	Continued From page 9 R195's Admission Record printed 8/30/18, indicated R195's diagnoses included major depressive disorder, dementia with behavioral disturbance, persistent mood disorder, and anxiety disorder. R195's Admission Record indicated R195 no longer resided in the facility as of 7/14/18. R195's care plan initiated 11/10/17, indicated R195 was at high vulnerability for abuse, and if an event occurred, staff were to intervene immediately, remove resident to safety, and report to the state agency, administrator, and social services. R195's care plan further indicated R195 was at moderate risk for abusing others, but had not been aggressive toward other vulnerable adults, though behaviors included screaming, yelling, hitting, kicking out at others (usually staff). R195's care plan indicated R195 had short-term and long-term memory deficits with a severely impaired decision making ability, and experienced post traumatic stress disorder (PTSD). An incident report submitted to the SA on 12/7/17, at 4:22 p.m. indicated R195 had made a report to registered nurse (RN)-A of a male care giver who allegedly raped her. RN-A did not immediately report the allegation to the SA. RN-A reported the incident to RN-C on 12/6/18. The police department and state agency were not notified until 12/7/17. R19's Admission Record printed 8/30/18, indicated R19's diagnoses included dementia with behavioral disturbance, and major depressive disorder. R19's care plan initiated 1/13/17, indicated R19	F 608	a) The IFCC Abuse Prevention Plan will be reviewed and revised to ensure clear guidance on what to report, who is required to report to whom, with emphasis on WHEN to report and a clear description of the concept/term IMMEDIATE but not later than 2 hours after forming the suspicion. b) An audit was conducted of the MDH OHFC Nursing Home Incident Reporting Web to ensure that 100% of the appropriate staff members have access to the On-Line portal and demonstrate they understand how and when to use it. c) All IFCC Staff will be re-educated on the IFCC Abuse Plan with emphasis on what and where each covered individual should report, who is required to report, WHEN to report and the term IMMEDIATE but not later than 2 hours after forming the suspicion. d) All IFCC Staff will be re-educated on the potential for abuse as it relates to resident behaviors especially in resident to resident situations. Reoccurrence Will Be Prevented By: a) Social Service will keep a daily log of any/all Vulnerable Adult (VA) OHFC Reports that will include date and time of incident VS date and time of report to the State Agency (SA) to ensure immediate reporting when mandated. b) VA log will be reviewed daily at AM meeting and reported on monthly at QA as a permanent agenda item. Correction will be monitored by: Administrator, GLSW, QA Committee	

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F 608	Continued From page 10	F 608		

was at low risk for abusing others and had not abused others, and directed staff to intervene if R19 became angry with another resident. R19's care plan further indicated R19 was at high risk for abuse by others, and directed staff to intervene if abused and indicated the state agency, social services, family and facility administrator would be notified for further interventions and protection.

R196's Admission Record printed 8/30/18, indicated 196's diagnoses included dementia without behavioral disturbance, major depressive disorder, and Parkinson's disease.

R196's care plan initiated 8/19/16, indicated R196 was at low risk for abusing others, and directed staff to intervene if R196 became angry or abusive towards others. R196's care plan further indicated R196 was at high risk for abuse by others, and directed staff to intervene immediately if abuse allegations were made or witnessed. The care plan also directed staff to report immediately to the administrator, director of nursing, social services for further intervention to protect R196.

An incident report submitted to the SA on 12/26/17, indicated that on 12/24/17, R19 walked into R196's room, yelled at 196, slapped R196 three times, and spilled water on R196's face. Licensed practical nurse (LPN)-A was alerted to the incident by staff. The allegation of abuse was not reported immediately to the SA.

R61's Admission Record printed 8/30/18, indicated R61's diagnoses included dementia without behavioral disturbance.

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F 608	Continued From page 11 R61's care plan initiated 8/22/17, indicated R61 was at moderate risk for abusing others, though had not been physically abusive to other residents, and directed staff to intervene immediately if R61 became agitated or aggressive toward other residents. The care plan further directed staff to report to social services, administrator, and director of nursing (DON). R61's care plan indicated R61 was at high risk for being abused by others, directed to staff to intervene in any situation that could lead to abuse of any kind, and report to social services, DON, and administrator for further intervention, including notification of the SA if suspected or reported abuse. An incident report submitted to the SA on 2/23/18, at 11:57 a.m. indicated on 2/22/18, at approximately 6:45 p.m., a potential abuse allegation involving R61's spouse was witnessed by two staff. The incident report indicated the staff reported the incident to RN-D, who initiated interventions to protect R61, and investigate the allegation. The incident was not reported immediately to the SA. R197's Admission Record printed 8/30/18, indicated R197's diagnoses included dementia without behavioral disturbance, pain, and encephalopathy (brain disease, damage, or dysfunction). R197's care plan initiated 7/19/13, indicated R197 was at low risk for abusing others, and was at high risk for abuse. R197's care plan directed staff to intervene in any situation likely to result in abuse or reports of abuse, move resident to safe area, and notify administrator, social services, and the SA.	F 608		

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F 608	Continued From page 12	F 608		

R94's Admission Record printed 8/30/18, indicated R94's diagnoses included dementia without behavioral disturbance, and major depressive disorder.

R94's care plan initiated 3/30/15, indicated R94 was at moderate risk for abusing others, and directed staff to remove R94 to a safe area if became aggressive with other residents. R94's care plan indicated R94 was at high risk for abuse, and directed staff to intervene immediately to protect resident if abuse reported, witnessed, or suspected, and notify social services, DON, administrator and SA.

An incident submitted to the state agency dated 9/4/17, at 10:17 a.m. indicated that on 9/3/17, at 7:00 p.m. R197 and R94 had an altercation. R197 had become upset with R94, and rammed the wheelchair into R94, causing a skin tear on R94's hand. LPN-B intervened in the altercation, and cared for the skin tear on R94's hand. The altercation was not immediately reported to the SA.

On 8/29/18, at 12:42 p.m. the DON stated the incident involving R195 had been reported in passing to RN-C as a behavior. The DON stated all staff were re-educated about their role in reporting abuse and if an act was willful, they are to report it.

On 8/29/18, at 1:53 p.m. RN-C stated any allegation of abuse would be reported immediately.

On 8/30/18, at 11:02 a.m. RN-B stated she would report all types of abuse, including

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F 608	Continued From page 13 resident-to-resident altercations when they intended to harm, or has harmed an individual physically or mentally. RN-B stated she would report immediately to the supervisor and to the SA first, then investigate. On 8/30/18, at 11:08 A.M. RN-C stated RN-A had reported the incident involving R195, and she called the resident's daughter, looked into it, and talked about it, then discussed it the next morning with the team, and it was reported then. RN-C verified it should have been reported immediately to the SA. RN-C stated there was a lot of education done with all the staff on what to report and when to report. On 8/30/18, at 12:03 p.m. social worker (SW)-A stated she would report all types of abuse immediately. SW-A stated resident-to-resident altercations would be reported if it was a willful act with the purpose to inflict harm. On 8/30/18, at 1:11 p.m. the DON stated incidents of potential abuse should be reported and investigated immediately. On 8/30/18, at 2:13 p.m. the DON verified the incidents reviewed were reported late and should have been reported immediately. The facility's Abuse Prohibition Policy and Procedure undated, directed staff to report all alleged violations, incidents of abuse, or suspected abuse immediately.	F 608		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		10/1/18

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F 880	Continued From page 14 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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 ______	08/30/2018

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 880	Continued From page 15 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was maintained during personal cares for 1 of 1 residents (R30) observed during personal cares. Findings include: R30's Admission Record printed 8/30/18, included diagnoses of macular degeneration, muscle weakness and a history of urinary tract infections. R30's quarterly Minimum Data Set dated 7/4/18,	F 880	Corrective Action a) Resident R30's Incontinence Care Plan was reviewed and updated as needed to ensure she is receiving appropriate incontinent services. b) Resident R30 will have her incontinence care audited on all 3 shifts once a week for 3 weeks to ensure that incontinence care and handwashing/sanitizing is being completed appropriately per policy. Corrective Action As It Applies To Other	

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F 880	Continued From page 16 indicated R30 was cognitively intact, and required extensive assistance with transfers, bed mobility, dressing, toilet use, and personal hygiene. The MDS further indicated R30 was frequently incontinent of bowel and bladder. On 8/29/18, at 9:04 a.m. R30's incontinence cares were observed provided by nursing assistant (NA)-A. NA-A and another NA transferred R30 from the wheelchair into the bed with a mechanical lift. NA-A disconnected the lift sling, lowered the head of the bed, placed the oxygen tubing under R30's nose, lifted the side rail, lowered R30's pants and without performing hand hygiene, donned gloves. NA-A then lowered R30's incontinent brief and assisted R30 onto her left side. R30 was incontinent of a large black, sticky bowel movement. NA-A cleansed the bowel movement from R30's skin using several disposable wipes,and removed a soiled dressing from a pressure ulcer on R30's coccyx. NA-A removed the soiled incontinent brief, and continued to clean R30's buttocks. NA-A then applied a new incontinent brief, removed the soiled gloves and without performing hand hygiene donned clean gloves. NA-A cleansed R30's peri area with disposable wipes, pulled the incontinent brief up, removed her soiled gloves, did not perform hand hygiene, and pulled up R30's pants. A licensed practical nurse (LPN) arrived to apply a new dressing to R30's coccyx. NA-A assisted R30 onto the right side, and lowered the incontinent brief. NA-A assist the LPN by holding R30's left buttock up with ungloved hands. NA-A then rolled R30 onto her back, secured the incontinent brief, pulled up R30's pants, and positioned R30 onto the left side with pillows. NA-A adjusted the pillows under R30's head, retrieved the foot cushion, raised the	F 880	Residents: a) 100% Audit of all resident's Incontinence Care Plans will be reviewed and updated as needed to ensure they are receiving appropriate incontinent services. b) A system of routine and random Handwashing and Incontinence Care Audits will be established by the Infection Control Committee to include audits on all 3 shifts to ensure that handwashing/sanitizing and incontinence care is being completed appropriately per policy. Reoccurrence Will Be Prevented By: a)) The IFCC policy and skill check for Handwashing was reviewed and updated with additional emphasis on handwashing/sanitizing when hands are contaminated, when Entering and Exiting rooms, and with every glove change. b) The IFCC policy and skill check for Incontinence Care was reviewed and updated with additional emphasis on glove use, handwashing/sanitizing when hands are contaminated, and with every glove change. c) All IFCC Staff in all departments will be re-educated on the updated IFCC Handwashing Policy and will complete a Handwashing skill check. d) All IFCC Nursing Staff will be re-educated on the updated IFCC Incontinence care Policy and will complete a Peri-Care skill check. e) Audit results will be reviewed weekly at Interdisciplinary Team meeting, monthly by the Infection Control Committee and	

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	245024	A. BUILDING ______ B. WING ______	08/30/2018

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F 880	Continued From page 17 head of the bed with the bed controls, covered R30 with a blanket and handed R30 two tissues. Without performing hand hygiene, NA-A donned a clean glove on the right hand, picked up the trash, exited R30's room, and went across the hall to the soiled utility room. NA-A opened the soiled utility room door, put the trash into the container, and washed her hands in the utility room. On 8/29/18, at 11:42 a.m. NA-A stated she washed her hands when she got into the soiled utility room. NA-A verified she did not wash or sanitize her hands between glove changes, because she did not have any hand sanitizer. NA-A stated she was aware she was suppose to sanitize her hands between glove changes. On 8/30/18, at 1:28 p.m. the director of nursing (DON) stated hands should be washed or sanitized after removing gloves, and prior to exiting the resident's room. The facility's Handwashing/Hand Hygiene policy dated 8/15, indicated the facility considered hand hygiene the primary means to prevent infection. All staff would follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other staff, residents and visitors. The policy further directed staff to use alcohol based hand sanitizer or soap and water before and after coming in direct contact with residents, before moving from a contaminated body site to a clean body site during resident cares and after removing gloves.	F 880	reported monthly for a minimum of 3 months to the QA Committee for further recommendations. Correction will be monitored by: DON, Nurse Managers, Infection Control and QA Committees	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245024	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 8/30/2018

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245024	A. BUILDING: ____ B. WING ____	8/30/2018

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 1

and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure the ombudsman was notified of hospitalization for 1 of 2 residents (R65) reviewed for hospitalization.

Findings include:

R65's Admission Record indicated R65's diagnoses included dementia, lower abdominal pain, compression fracture of the lumbar vertebra (lower spine), and fracture of the right wrist and right femur (upper leg/hip).

R65's progress notes indicated R65 had a fall on 6/16/18, and was transferred to the hospital with right wrist and hip pain.

A review of R65's medical record lacked notification of the ombudsman regarding R65's hospitalization.

On 8/29/18, at 1:48 p.m. registered nurse (RN)-C verified R65 had a fall with a hip fracture, and was hospitalized at that time. RN-C stated she did not know if the ombudsman was notified of R65's hospitalization.

On 8/30/18, at 11:59 a.m. social worker (SW)-A stated the admissions coordinator notifies the ombudsman quarterly of hospitalizations.

On 8/30/18, at 12:24 p.m. the admissions director (AD)-A verified the facility have not notified the ombudsman of hospital visits or hospitalizations, only of discharges. AD-A verified they do not have a policy regarding notification of the ombudsman.

On 8/30/18, at 1:18 p.m. the director of nursing (DON) verified notification of the ombudsman was not done, and the facility did not have a policy for notification of the ombudsman for hospitalizations.

PRINTED: 09/25/2018
FORM APPROVED
OMB NO. 0938-0391

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

F5024027

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245024	A. BUILDING **01 - MAIN BUILDING** B. WING	**08/28/2018**

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 FIRE SAFETY 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 WILL BE USED AS VERIFICATION OF 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Inter-Faith Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000	 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 09/18/2018

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.

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

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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Inspected as one building: 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. The building is fully fire sprinkler protected and has a complete fire alarm system with smoke	K 000		

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K 000	Continued From page 2 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 96 beds and had a census of 94 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to identify the sprinkler system	K 351	Corrective Action for K351 A sign was applied to the door of the sprinkler room per NFPA 13 the Standard for the installation of Sprinkler Systems 2010 edition.	9/18/18

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K 351	Continued From page 3 locations in compliance with NFPA 13 (10) could allow delays in system maintenance and shutdown that could adversely affect residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:30 a.m. to 1:30 p.m. on 08/28/2018, observations revealed that the door to the mechanical room next to the maintenance office did not have any sign or labeling identifying that there is fire sprinkler equipment located in that room. This deficient condition was confirmed by a Maintenance Supervisor.	K 351	Reoccurrence will be prevented by: This is the only room that houses sprinkler controls, it will be checked annually to make sure the sign is still adhered to the door. A sign reading "sprinkler control valve inside" was installed on 8/29/2018	