

Electronically delivered July 22, 2021

Administrator Interfaith Care Center 811 Third Street Carlton, MN 55718

RE: CCN: 245024 Cycle Start Date: June 9, 2021

Dear Administrator:

On June 25, 2021, we notified you a remedy was imposed. On July 13, 2021 the Minnesota Department of Health 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 July 5, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 10, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 25, 2021, 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 July 10, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 5, 2021, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

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



Electronically delivered

July 22, 2021

Administrator Interfaith Care Center 811 Third Street Carlton, MN 55718

Re: Reinspection Results Event ID: 05PG12

Dear Administrator:

On July 13, 2021 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 July 13, 2021. At this time these correction orders were found corrected.

Please feel free to call me with 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 June 28, 2021

Administrator Interfaith Care Center 811 Third Street Carlton, MN 55718

RE: CCN: 245024 Cycle Start Date: June 9, 2021

Dear Administrator:

On June 9, 2021, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 13, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 13, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 13, 2021.

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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 \$11,160; 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 July 13, 2021, 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 July 13, 2021. 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 this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

> Terri Ament, Unit Supervisor Duluth District Office 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 Office: (218) 302-6151 Mobile: (218) 766-2720

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 December 9, 2021 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 CFR § 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.

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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at <u>Tamika.Brown@cms.hhs.gov.</u>

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:

Interfaith Care Center June 28, 2021 Page 5 <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O	<u>MB NO</u>	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			`´CO№	E SURVEY IPLETED
		245024	B. WING _				C /09/2021
NAME OF F	PROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	05/2021
INTERFA	ITH CARE CENTER				11 THIRD STREET CARLTON, MN 55718		
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F 000	INITIAL COMMENT	ſS	F 0(00			
	abbreviated survey Your facility was NC with the requirement	6/9/21, a standard was conducted at your facility. OT found to be in compliance hts of 42 CFR 483, Subpart B, ong Term Care Facilities.					
	SUBSTANTIATED:	60) Deficiencies were issued					
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 637 SS=D	onsite revisit of you validate that substa regulations has bee Comprehensive As	sessment After Signifcant Chg	F 63	37			7/5/21
	determines, or shou there has been a si resident's physical purpose of this sec means a major deo resident's status tha itself without further implementing stand interventions, that h	(ithin 14 days after the facility uld have determined, that gnificant change in the or mental condition. (For tion, a "significant change" line or improvement in the at will not normally resolve r intervention by staff or by lard disease-related clinical has an impact on more than ident's health status, and					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						06/30/2021

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.

PRINTED: 07/02/2021

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		& MEDICAID SERVICES				0938-039
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INTERFA	ITH CARE CENTER			811 THIRD STREET CARLTON, MN 55718		
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F 637	Continued From pa	ige 1	F 6	37		
	care plan, or both.)	linary review or revision of the NT is not met as evidenced				
	by: Based on interview facility failed to com reassessment using Instrument (RAI) pr in Status Assessme (R1) following a sig The RAI indicates a five percent or more percent or more in Findings include: The Centers for Me (CMS) Long-Term	v and document review, the pplete a comprehensive g the Resident Assessment rocess and Significant Change ent (SCSA) for 1 of 1 residents nificant unplanned weight loss. an unplanned weight loss of e in the past month, or 10 the past six months.		56F 637: Comprehensive after Significant Change Resident R1 discharged f Corrective Action As It Ap Residents a. A 100% Audit of reside conducted for Significant nurse managers including weight, current weight and notifications/interventions taken were documented i resident □ s EMR. Reoccurrence Will Be Pre	from the facility plies to Other ent weights was Change by the baseline d all and actions n each	
	dated 10/2019, ider assessment tool wh use. The manual pr	ntified the MDS as an nich facilities are required to rovided instructions to ensure lete coding for each section of		a. The facility policy on w written to include Floor Nu Responsibility, reporting p Nurse Manager Responsi Notification of Dietician ar IDT team weekly review.	veights was urse parameters, ibilities,	
	Indicated, "The iten to assess the many the residents' ability	ing/Nutritional Status ns in this section are intended / conditions that could affect / to maintain adequate ion. This section covers		b. The facility policy on N to include IDT Member ro definition of Significant Ch	les and the	
	swallowing disorder loss, and nutritional should collaborate staff to ensure that	rs, height and weight, weight l approaches. The assessor with the dietitian and dietary items in this section have d calculated accurately."		c. The facility policy on In Team (IDT) was permane include Significant Chang be reviewed weekly	ently updated to les as an area to	
	R1's diagnoses incl	ord printed 6/9/21, indicated luded stroke, dysphagia g) weakness, and dementia		 d. All Interdisciplinary tea members who complete of assessments will be educe MDS policy including emp 	departmental ated on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245024 B. WING 06/09/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 811 THIRD STREET CARLTON, MN 55718 STREET ADDRESS, CITY, STATE, ZIP CODE			AND HUMAN SERVICES				FORM	07/02/2021 APPROVED 0938-0391
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INTERFAITH CARE CENTER CARLTON, MN 55718	NAME OF	PROVIDER OR SUPPLIER						
(X4) D SUMMARY STATEMENT OF DEFICIENCIES IN PROVIDER'S PLAN OF CORRECTION	INTERFA	AITH CARE CENTER						
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE		(EACH DEFICIENC)	MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
 F 637 Continued From page 2 with behavioral disturbances. R1's admission Minimum Data Set (MDS) dated 3/16/21, identified R1 had moderate cognitive impairment, and required extensive assistance with bed mobility, transfers, dressing, tolleting, personal hygiene and bathing. The MDS identified R1 required set up assist for meals and supervision for eating. The MDS identified R1 had no weight loss and had no difficulty with swallowing liquids/solids. R1's weekly weights indicated the following documented weights: 3/9/21, 196.4 lbs. 3/27/21, 182.4 lbs indicating a weight loss of -14% since 3/9/21 4/17/21, 163.8 lbs. 4/24/21, 142 lbs. indicating a 30 lbs. weight loss since 3/9/21 R1's medical record lacked evidence of a completed SCSA, after R1's significant weight loss. On 6/9/21, at 9:39 a.m. the facility MDS coordinator, registered nurse (RN)-A confirmed that R1 idd not have a SCSA completed when he experienced an unplanned weight loss of five percent or more in less than a six months' timeframe. RN-A further stated there should have been a SCSA completed for R1 when he first started experiencing upplaned weight loss. RN-A 	F 637	with behavioral dist R1's admission Min 3/16/21, identified F impairment, and reaving with bed mobility, tr personal hygiene and identified R1 requires swallowing liquids/s R1's weekly weight documented weight 3/9/21, 196.4 lbs. 3/18/21, 190.2 lbs. 3/27/21, 182.4 lbs. -14% since 3/9/21 4/3/21, 184.4 lbs. 4/11/21, 166.4 lbs. since 3/9/21 4/17/21, 163.8 lbs. 4/24/21, 142 lbs. in- since admission on R1's medical record completed SCSA, a loss. On 6/9/21, at 9:39 a coordinator, register that R1 did not have experienced an unp percent or more in or more in less than RN-A further stated SCSA completed for	urbances. imum Data Set (MDS) dated R1 had moderate cognitive quired extensive assistance ansfers, dressing, toileting, nd bathing. The MDS ed set up assist for meals and ng. The MDS identified R1 and had no difficulty with solids. indicated the following ts: indicating a weight loss of indicating a 30 lbs. weight loss dicating a 52 lbs. weight loss 3/9/21. d lacked evidence of a after R1's significant weight a.m. the facility MDS red nurse (RN)-A confirmed e a SCSA completed when he blanned weight loss of five the past month, or 10 percent n a six months' timeframe. there should have been a or R1 when he first started	F	537	 e. Resident weights will be audited weekly by the unit managers includin baseline weight and current weight of time using the Weight Summary Regenerated by Point Click Care (PCC Any significant findings will be used identify residents potentially needing. Significant Change Assessment. Au and actions taken will be presented Interdisciplinary Team (IDT) meeting weekly basis. f. The Interdisciplinary Team (IDT) weight Review / Significant Change Status Review and Audit findings will reported to QA monthly for 6 months as recommended by the QA Commit thereafter. Correction will be Monitored by: DON, RAI-MDS Coordinator, Nurse 	over port to g a udits at the g on a will Veekly ll be s and ittee	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/02/2021 APPROVED 0938-0391
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F 637	been on R1's admis had a swallowing di been properly ident assessment complet there was not a faci to guidance on com followed the most of Instrument manual On 6/9/21, at 11:39 (DON) stated that the resident was appropriate five percent or more percent or more in the timeframe a significe required. The Resident Assess manual dated Octor purpose of this mar about how to use the Instrument (RAI) cor provide appropriate (SCSA) comprehen completed on the 15 determination that as status occurred (de calendar days) The RAI manual ind significant change as a resident's status to A "significant change as a	ssion MDS which indicated R1 ifficulty /disorder and had not iffied on R1's admission ated on 3/16/21. RN-A stated ility policy specifically related opleting MDS, the facility urrent Resident Assessment from CMS. p.m. the director of nursing he facility would discuss if a priate for a SCSA during gs. The DON stated if a ed an unplanned weight loss of e in the past month, or 10 less than a six months' cant change MDS would be ssment Instrument (RAI) ber 2019, indicated the nual is to offer clear guidance ne Resident Assessment prectly and effectively to help care. The manual indicated a nsive assessment is to be 4th calendar day after significant change in resident's termination date + 14	F	637	7		

Facility ID: 00047

If continuation sheet Page 4 of 16

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPLE	
			A. BUILDING	3		С
	PROVIDER OR SUPPLIER	245024		STREET ADDRESS, CITY, STATE, ZIP CODE	06	/09/2021
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F 637	is not considered "s 2. Impacts more th health status; and	self-limiting"; an one area of the resident's sciplinary review and/or	F 637	7		
	Nutrition/Hydration CFR(s): 483.25(g)(Status Maintenance 1)-(3)	F 692	2		7/5/21
	(Includes naso-gas both percutaneous percutaneous endo enteral fluids). Bas	sessment, the facility must				
	of nutritional status desirable body weig balance, unless the	tains acceptable parameters , such as usual body weight or ght range and electrolyte e resident's clinical condition this is not possible or resident te otherwise;				
	§483.25(g)(2) Is off maintain proper hyd	fered sufficient fluid intake to dration and health;				
	there is a nutritional provider orders a th	fered a therapeutic diet when I problem and the health care herapeutic diet. NT is not met as evidenced				
	Based on interview facility failed to con weight monitoring a 1 of 3 residents (R This resulted in act	v, and document review, the pplete accurate and ongoing and nutritional assessment for 1) reviewed for weight loss. ual harm to R1, who weight loss in 6 weeks.		F 692: Nutrition/Hydration Statu Maintenance Resident R1 discharged from the Corrective Action As It Applies to Residents	e facility	

Facility ID: 00047

If continuation sheet Page 5 of 16

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				NTED: 07/02/2021 FORM APPROVED B NO. 0938-0391
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	245024	B. WING		06/09/2021
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
INTERFAITH CARE CENTER			11 THIRD STREET CARLTON, MN 55718	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION ATE DATE
 R1's diagnoses incluaccident (CVA, comwith left side weakness swallowing) and derdisturbances. R1's admission Mini 3/16/21, identified R1 impairment, and recowith bed mobility, trapersonal hygiene aridentified R1 requires supervision for eatir had no weight loss a swallowing liquids/s R1's Care Area Asset 3/19/21, indicated R to recent stroke that sided weakness/her and diabetes among R1's care plan initia the potential for alted diagnosis which incluneglect, dysphagia, appetite. The care princluded to keep R1 current weight and fluids. The staff to perform weak fluid intakes and door Registered Dieticiar upon admission, an changes. Dietary Mathematical stafe staff to perform weak fluid intakes and door Registered Dieticiar upon admission, an changes. Dietary Mathematical stafe sta	ord printed 6/9/21, indicated uded cerebral vascular imonly known as a stroke) ess, dysphagia (difficulty mentia with behavioral imum Data Set (MDS) dated A1 had moderate cognitive quired extensive assistance ansfers, dressing, toileting, nd bathing. The MDS ed set up assist for meals and ng. The MDS identified R1 and had no difficulty with	F 692	 conducted for significant change by nurse managers including baseline weight, current weight and all notifications/interventions and action taken were documented in each resident □s EMR. b. Audit findings were reviewed by the Registered Dietician (RD), the Dietate Manager (DM) and the IDT Team. Reoccurrence Will Be Prevented By a. The facility policy on weights was written to include Floor Nurse Responsibility, reporting parameters Nurse Manager Responsibilities, Notification of Dietician and permane IDT team weekly review. b. The roles of the Dietician, Dietary Manager (CDM), RAI-MDS staff and nurse managers were clarified in regit to resident Nutrition Hydration assessment, weight loss and gain, II review and ongoing monitoring. c. The Certified Dietary Manager (Cunder the guidance of the Dietician weekly the IDT team and the Weight Summ Report and Nurse Manager Weekly Weight Review will be sent to the Dietician Change Nutritional assessment will be completed by the Dietician and revie by the MDS assessor to ensure item section K are assessed and calculate 	s he ry , ent , jards DT DM) vill with ary etitian t be wed s is

Facility ID: 00047

If continuation sheet Page 6 of 16

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/02/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245024	B. WING	i		06/0))9/2021
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
INTERFA	ITH CARE CENTER				11 THIRD STREET ARLTON, MN 55718		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	Continued From pa	ge 6	F6	692			
		m (IDT) meeting. Dietary weights for quarterly			accurately		
		IDS. R1's care plan also			e. A Quarterly Nutrition Review will	be	
		risk for changes in weight			completed by the Dietician / Certifie	d	
		to diagnosis of depression			Dietary Manager (CDM) and review		
	and administration	of antidepressant medications.			the MDS assessor to ensure items section K are assessed and calcula		
	R1's admission Nut	rition Assessment dated			accurately.	lieu	
		s current weight but had been					
		caloric carbohydrate (LCC)			f. All facility licensed staff were edu	icated	
		tures. The assessment			on the facility Weight Policy includin		
		cently been progressed from		roles, responsibilities, significant wei			
		al nutritional intake during . The assessment also			loss / gains and notifications.		
		dependent at meals but			g. Resident weights will be audited		
		n and cues. Recorded intakes			weekly by the unit managers for		
		with IBW (ideal body weight)			significant change including baselin	е	
		rected staff to monitor weight			weight and current weight over time		
	and intake per proto	ocol.			the Weight Summary Report genera Point Click Care (PCC). Audits and		
	R1's Physician Ord	ers initiated 3/13/21, included			actions taken will be presented at th		
	weight to being take				Interdisciplinary Team (IDT) meeting		
		previous weights and reweigh			weekly basis.	-	
		Progress notes to be made					
		it scale used, if on wheelchair			h. The Interdisciplinary Team (IDT)		
	and if foot rests we	re in place.			audit compliance with the Nursing V		
	On 4/6/21 a Physic	ian Visit form indicated R1			Weight Review and Audit findings w reported to QA monthly for 6 month		
		ss which was likely related			as recommended by the QA Comm		
		nd to the medications he had			thereafter		
	been started on rec	ently.					
	0 1/00/04				Correction will be Monitored by:		
		8 p.m. a progress note l intake had been quite			DON, RAI-MDS Coordinator, Nurse	•	
		stay and had been mostly			Managers, QA Committee		
		reached out to dietary					
		on this and request someone					
	discuss with resider	nt what his dietary preferences					
	are and see what w	e can do to personalize his					

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		AND HUMAN SERVICES				FORM	07/02/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245024	B. WING				C 09/2021
NAME OF F	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
INTERFA	ITH CARE CENTER				811 THIRD STREET CARLTON, MN 55718		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	indicated R1 had a 25% or less most of On 4/23/21, at 9:03 indicated R1 had si pounds (lbs) since a reported poor apper Discussed medicated decreased appetite decrease in stimula such as appetite stimular such as appetite stimular of A/23/21, at 2:41 indicated R1's MD r supplement shakes (appetite stimulation daily, as well decrease (appetite stimulant) indicated R1's insurstimulant medication been started prior to on 4/25/2021, at 8 indicated R1 had di medications and swindicated both wate mouth. R1 was note	 p.m. a progress note decline in his eating, eating f the time. a.m. a progress note gnificant weight loss of 30 admission to the facility. R1 tite. Fluid intake poor as well. ions that may have caused . Discussed a potential int medication and options mulation medication with R1. R1's MD was updated. p.m. a progress note replied back with OK to start a 2 times daily and Marinol n) 2.5 milligrams (mg) 2 times asing Methylphenidate to 5 mg twice daily. The note rance had not approved on, and medication had not o readmission to the hospital 8:50 a.m. a progress note fficulty swallowing morning vallowing water. The note or and pills ran out of R1's ed to have been weaker and 	F	592			
	leaning to the left m appear to be in pair should be evaluated (ER), R1 replied, "N R1 was reevaluated	Ity with balance and was nore than usual. R1 did not n. When asked if R1 felt he d at the emergency room lo, I'm not going anywhere." d 15 minutes later and was nd R1 refused. Facility					

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		AND HUMAN SERVICES				FORM	07/02/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245024	B. WING) 09/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
INTERFA	ITH CARE CENTER				11 THIRD STREET ARLTON, MN 55718		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	continued to monito On 4/25/21, at 1:50 indicated R1 had be difficulties following weakness. R1 was and was transferred R1's weight record record (EHR) 3/9/2 3/9/21, 196.4 lbs. 3/18/21, 190.2 lbs. 3/27/21, 182.4 lbs. 4/3/21, 184.4 lbs. 4/11/21, 166.4 lbs. 4/17/21, 163.8 lbs. 4/24/21, 142 lbs. in or 25% since admis R1's meal intake re 3/9/21, to 4/25/21, at three daily meal (br averages included: 3/9/21, through 3/10 meal intake for all 7 3/16/21, through 3/10 meal intake for all 7 3/23/21, through 3/10 average intake for a 3/30/21, through 4/10 average intake for a 4/6/21, through 4/10 average intake for a 4/13/21, through 4/10 average intake for a 4/13/21, through 4/10 average intake for a 4/13/21, through 4/10 average intake for a	 br. R1 refused breakfast. p.m. a progress note been having increased direction and increased a requesting to go to hospital, dout. from the electronic health 1, to 4/24/21, indicated: dicating a 52 lbs. weight loss, asion on 3/9/21. cords from the EHR from and weekly total combined eakfast, lunch, and dinner) 6/21, 81% combined average 7 days. 29/21, 56% combined meal all 7 days. 20/21, 32% combined meal all 7 days. 20/21, 32% combined meal all 7 days. 20/21, 32% combined meal all 7 days. 20/21, 35% combined meal all 7 days. 20/21, 32% combined meal all 7 days. 20/21, 15% combined meal all 7 days. 	F 6	92			

Facility ID: 00047

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/02/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
		245024	B. WING) 09/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
INTERFA	NITH CARE CENTER				811 THIRD STREET CARLTON, MN 55718		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	coordinator, registe interviewed and sta reviewed weekly to discussed at the int (IDT)weekly meetin always attended all a residents would h a team, they would maybe they needed the nurse managers collecting the inform and would investiga for the weight loss. managers were res registered dietician, notifying the dietary had not been made weight loss, but her would have been no RN-A verified signif could contribute to integrity and overall On 6/9/21, at 9:39 a was interviewed an loss was reviewed a weekly meetings. D all IDT meetings. D all IDT meetings. D residents the day of assessment, and fin preferences were. did not review resid loss or weight gain. not been reviewing DM-A further stated education to becom	red nurse (RN)-A was ted all resident's weights were identify weight loss and erdisciplinary team gs. RN-A stated she had not IDT meetings. RN-A stated if ave unplanned weight loss as discuss interventions such as I a supplement. RN-A stated s were responsible for nation related to weight loss, ate what the causes might be RN-A stated the nurse ponsible for contacting the updating the physician, and manager. RN-A stated she aware of R1's significant expectation was that she otified by the nurse managers. icant unplanned weight loss changes in cognition, skin	Fé	\$92			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES			FORM	: 07/02/2021 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	LTIPLE CONSTRUCTION DING	(X3) DAT COM	TE SURVEY MPLETED
245024	B. WING	S		C / 09/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
INTERFAITH CARE CENTER		811 THIRD STREET CARLTON, MN 55718		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE
 F 692 Continued From page 10 residents were having weight loss. DM-A stated she would then initiate other food options and or nutritional supplement. DM-A stated she had noi personally revisited R1 to discuss other food options to increase his meal percentage intake. On 6/9/21, at 10:18 a.m. RD-A was interviewed and stated she had not been to the facility since the pandemic; however, she had been checking in with DM-A. RD-A stated she was always available to the facility via phone or email. RD-A stated she mainly currently had been working wit the nurse managers of the facility. RD-A stated she had run a facility weight report at the end of April, and noticed R1 had a significant weight loss. RD-A stated at that time, she passed it on to registered nurse (RN)-A and the nurse managers. RD-A stated the nurse manager had responded immediately and indicated in an emai they had been aware of R1's weight loss and were looking at possible medication changes wit adding an appetite stimulant. RD-A stated she would expect to be notified unplanned weight los of 5 percent or more in the past month, or 10 percent or more in less than six months. RD-A stated before she could put any interventions in place, R1 had already been admitted to the hospital. RD-A stated she had not received a weight summary report for quite some time. RD- verified the email correspondence between herself, and the facility nurse managers had beel sent out 4/27/21. On 6/9/21, at 11:16 a.m. RN-B was interviewed and stated she was the nurse manager on the unit R1 had resided while at the facility. RN-B stated the nurse manager on the unit R1 had resided while at the facility. RN-B stated the nurse manager on the unit R1 had resided the nurse manager on the unit R1 had resided the nurse manager on the unit R1 had resided the nurse manager on the unit R1 had resided the nurse manager on the unit R1 had resided the nurse manager on the unit R1 had resided the nurse manager on the unit R1 had resided the nurse manager on the unit	a h h s A	692		

Facility ID: 00047

If continuation sheet Page 11 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245024 B. WING 06/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 811 THIRD STREET CARLTON, MN 55718 STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			AND HUMAN SERVICES				FORM	07/02/2021 APPROVED 0938-0391
245024 B: WING 06/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, UP CODE SITTERFATH CARE CENTER STREET ADDRESS, CITY, STATE, UP CODE SITTERFATH, CARE CONTENT, STATE, UP CONTENT, STATE, STA	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
BIT THREP STREET CARLTON, MN 55718 CMUD PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REACH DEFICIENCY MUST BE PRECEDED BY FULL TAG OPONDER'S FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX F 692 Continued From page 11 weight loss and reviewed or added interventions if past month, or 10 percent or more in less than as months. RN-A stated uplanned weight loss would be 5 percent or more in less than as months. RN-A stated typically if they started seeing weight loss, the facility would start with a nutritional supplement. RN-A stated she had not been made aware sooner. RN-A verified nutrition supplements had not been started for R1 until 4/23, and at that time R1 weighed 142 lbs. RN-A stated the ideitician and physician should have been nutfied as early as 3/18/21 when R1 first had documented weight loss. On 6/9/21, at 11:39 p.m. the director of nursing (DON) stated the importance of reviewing the percentage of meals the residents weights are to be reviewed weekly at the IDT meetings to identify weight loss and put interventions place. The DON stated if a resident's weights are to be reviewed weekly at the IDT meetings to identify weight loss and put interventions place. The DON stated if a resident experienced unplanned weight loss of 5 percent or more in less than a six months' timeframe she would be to see what percent or more in less than a six months' timeframe she would be to see what percent or more in less than a six months' timeframe she would be to see there uppercent to have notified the registreed diletary, weight loss and put interventions place. The DON stated if a resident synerincore in the past month, or 10 percent or more in less			245024	B. WING				
INTERPATH CARE CENTER CARLTON, MN 55718 (W) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FUL RECOUNTORY OR LSC DENTIFYING INFORMATION) ID TAG PROVIDER'S INAN OF CORRECTIVE (EACH DEFICIENCY MUST BE PRECEEDED BY FUL RECOUNTORY OR LSC DENTIFYING INFORMATION) ID TAG PROVIDER'S INAN OF CORRECTIVE (EACH DEFICIENCY MUST BE PRECEEDED BY FUL RECOUNTORY OR LSC DENTIFYING INFORMATION) PROVIDER'S PROVIDER'S INAN OF CORRECTIVE (EACH DEFICIENCY MUST BE PRECEEDED BY FUL RECOUNTORY OR LSC DENTIFYING INFORMATION) PROVIDER'S PROVIDER'S INAN OF CORRECTIVE (EACH DEFICIENCY) OWNET (EACH DEFICIENCY) F 692 Continued From page 11 weight loss and reviewed or added interventions if needed at that time. RN-A stated be had biscussed weight loss around 4/6/21, with R1's primary physician, and medications changes had been made at that time. RN-A stated by possility if they startd seeing weight loss, the facility would start with a nutritional supplement. RN-A stated the head not been made aware of R1's weight loss until around 4/6/21, but she should have been made aware sooner. RN-A verified nutrition supplements had not been started for R1 until 4/23, and at that time R1 weight 10s. SN-A stated the deitician and physician should have been notified as early as 3/18/21 when R1 first had documented weight loss. On 6/9/21, at 11:39 p.m. the director of nursing (DON) stated the importance of reviewing the percentage of meals there would be to see what percentage of meals there weights are to be reviewed weekly at the IDT meetings to identify weight loss and put interventions place. The DON stated if a resident experienced unplanned weight loss of 5 percent or more in the past month. or 10 percent or more in less than a six months' timeframe she would b	NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
Preferst TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE COMMETING INTERPORTATION F 692 Continued From page 11 weight loss and reviewed or added interventions if needed at that time. RN-A stated unplanned weight loss would be 5 percent or more in the past month, or 10 percent or more in the sast month. RN-A stated she had discussed weight loss around 4/6/21, with R1's primary physician, and medications changes had been made at that time. RN-A stated typically if they started seeing weight loss, the facility would start with a nutritional supplement. RN-A stated the had not been made aware of R1's weight loss until around 4/6/21, but she should have been made aware sooner. RN-A verified nutrition supplements had not been started for R1 until 4/23, and at that time R1 weighed 142 lbs. RN-A stated the dietician and physician should have been notified as early as 3/18/21 when R1 first had documented weight loss. On 6/9/21, at 11:39 p.m. the director of nursing (DON) stated the importance of reviewing the percentage on meal tickets would be to see what percentage on meal tickets would be to see what percentor more in the past month, or 10 percent or more in less than a six months' timeframe she would expect the nurse managers to have notified the registered dietician, ideary manager, and primary physician. The DON stated the facility had not been sending the weekly weight loss on The DON stated if the registered dietician, ideary manager, and primary physician. The DON stated the facility had not been sending to review but should have been doing so. The DON stated it was important to identify unplanned weight lo	INTERFA	ITH CARE CENTER						
 weight loss and reviewed or added interventions if needed at that time. RN-A stated unplanned weight loss would be 5 percent or more in the past month, or 10 percent or more in less than six months. RN-A stated she had discussed weight loss around 4/6/21, with R1's primary physician, and medications changes had been made at that time. RN-A stated typically if they started seeing weight loss, the facility would start with a nutritional supplement. RN-A stated she had not been made aware of R1's weight loss until around 4/6/21, but she should have been made aware as oner. RN-A verified nutrition supplements had not been started for R1 until 4/23, and a that time R1 weighed 142 lbs. RN-A stated the dietician and physician should have been notified as early as 3/18/21 when R1 first had documented weight loss. On 6/9/21, at 11:39 p.m. the director of nursing (DON) stated the importance of reviewing the percentage on meal tickets would be to see what percentage of meals the residents were eating. The DON stated residents' weights are to be reviewed weekly at the IDT meetings to identify weight loss and put interventions place. The DON stated if a resident experienced unplanned weight loss of 5 percent or more in the past month, or 10 p	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
A facility policy related to Weight Monitoring and	F 692	weight loss and rev needed at that time weight loss would b past month, or 10 p months. RN-A state loss around 4/6/21, and medications ch time. RN-A stated ty weight loss, the fac nutritional suppleme been made aware of 4/6/21, but she sho sooner. RN-A verifi not been started for R1 weighed 142 lbs and physician shou as 3/18/21 when R2 loss. On 6/9/21, at 11:39 (DON) stated the in percentage on mea percentage on mea percentage of meal The DON stated res reviewed weekly at weight loss and put stated if a resident of loss of 5 percent or percent or more in I timeframe she woul to have notified the manager, and prima the facility had not b weights to the dietic been doing so. The to identify unplanne further decline in the	riewed or added interventions if a. RN-A stated unplanned be 5 percent or more in the bercent or more in less than six ed she had discussed weight with R1's primary physician, hanges had been made at that ypically if they started seeing ility would start with a ent. RN-A stated she had not of R1's weight loss until around uld have been made aware ied nutrition supplements had r R1 until 4/23, and at that time s. RN-A stated the dietician ld have been notified as early 1 first had documented weight p.m. the director of nursing mortance of reviewing the al tickets would be to see what ls the residents were eating. sidents' weights are to be the IDT meetings to identify tinterventions place. The DON experienced unplanned weight more in the past month, or 10 less than a six months' ld expect the nurse managers registered dietician, dietary ary physician. The DON stated been sending the weekly cian to review but should have e DON stated it was important ed weight loss early to prevent the residents condition.	F 6	92			

If continuation sheet Page 12 of 16

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
		245024	B. WING _		C 06/09/2021		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 811 THIRD STREET CARLTON, MN 55718	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	HOULD BE	(X5) COMPLETIC DATE	
F 801	Continued From pa Nutrition was reque Qualified Dietary St CFR(s): 483.60(a)(ested but not received. aff	F 69 F 80			7/1/21	
	appropriate competent out the functions of taking into consider individual plans of consider and diagnoses of the	nploy sufficient staff with the tencies and skills sets to carry the food and nutrition service, ration resident assessments, care and the number, acuity he facility's resident population the facility assessment					
	clinically qualified n full-time, part-time, qualified dietitian or nutrition profession (i) Holds a bachelor a regionally accredi United States (or an with completion of t a program in nutrition an appropriate nation recognized for this (ii) Has completed a supervised dietetics supervision of a region professional. (iii) Is licensed or com	r's or higher degree granted by ited college or university in the n equivalent foreign degree) the academic requirements of on or dietetics accredited by onal accreditation organization purpose. at least 900 hours of					
	services are perform provide for licensur will be deemed to h or she is recognized	med. In a State that does not e or certification, the individual ave met this requirement if he d as a "registered dietitian" by Dietetic Registration or its					

A BUILDING C C 06/09/ NAME OF PROVIDER OR SUPPLIER INTERFAITH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 811 THIRD STREET CARLTON, MN 55718 (X) 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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CARLTON, MN 55718 CC F 801 Continued From page 13 successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. F 801 §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 yea			(X1) PROVIDER/SUPPLIER/CLIA	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INTERFAITH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONTINUED (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 801 F 801 Continued From page 13 successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. F 801 §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to service as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national		or connection	IDENTIFICATION NOMBER.		IG			
BIT THIRD STREET CARLTON, MN 55718 (X4) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WID BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY WID BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. F 801 V) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. F 801 \$483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, is: (A) A certified dietary manager; or (B) A certified dietary manager; or (C) Has similar national certification for food service management and safety from a national Bit THIRD STREET CARLTON, MN 55718			245024	B. WING		06/	09/2021	
INTERFAITH CARE CENTER 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) C F 801 Continued From page 13 successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. F 801 F 801 (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. F 833.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, or no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, for manager; or (B) A certified dietary manager; or (C) Has similar national certification for food service management and safety from a national <	NAME OF	PROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED to THE APPROPRIATE DEFICIENCY) CC F 801 Continued From page 13 successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. F 801 §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016 for designations after November 28, 2016 for designations	INTERF	AITH CARE CENTER						
successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETIO DATE	
certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by:	F 801	successor organize requirements of patthis section. (iv) For dietitians h November 28, 201 no later than 5 yea as required by stat §483.60(a)(2) If a c clinically qualified r employed full-time person to serve as nutrition services w (i) For designation meets the following years after Novemb after November 28 (A) A certified dieta (B) A certified dieta (C) Has similar nat service management certifying body; or D) Has an associa service management course study include management, fror higher learning; an (ii) In States that has food service mana meets State require managers or dietant (iii) Receives frequent from a qualified dietant qualified nutrition patheters.	ation, or meets the aragraphs (a)(1)(i) and (ii) of ired or contracted with prior to 6, meets these requirements rs after November 28, 2016 or e law. qualified dietitian or other nutrition professional is not , the facility must designate a the director of food and who- is prior to November 28, 2016, g requirements no later than 5 ber 28, 2016, or no later than 1 er 28, 2016 for designations 6, 2016, is: ary manager; or service manager; or tional certification for food ent and safety from a national te's or higher degree in food ent or in hospitality, if the des food service or restaurant n an accredited institution of d ave established standards for gers or dietary managers, ements for food service ry managers, and ently scheduled consultations etitian or other clinically professional.	F 80				

If continuation sheet Page 14 of 16

STATEMEN	T OF DEFICIENCIES DF CORRECTION	KANNERS KANNERS	· ·	TIPLE CONSTRUCTION		SURVEY PLETED
		245024	B. WING_		06/0) 9/2021
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 811 THIRD STREET CARLTON, MN 55718		, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 801	certified and creder preparation and se potential to affect a who consumed foo Findings include: On 6/9/21 at 9:39 a stated that she was manager. DM-A state education, and had test related to beco obtaining her Servs On 6/9/21, at 10:18 (RD)-A was intervie DM-A had not com certified DM. RD-A providing approxim facility as a register needed. RD-A state facility since the pa been checking in w DM-A. RD-A state the facility via phon On 6/9/21, at 11:57 that DM-A was put January 2020, after resigned. The adm finished the educat take her test related certification. The a signed off on paper dietary manager tra The facility's dietary dated 1/23/19, inclu	A minimum of the kitchen. This had ll 77 residents and facility staff d from the kitchen. A.m. dietary manager (DM)-A s not a certified dietary ated she recently finished the been signed up to take her oming a certified DM and Safe certification. B a.m. registered dietician ewed. RD-A stated the acting pleted her test to become a stated she was currently ately 4 hours a month to the red dietician, and worked as red she had not been to the ndemic; however, she had with the acting non-certified d she was always available to e or email. T a.m. the administrator stated in the position of DM in r the previous DM had ion and had been signed up to d to DM-C ServSafe dministrator stated he had work regarding the certified	F 8(01 1. The facility Dietary I the Certified Dietary Maprogram through NDU passed the PSI examin Dietary Manager (CDM) 2. The Facility Register is available in-person of 4 hours weekly and as also readily available v mail. 3. Facility Administratin the Administrator, DON Resources On-Boardin Certified Dietary Mana- educated on qualification a dietary manager. Correction will be Monia Administrator, DON 	anager certification and successfully hation for Certified 1) 6-18-2021. ered Dietician (RD) on site in the facility needed. The RD is ia telephone or e ve Staff including J, Human ng staff and the ger (CDM) were on requirements for	

If continuation sheet Page 15 of 16

		AND HUMAN SERVICES				FORM	07/02/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245024	B. WING	÷			09/2021
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
INTERF	AITH CARE CENTER				811 THIRD STREET CARLTON, MN 55718		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 801	approved Dietary M State and Federal r	Anager's course that meets requirements. The policy is requirement must be met	F	801			

Facility ID: 00047



Electronically delivered June 28, 2021

Administrator Interfaith Care Center 811 Third Street Carlton, MN 55718

Re: State Nursing Home Licensing Orders Event ID: 05PG11

Dear Administrator:

The above facility was surveyed on June 8, 2021 through June 9, 2021 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 <u>only a suggestion</u> 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 <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. 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:

Terri Ament, Unit Supervisor Duluth District Office 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 Office: (218) 302-6151 Mobile: (218) 766-2720

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 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.

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				"THOTED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE COMP	SURVEY LETED
		00047	B. WING		06/0) 9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
INTERFA	NITH CARE CENTER		D STREET I, MN 55718			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	was conducted at y the Minnesota Depa facility was found N with the MN State L	6/9/21, a complaint survey our facility by surveyors from artment of Health (MDH). Your OT found to be in compliance icensure.				
Ainerson	. .	laint was found to be				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 06/30/21

Electronically Signed

6899

If continuation sheet 1 of 16

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00047	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
					00/	09/2021
NAME OF F	ROVIDER OR SUPPLIER			TATE, ZIP CODE		
NTERFA	ITH CARE CENTER	811 THIRE CARLTON	, MN 55718			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLE DATE
2 000	Continued From pa	age 1	2 000			
	SUBSTANTIATED: H5024037 (MN733 issued at: 4658.0525 Subp 7 4658.0605 Subp 2	60) Licensing orders were 0956				
	the State Licensing Federal software. T assigned to Minnes Nursing Homes. Th appears in the far-I Tag." The state sta listed in the "Summ column and replace the correction orde the findings which statute after the sta as evidence by." Fe are the Suggested Time Period for Co You have agreed to receipt of State lice the Minnesota Dep Informational Bulle https://www.health. n/infobulletins/ib14 orders are delineat Department of Hea you electronically. is necessary for State lice heading completion	o participate in the electronic ensure orders consistent with				
unesota De	the Minnesota Dep is enrolled in ePOC	artment of Health. The facility C and therefore a signature is bottom of the first page of				

Minnesc	ota Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00047	B. WING		06/0	C 9/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
INTERFA	NITH CARE CENTER	-	D STREET I, MN 55718			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	state form.					
	FOURTH COLUMN "PROVIDER'S PLA	N OF CORRECTION." THIS RAL DEFICIENCIES ONLY.				
2 550	MN Rule 4658.0400 Resident Assessme) Subp. 4 Comprehensive ent; Review	2 550			7/5/21
	home must examin quarterly and must comprehensive ass	assessments. A nursing e each resident at least revise the resident's essment to ensure the y of the assessment.				
	by: Based on interview facility failed to com reassessment using Instrument (RAI) pr in Status Assessme (R1) following a sig The RAI indicates a five percent or more	ent is not met as evidenced and document review, the plete a comprehensive g the Resident Assessment ocess and Significant Change ent (SCSA) for 1 of 1 residents nificant unplanned weight loss. In unplanned weight loss of e in the past month, or 10 the past six months.		CORRECTED		
	Findings include:					
Minnosota	(CMS) Long-Term (Assessment Instrur dated 10/2019, ider assessment tool wh use. The manual pr	dicare and Medicaid Services Care Facility Resident nent (RAI) 3.0 User's Manual htified the MDS as an hich facilities are required to ovided instructions to ensure lete coding for each section of				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00047	B. WING			C 09/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
INTERF	AITH CARE CENTER		D STREET N, MN 55718			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 550	Continued From pa	age 3	2 550			
	the assessment as	follows:				
	Indicated, "The item to assess the many the residents' ability nutrition and hydraf swallowing disorde loss, and nutritiona should collaborate staff to ensure that been assessed and R1's admission rec R1's diagnoses inc	ing/Nutritional Status ns in this section are intended y conditions that could affect y to maintain adequate tion. This section covers rs, height and weight, weight I approaches. The assessor with the dietitian and dietary items in this section have d calculated accurately." Ford printed 6/9/21, indicated luded stroke, dysphagia g) weakness, and dementia turbances.				
	3/16/21, identified F impairment, and re with bed mobility, tr personal hygiene a identified R1 requir supervision for eati	nimum Data Set (MDS) dated R1 had moderate cognitive quired extensive assistance ransfers, dressing, toileting, nd bathing. The MDS ed set up assist for meals and ng. The MDS identified R1 and had no difficulty with solids.				
	documented weigh 3/9/21, 196.4 lbs. 3/18/21, 190.2 lbs. 3/27/21, 182.4 lbs. -14% since 3/9/21 4/3/21, 184.4 lbs. 4/11/21, 166.4 lbs. since 3/9/21 4/17/21, 163.8 lbs.	· indicating a weight loss of indicating a 30 lbs. weight loss dicating a 52 lbs. weight loss				

Minnesota Department of Health STATE FORM

05PG11

If continuation sheet 4 of 16

	ota Department of He	(X1) provider/supplier/clia	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
		00047	B. WING			C 09/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		811 THIR	D STREET			
INTERFA	AITH CARE CENTER	CARLTO	N, MN 55718			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 550	Continued From pa	ge 4	2 550			
		d lacked evidence of a after R1's significant weight				
	coordinator, registe that R1 did not have experienced an unp percent or more in to or more in less than RN-A further stated SCSA completed for experiencing unplan verified R1's diagnor been on R1's admis had a swallowing di been properly ident assessment complet there was not a fact to guidance on com	a.m. the facility MDS red nurse (RN)-A confirmed e a SCSA completed when he blanned weight loss of five the past month, or 10 percent n a six months' timeframe. I there should have been a or R1 when he first started nned weight loss. RN-A basis of dysphagia should have ssion MDS which indicated R1 ifficulty /disorder and had not iffied on R1's admission eted on 3/16/21. RN-A stated ility policy specifically related npleting MDS, the facility surrent Resident Assessment from CMS.				
	(DON) stated that the resident was appro- weekly IDT meeting resident experience five percent or more percent or more in	p.m. the director of nursing he facility would discuss if a priate for a SCSA during gs. The DON stated if a ed an unplanned weight loss of e in the past month, or 10 less than a six months' cant change MDS would be				
	manual dated Octo purpose of this mar about how to use th Instrument (RAI) co	ssment Instrument (RAI) ber 2019, indicated the nual is to offer clear guidance ne Resident Assessment prrectly and effectively to help e care. The manual indicated a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000047	(X2) MULTIPLE A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 06/09/2021			
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE	·			
	NTH CARE CENTER	811 THIR	D STREET N, MN 55718					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
2 550	completed on the 14 determination that s status occurred (de calendar days) The RAI manual ind significant change a a resident's status t A "significant change improvement in a re 1. Will not normally intervention by staff disease-related clin is not considered "s 2. Impacts more that health status; and 3. Requires interdis	sive assessment is to be 4th calendar day after significant change in resident's termination date + 14 cluded the definition of a as a decline or improvement in hat: ie" is a major decline or esident's status that: resolve itself without f or by implementing standard ical interventions, the decline self-limiting"; an one area of the resident's ciplinary review and/or						
2 965	director of nursing (review applicable pre- ensure the timely and resident information Data Set (MDS); the ensure compliance. TIME PERIOD FOF (21) days. MN Rule 4658.0600 -Nutritional Status Subpart. 2. Nutrition must ensure that a which supplies the o	HOD OF CORRECTION: The DON) or designee could rocedures and policies to and accurate capture of a pertaining to the Minimum en educate staff and audit to	2 965			7/5/21		

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00047	B. WING		C 06/09/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
INTERFA	ITH CARE CENTER	-	D STREET N, MN 55718	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 965	Continued From pa must be offered to r served.	ge 6 residents who refuse food	2 965			
	by: Based on interview, facility failed to com weight monitoring a 1 of 3 residents (R1 This resulted in actu	ent is not met as evidenced , and document review, the plete accurate and ongoing nd nutritional assessment for) reviewed for weight loss. ual harm to R1, who weight loss in 6 weeks.		CORRECTED		
	Findings include:					
	R1's diagnoses incl accident (CVA, com with left side weakn	ord printed 6/9/21, indicated uded cerebral vascular monly known as a stroke) ess, dysphagia (difficulty mentia with behavioral				
	3/16/21, identified F impairment, and rec with bed mobility, tr personal hygiene an identified R1 require supervision for eating	imum Data Set (MDS) dated R1 had moderate cognitive quired extensive assistance ansfers, dressing, toileting, nd bathing. The MDS ed set up assist for meals and ng. The MDS identified R1 and had no difficulty with solids.				
	3/19/21, indicated F to recent stroke tha sided weakness/he	essment (CAA) dated A was a nutrition risk related t has caused dysphagia, left miplegia and left side neglect g other disease processes.				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED C
		00047	B. WING			09/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NTERFA	NITH CARE CENTER		N, MN 55718			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 965		- ited 3/18/21, identified R1 had	2 965			
	diagnosis which inc neglect, dysphagia, appetite. The care p included to keep R current weight and meals and fluids. T staff to perform we fluid intakes and do Registered Dietician upon admission, ar changes. Dietary M weights weekly with interdisciplinary tea Manager to analyze assessments and N identified R1 was a	eration in nutrition related to cluded CVA with left sided and diabetes that affect olan indicated goals which 1's weight stable, maintain R1 would consume 75% of he care plan further instructed ekly weights, monitor food and ocument after each meal, n (RD) to monitor weights innually and with significant anager (DM) to monitor n focus for weight loss/gain at m (IDT) meeting. Dietary weights for quarterly /IDS. R1's care plan also t risk for changes in weight d to diagnosis of depression				
	R1's admission Nut 3/19/21, lacked R1' noted to have a low diet with regular tex indicated R1 had re tube feedings to ora recent hospital stay indicated R1 was in requires supervision have been 75-100%	of antidepressant medications arition Assessment dated s current weight but had been a caloric carbohydrate (LCC) atures. The assessment ecently been progressed from al nutritional intake during the assessment also independent at meals but in and cues. Recorded intakes 6 with IBW (ideal body weight) rected staff to monitor weight bocol.				
	weight to being take Saturdays. Check if off +/- 5 pounds.	previous weights and reweigh Progress notes to be made at scale used, if on wheelchair				

		AN OF CORRECTION		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00047	B. WING		06/	09/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
INTERFA	ITH CARE CENTER		N, MN 55718			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From page	ge 8	2 965			
	had some weight lo	ian Visit form indicated R1 ss which was likely related nd to the medications he had ently.				
	indicated R1's meal variable throughout inadequate. Writer r manager to update discuss with resider	8 p.m. a progress note intake had been quite stay and had been mostly reached out to dietary on this and request someone nt what his dietary preferences e can do to personalize his				
		p.m. a progress note decline in his eating, eating f the time.				
	indicated R1 had sig pounds (lbs) since a reported poor appel Discussed medicati decreased appetite. decrease in stimula such as appetite sti	a.m. a progress note gnificant weight loss of 30 admission to the facility. R1 tite. Fluid intake poor as well. ons that may have caused . Discussed a potential nt medication and options mulation medication with R1. R1's MD was updated.				
	indicated R1's MD r supplement shakes (appetite stimulation daily, as well decrea (appetite stimulant) indicated R1's insur stimulant medication	p.m. a progress note eplied back with OK to start 2 times daily and Marinol n) 2.5 milligrams (mg) 2 times asing Methylphenidate to 5 mg twice daily. The note ance had not approved n, and medication had not o readmission to the hospital				

STATEMENT	Department of He OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED		
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
INTERFAIT	H CARE CENTER		D STREET N, MN 55718					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE		
ii ir ii ir ii ir ii ir ii ir ii ir ii ir ii ir ii ir ii ir ii ir ii ir ii ir ii ir ii ir ii ir ii ir ii ii	ndicated R1 had di nedications and sw ndicated both wate nouth. R1 was note aving some difficu eaning to the left m appear to be in pair should be evaluated ER), R1 replied, "N R1 was reevaluated offered ER again ar continued to monito Dn 4/25/21, at 1:50 ndicated R1 had be difficulties following veakness. R1 was and was transferred R1's weight record ecord (EHR) 3/9/21 8/9/21, 196.4 lbs. B/27/21, 182.4 lbs. B/3/21, 196.4 lbs. B/3/21, 196.4 lbs. B/3/21, 184.4 lbs. B/3/21, 184.4 lbs. B/3/21, 184.4 lbs. B/3/21, 184.4 lbs. B/3/21, 184.4 lbs. B/24/21, 142 lbs. in or 25% since admis R1's meal intake re B/9/21, to 4/25/21, a hree daily meal (br averages included: B/9/21, through 3/16 neal intake for all 7 B/16/21, through 3/16 neal intake for all 7 B/16/21, through 3/16	 a:50 a.m. a progress note fficulty swallowing morning vallowing water. The note r and pills ran out of R1's ed to have been weaker and lty with balance and was hore than usual. R1 did not h. When asked if R1 felt he d at the emergency room lo, I'm not going anywhere." d 15 minutes later and was nd R1 refused. Facility or. R1 refused breakfast. p.m. a progress note een having increased direction and increased requesting to go to hospital, d out. from the electronic health 1, to 4/24/21, indicated: dicating a 52 lbs. weight loss, and weekly total combined eakfast, lunch, and dinner) b/21, 81% combined average days. 22/21, 78% combined average 	2 965					

STATE FORM

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00047			06/	09/2021
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
NTERFA	ITH CARE CENTER		N, MN 55718			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
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2 965	Continued From pa	age 10	2 965			
	average intake for 4/6/21, through 4/1 average intake for 4/13/21, through 4/ average intake for 4/21//21, through 4 average intake for On 6/9/21, at 9:01 coordinator, registe interviewed and sta reviewed weekly to discussed at the in (IDT)weekly meetin always attended all a residents would f a team, they would maybe they needed the nurse manager collecting the inform and would investiga for the weight loss. managers were rear registered dietician notifying the dietary had not been made weight loss, but he would have been in RN-A verified signif could contribute to integrity and overal On 6/9/21, at 9:39 was interviewed an loss was reviewed	 /5/21, 30% combined meal all 7 days. 2/21, 28% combined meal all 7 days. /20/21, 32% combined meal all 7 days. /25/21, 15% combined meal 				
nesota De	all IDT meetings. I	DM-A stated she met with all of admission to complete an				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 06/09/2021	
		00047	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE		
INTERFA	ITH CARE CENTER		D STREET N, MN 55718			
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2 965	Continued From pa	ge 11	2 965			
	assessment, and fir	nd out what the residents food				
		DM-A stated she personally				
		ents' weights for either weight				
		DM-A stated she also had				
		intake of meal percentages.				
	DM-A further stated	DM-A further stated she had just finished her				
	education to become certified dietary manager					
	and would be taking her test later that month.					
	DM-A stated she relied on the nurses and					
	registered dietician (RD)-A to notify her if					
	residents were having weight loss. DM-A stated					
	she would then initiate other food options and or a		1			
	nutritional supplement. DM-A stated she had not					
	personally revisited R1 to discuss other food options to increase his meal percentage intake.					
		nis meai percentage intake.				
	On 6/9/21 at 10.18	a m_RD-A was interviewed				
		On 6/9/21, at 10:18 a.m. RD-A was interviewed and stated she had not been to the facility since				
		ever, she had been checking				
		stated she was always				
		lity via phone or email. RD-A				
		urrently had been working with	n l			
		s of the facility. RD-A stated				
	she had run a facilit	ty weight report at the end of				
		1 had a significant weight				
		at that time, she passed it on				
		(RN)-A and the nurse				
	5	tated the nurse manager had				
		ately and indicated in an email				
		re of R1's weight loss and				
	.	sible medication changes with				
		stimulant. RD-A stated she				
	would expect to be notified unplanned weight loss of 5 percent or more in the past month, or 10					
		less than six months. RD-A				
		ould put any interventions in				
		idy been admitted to the				
		ed she had not received a				
		port for quite some time. RD-A				
		prrespondence between				
	verified the email co	briespondence between				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00047		B. WING		C 09/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NTERFA	AITH CARE CENTER		D STREET N, MN 55718			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
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2 965	Continued From pa	ge 12	2 965			
	herself, and the fac sent out 4/27/21.	ility nurse managers had been				
	and stated she was unit R1 had resided stated IDT meeting residents' weights w time. RN-A stated to weight loss and rev needed at that time weight loss would b past month, or 10 p months. RN-A stated loss around 4/6/21, and medications ch time. RN-A stated to weight loss, the fac nutritional supplement been made aware of 4/6/21, but she sho sooner. RN-A verifi not been started for R1 weighed 142 lbs and physician shou as 3/18/21 when R2 loss.	a.m. RN-B was interviewed the nurse manager on the while at the facility. RN-B s were held weekly, and all were being reviewed at that the nurse managers discussed iewed or added interventions if . RN-A stated unplanned be 5 percent or more in the bercent or more in less than six ed she had discussed weight with R1's primary physician, hanges had been made at that ypically if they started seeing ility would start with a ent. RN-A stated she had not of R1's weight loss until around uld have been made aware ied nutrition supplements had r R1 until 4/23, and at that time s. RN-A stated the dietician Id have been notified as early 1 first had documented weight				
	(DON) stated the in percentage on mea percentage of meal The DON stated re- reviewed weekly at weight loss and put	p.m. the director of nursing nportance of reviewing the il tickets would be to see what is the residents were eating. sidents' weights are to be the IDT meetings to identify interventions place. The DON experienced unplanned weight				
	loss of 5 percent or percent or more in timeframe she wou	more in the past month, or 10 less than a six months' ld expect the nurse managers registered dietician, dietary				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C 06/09/202			
				DRESS, CITY, STATE, ZIP CODE			
INTERFAITH CARE CENTER 811 THIRD STREET CARLTON, MN 55718							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
2 965	manager, and prim the facility had not I weights to the dietic been doing so. The to identify unplanne further decline in th A facility policy relat Nutrition was reque SUGGESTED MET The administrator, and/or revise policie identifying weight lo intake/meal percen could educate the a policies/procedures develop a monitorir compliance.	ary physician. The DON stated been sending the weekly cian to review but should have a DON stated it was important ed weight loss early to prevent e residents condition. ted to Weight Monitoring and ested but not received. THOD OF CORRECTION: or designee, could review es and procedures related to best and monitor nutritional tages. The DON or designee appropriate staff on the s. The DON or designee could ing system to ensure ongoing R CORRECTION: Twenty-one	2 965				
2 980	service; Director Subp. 2. Director of dietitian is not empl administrator must service who is enro minimum, a dietary receives frequently qualified dietitian. consultation must b the nursing home.	designate a director of dietary olled in or has completed, at a manager course, and who scheduled consultation from a The number of hours of be based upon the needs of Directors of dietary service 8, 1995, are not required to	2 980			6/30/21	

Minneso	ota Department of He	alth			FORM	APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00047	B. WING		C 06/09/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
INTERF	AITH CARE CENTER	811 THIRE CARLTON	D STREET I, MN 55718	ł		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 980	Continued From pa	ge 14	2 980			
2 980	This MN Requireme by: Based on interview facility failed to ensu- certified and creder preparation and ser potential to affect al who consumed food Findings include: On 6/9/21 at 9:39 a stated that she was manager. DM-A sta education, and had test related to becor obtaining her ServS On 6/9/21, at 10:18 (RD)-A was intervie DM-A had not comp certified DM. RD-A providing approxima	ent is not met as evidenced and document review, the ure the dietary manager was ntialed to oversee food vice in the kitchen. This had I 77 residents and facility staff d from the kitchen. .m. dietary manager (DM)-A not a certified dietary ted she recently finished the been signed up to take her ming a certified DM and cafe certification. a.m. registered dietician wed. RD-A stated the acting bleted her test to become a stated she was currently ately 4 hours a month to the	2 980	CORRECTED		
	facility as a registern needed. RD-A state facility since the par been checking in wi DM-A. RD-A state the facility via phone On 6/9/21, at 11:57 that DM-A was put i January 2020, after resigned. The admi finished the educati take her test related certification. The ad	ed dietician, and worked as ed she had not been to the ndemic; however, she had ith the acting non-certified d she was always available to e or email. a.m. the administrator stated in the position of DM in the previous DM had nistrator stated that DM-A on and had been signed up to d to DM-C ServSafe dministrator stated he had work regarding the certified				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00047	B. WING			C 09/2021
IAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
NTERF	AITH CARE CENTER		D STREET N, MN 55718			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 980	The facility's dietary dated 1/23/19, inclu- dietary director mus- approved Dietary M State and Federal n further indicated thi- within one year from SUGGESTED MET Administrator or de and/or revise polici the Dietary Manage for the position. Th could educate all a and procedures. Th could develop mon ongoing complianc	y manager position description uded the requirement that st be a graduate of an Manager's course that meets requirements. The policy is requirement must be met m date of hire. THOD OF CORRECTION: The signee could develop, review, es and procedures to ensure er has the proper qualifications he Administrator or designee ppropriate staff on the policies he Administrator or designee itoring systems to ensure				