



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 23, 2025

Administrator
Interfaith Care Center
811 Third Street
Carlton, MN 55718

RE: CCN: 245024
Cycle Start Date: February 6, 2025

Dear Administrator:

On March 12, 2025, we notified you a remedy was imposed. On April 3, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 3, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 6, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 12, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 6, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 3, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 23, 2025

Administrator
Interfaith Care Center
811 Third Street
Carlton, MN 55718

Re: Reinspection Results
Event ID: V4DC12

Dear Administrator:

On March 10, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 6, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



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March 12, 2025

Administrator
Interfaith Care Center
811 Third Street
Carlton, MN 55718

RE: CCN: 245024
Cycle Start Date: February 6, 2025

Dear Administrator:

On February 11, 2025, we informed you that we may impose enforcement remedies.

On March 6, 2025, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

K363 - Corridor - Doors S/S D

K761 - Maintenance, Inspection & Testing - Doors S/S F

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 6, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 6, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 6, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial

compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 6, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Interfaith Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 6, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 August 6, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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

Interfaith Care Center

March 12, 2025

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you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 11, 2025

Administrator
Interfaith Care Center
811 Third Street
Carlton, MN 55718

RE: CCN: 245024
Cycle Start Date: February 6, 2025

Dear Administrator:

On February 6, 2025, a 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 May 6, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by August 6, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
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Interfaith Care Center

February 11, 2025

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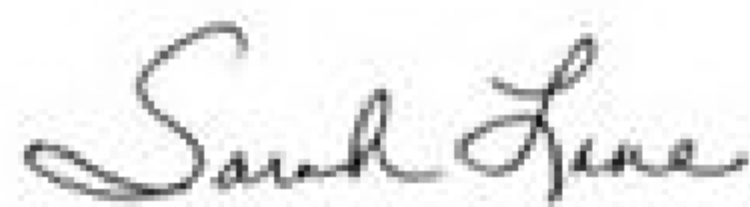
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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

PRINTED: 03/04/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2025
NAME OF PROVIDER OR SUPPLIER INTERFAITH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	E 000			
	On 2/3/25 - 2/6/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance.				
	The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.				
F 000	INITIAL COMMENTS	F 000			
	On 2/3/25 to 2/6/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.				
	The following complaints were reviewed with NO deficiencies cited: H50246144C(MN00106828), H50246145C(MN00102037), H50246146C(MN00100474).				
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/18/2025

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2025
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(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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess smoking safety for 1 of 1 resident (R38) reviewed for smoking. Findings include: R38's quarterly Minimum Data Set (MDS) dated 1/9/25, identified R38 was admitted to the facility on 10/8/24 and was cognitively intact. R38's diagnoses include depression, chronic pain, difficulty walking, and syncope and collapse (fainting due to a brief loss of consciousness). R38's history and physical report dated 10/3/24, identified R38 was a current everyday smoker of cigarettes. R38's care plan printed on 2/6/25, identified R38 was at risk for falls due to generalized muscle weakness, difficulty walking, pulmonary disease, and medication side effects. Care plan lacked any indication of R38's current smoking status and/or safe smoking interventions. R38's medical record lacked any smoking assessments completed prior to 2/4/25.	F 689	F689 It is the policy of Inter-Faith Care Center to ensure the resident environment remains as free of accident hazards as possible. On 2/5/2025 date a smoking assessment was completed on R38. The resident's care plan was updated to ensure smoking status was addressed. All residents in the facility identified have been assessed for smoking. A new policy and procedure were implemented that addresses smoking status upon admission, if resident is identified as a smoker, the smoking assessment will be completed and a care plan completed regarding smoking as well. All staff will be educated on the new policy and procedure by 2/28/2025. The Director of Nursing (DON) or designee will audit all new admissions for smoking status for a period of three months to ensure compliance. Results of audits will be reviewed by the facility Quality Assurance Performance Improvement committee. Corrected by 2/28/2025.		2/28/25

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245024		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2025	
NAME OF PROVIDER OR SUPPLIER INTERFAITH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	Continued From page 2 R38's progress note dated 10/8/24, identified the facility smoking policy was reviewed and further discussed upon admission. R38's progress note dated 10/16/24, identified R38 wanted to go outside and smoke. R38's progress note dated 10/24/24, identified R38's visitor asked why R38 cannot go outside and smoke. Nurse informed R38 and visitor smoking was not allowed on property and this information was reviewed on admission. R38's progress note dated 12/4/24, identified staff witnessed R38 smoking in the facility parking lot twice. R38 confirmed had smoked after returning from outing with friends. Smoking issue and resident safety discussed. During interview on 2/5/25 at 10:21 a.m., nursing assistant (NA)-A identified R38 was a current smoker and the facility was non-smoking. Any resident who wishes to smoke must go off facility property to smoke. During interview on 2/5/25 at 12:33 p.m., registered nurse (RN)-D identified the facility as non-smoking and the smoking policy was reviewed upon admission. Residents cannot smoke on property but can leave the property with friends or family to smoke. RN-D confirmed R38 was a current smoker and explained there was one occasion were R38 was witness smoking across the street after returning from an outing with friends/family. R38 was not assessed for smoking upon admission or after this incident occurred. Due to the lack of assessment, it was uncertain if R38 was safe to smoke.			F 689			

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

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NAME OF PROVIDER OR SUPPLIER INTERFAITH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	Continued From page 3 During interview on 2/6/25 at 2:09 p.m., director of nursing (DON) identified all residents were informed of the facilities non-smoking policy prior to and again at the time of admission. When a resident was admitted as or later identified as a smoker, the non-smoking policy was reviewed and the resident was offered nicotine replacement therapy. Resident smoking has not been an issue until recently and the facility has not been completing smoking assessment on residents who are identified as a smoker. Effective immediate the facility will create a policy to address resident smoking safety and will complete smoking assessments on all residents who are identified as a smoker. Smoking assessments were important because the resident could be injured while smoking. Even when they are off our property, they are still our resident, and we need to make sure they are safe and can smoke safely. A policy Resident Care Polices section Smoke-Free Policy revised 10/29/19, identified no resident will be allowed to smoke in the facility or on the grounds. All residents will be notified of the smoke-free policy.	F 689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 11, 2025

Administrator
Interfaith Care Center
811 Third Street
Carlton, MN 55718

Re: State Nursing Home Licensing Orders
Event ID: V4DC11

Dear Administrator:

The above facility was surveyed on February 3, 2025 through February 6, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

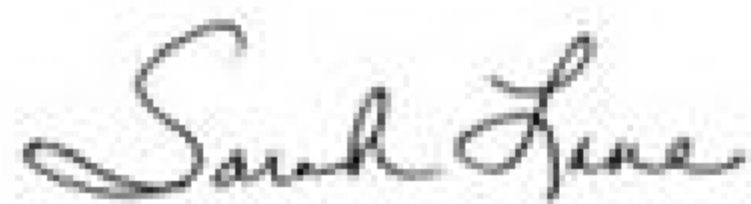
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00047	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2025
NAME OF PROVIDER OR SUPPLIER INTERFAITH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/3/25 to 2/6/25 , a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: 1426.	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

02/18/25

Minnesota Department of Health

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2 000	Continued From page 1 The following complaints were unsubstantiated: H50246144C (MN00106828), H50246145C(MN00102037), H50246146C (MN00100474). Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000			

Minnesota Department of Health
STATE FORM 6899 V4DC11 If continuation sheet 3 of 5

Minnesota Department of Health

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21426	Continued From page 3 screenings for 5 of 5 employees prior to their start date. Findings include: Registered nurse (RN)-A was hired on 12/12/24. RN-A's Quantiferon-TB blood test dated 11/24/24 indicated a negative test. RN-A's employee file lacked a TB screening report. Registered nurse (RN)-B was hired on 10/16/24. RN-B's Quantiferon-TB blood test dated 10/8/24 indicated a negative test. RN-B's employee file lacked a TB screening report. Registered nurse (RN)-C was hired on 11/18/24. RN-C's Quantiferon-TB blood test dated 7/17/24 indicated a negative test. RN-C's employee file lacked a TB screening report. Nurse assistant (NA)-A was hired on 12/11/24. NA-A's Quantiferon-TB blood test dated 12/10/24 indicated a negative test. NA-A's employee file lacked a TB screening report. Nurse assistant (NA)-B was hired on 10/3/24. NA-B's Quantiferon-TB blood test dated 10/3/24 indicated a negative test. NA-B's employee file lacked a TB screening report. During interview on 2/6/25 at 11:44 a.m., the assisted living director (ALD) stated he had been helping with the highering and on boarding of all new staff for the care center. All new staff would be sent to the local clinic to have a Quantiferon-TB blood test done prior to start. A screening had not been done on any new highers for around 2 yrs. ALD stated he asked if they needed to be done because they were seen in older staff files and he was told they were not	21426	It is the policy of Inter-Faith Care Center to establish and maintain a comprehensive tuberculosis infection control program. The policy on Tuberculosis screening was reviewed and remains current. All employees will complete a new tuberculosis screening form by 2/28/2025. The DON or designee will audit all new employee files for a period of three months to ensure compliance. Results of audits will be reviewed by the facility Quality Assurance Performance Improvement committee.		

Minnesota Department of Health

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21426	Continued From page 4 needed. During interview on 2/6/25 at 2:11 p.m., the director of nursing stated the TB screening forms needed to be done along with the blood work prior to start of employment. The facility Tuberculosis (TB)Screening Policy last revised 9/24, indicated a screening for TB symptoms would be completed and placed in the employee medical record prior to starting. Suggested method of correction: The director of nursing or designee could review and update systems for employee tuberculosis screenings. The director of nursing or designee could educate all appropriate staff. The director of nursing or designee could monitor to ensure ongoing compliance with tuberculosis policy and procedures. Time period for correction: 21 days	21426			

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

PRINTED: 02/21/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245024		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2025	
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/05/2025. At the time of this survey, Interfaith 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/21/2025

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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 facility has a capacity of 95 beds and had a census of 80 at the time of the survey.	K 000			

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K 000	Continued From page 2			K 000			
K 211 SS=D	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear path of egress system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: 1) On 02/05/2025 between 09:00am and 1:00pm, it was revealed by observation that the door in the fire barrier wall was blocked by floor cleaning equipment and/or service materials, door location was in serving kitchen / elevator room. 2) On 02/05/2025 between 09:00am and 1:00pm, it was revealed by observation that the door in the fire barrier wall leading from the dining room had an inoperable leaf, making half the door opening unusable when tested.			K 211			2/28/25
					It is the policy of Inter-Faith Care Center to ensure that all passageways, corridors, exit discharges and locations are free from obstructions in the case of emergency. Items noted to be blocking the fire door on the 2nd floor serving kitchen have been removed. The door in the dining room was repaired and is now usable. The facility Maintenance Director reviewed all fire doors to ensure that no other blockages were noted. In addition, all fire doors in the facility were checked to ensure they are working properly. All facility staff will be re-educated on fire doors by 2/28/2025. The facility Maintenance Director or designee will audit all fire doors weekly for a period of one month and then biweekly for three months to ensure compliance. Results of all audits will be reviewed by the facility Quality Assurance Performance		

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K 211	Continued From page 3 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	Improvement committee (QAPI).	2/28/25	
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not properly maintain enclose stairways used for exits and smoke proof enclosures in accordance with NFPA 101 (2012), Life Safety Code, section 7.1.3.2.1. These deficient findings could a widespread impact on the residents within the facility. Findings include: On 02/05/2025 between 09:00am and 1:00pm, t was revealed by observation that storage materials had been placed in the emergency exit stairwells in the follo9wing: 1) Stairwell leading from Maple Wing to Cedar Wing - Chairs on platform and on top / bottom landing 2) Stairwell leading from Oak Wing to Birch Wing - Chairs on platform and on top / bottom landing An interview with the Maintenance Director	K 225	It is the policy of Inter-Faith Care Center to ensure that all stairways and smokeproof enclosures are kept free of obstructions. The chairs in the stairwells were removed. All staff will be educated on the policy by 2/28/2025. The facility Maintenance Director or designee will audit all stairwells weekly for a period of one month and then biweekly for three months to ensure compliance. Results of all audits will be reviewed by the facility Quality Assurance Performance Improvement committee (QAPI).		

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K 225	Continued From page 4 verified this deficient finding at the time of discovery.	K 225			
K 226 SS=F	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell arrangement and markings per NFPA 101 (2012 edition), Life Safety Code, section 19.1.1.4.1.1, 19.1.1.4.1.2, 19.1.1.4.1.3, 19.2.2.2.7, Chapter 7, section 7.2.1.4.5.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1) On 02/05/2025 between 09:00am and 1:00pm, it was revealed by observation that the exit door at the end of Sunshine wing did not open 30psi of force and was unable to be continued in operation with a maximum force of 15psi. When tested the emergency exit was catching on baseplate /sill plate area. An interview with the Maintenance Director verified this deficient finding at the time of	K 226		2/28/25	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 226	Continued From page 5 discovery.	K 226			
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/05/2025 between 0900am and 100pm, it was revealed by observation that the exterior lights for Birch Wing Exit to Court Yard has only one bulb for illumination. Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2.2 lux) in any designated area. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 281		2/28/25	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities	K 324	It is the policy of Inter-Faith Care Center to ensure that all means of egress have appropriate illumination. The light fixture at the exit of Birch wing was replaced with an LED fixture. All fixtures outside of means of egress were audited and meet the appropriate life safety requirements. LED bulbs will be audited quarterly to ensure adequate illumination. Results of all audits will be reviewed by the facility Quality Assurance Performance Improvement committee (QAPI).	2/28/25	

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K 324	Continued From page 6 Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/05/2025 between 09:00am and 1:00pm, it was revealed by observation that the residential			K 324	It is the policy of Inter-Faith Care Center to ensure that cooking facilities maintain all appropriate safety measures per NFPA 101. The stove on the birch unit was turned to off mode. All facility staff will be educated on the need to ensure the stove is turned to off mode after use. The facility Maintenance Director or designee will audit all cooking facilities weekly for a period of one month and then biweekly for three months to ensure compliance. Results of all audits will be reviewed by		

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K 324	Continued From page 7 stove located on Birch Wing was not equipped with a lock-out switch and was not on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cook-top or range, independent of staff action.			K 324	the facility Quality Assurance Performance Improvement committee (QAPI).		
K 355 SS=D	An interview with the Maintenance Director verified this deficient finding at the time of discovery. Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/05/2025 between 0900am and 1200pm, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with the Maintenance Director verified this deficient finding at the time of			K 355	It is the policy of Inter-Faith Care Center to ensure that all fire extinguishers are selected, installed, inspected and maintained in accordance with NFPA 10. Fire extinguisher annual inspection documentation was provided during the survey. In addition, the vendor (Northland Fire Safety) provided documentation of the annual inspection completed on 11/29/2025.		2/28/25

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K 355	Continued From page 8 discovery.	K 355			
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485	K 363		2/28/25	

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K 363	Continued From page 9 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/05/2025 between 09:00am and 1:00pm, it was revealed by observation that the Soiled Utility room door did not latch when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	It is the policy of Inter-Faith Care Center to ensure that corridor doors are maintained per NFPA 101 standards. The soiled utility room door was repaired. All other facility doors were audited to ensure proper latching. All facility staff will be educated on the need to report any doors that do not latch to the Maintenance Director for repair. The facility Maintenance Director or designee will audit all corridor doors for proper latching weekly for a period of one month and then biweekly for three months to ensure compliance. Results of all audits will be reviewed by the facility Quality Assurance Performance Improvement committee (QAPI).		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review.	K 761		2/28/25	

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K 761	Continued From page 10 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/05/2025 between 9:00am and 12:00pm, it was revealed by observation that the following fire doors and/or fire door frames were missing door rating tags. 1) Fire doors leading to Assisted Living wing - missing tags on door frame 2) Fire doors by Activities - missing tags on door frame 3) Fire doors leading to Maple, Cedar, Birch and Oak wings An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	It is the policy of Inter-Faith Care Center to ensure that all fire door assemblies are inspected and tested annually in accordance with NFPA 80. The facility has been in contact with two vendors (WL Hall & UL Solutions) to obtain quotes and to schedule inspection and certification of the doors. This work will be completed as soon as possible per the vendors availability. Facility will have contract in place for work by 2/28/2025.		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment	K 920		2/28/25	

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K 920	Continued From page 11 (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 02/05/2025, between 9:00am and 1:00pm, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; 1) Power-strip w/ Refrigerator in D.O.N.Office	K 920	It is the policy of Inter-Faith Care Center to ensure that Power strips in a patient care vicinity are only used for components of movable patient-care related electrical equipment. The refrigerators and microwaves were removed from power strips in the administration offices. All rooms were audited to ensure proper use of power strips in the building. All staff will be educated on the use of power strips by 2/28/2025. The facility Maintenance Director or designee will audit all spaces for use of power strips weekly for a period of one month and then biweekly for three months to ensure compliance. Results of all audits will be reviewed by the facility Quality Assurance Performance Improvement committee (QAPI).		

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K 920	Continued From page 12 2) Power-strip w/ Microwave in H.R. 3) Power-strip w/ Refrigerator in Administrators Office 4) Power-strip w/ Refrigerator in Therapy Office An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920			