DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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 Therefore, the NATCEP prohibition is rescinded.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 Tamika.Brown@cms.hhs.gov.

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:

https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245024	A. BUILDING _____ B. WING _____	C 06/09/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/8/21, through 6/9/21, a standard abbreviated survey was conducted at your facility. Your facility was NOT found to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5024037 (MN73360) Deficiencies were issued at F637, F692, F801. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and	F 637		7/5/21

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

Electronically 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.

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F 637	Continued From page 1 requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive reassessment using the Resident Assessment Instrument (RAI) process and Significant Change in Status Assessment (SCSA) for 1 of 1 residents (R1) following a significant unplanned weight loss. The RAI indicates an unplanned weight loss of five percent or more in the past month, or 10 percent or more in the past six months. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the MDS as an assessment tool which facilities are required to use. The manual provided instructions to ensure accurate and complete coding for each section of the assessment as follows: Section K: Swallowing/Nutritional Status Indicated, "The items in this section are intended to assess the many conditions that could affect the residents' ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately." R1's admission record printed 6/9/21, indicated R1's diagnoses included stroke, dysphagia (difficulty swallowing) weakness, and dementia	F 637	56F 637: Comprehensive Assessment after Significant Change Resident R1 discharged from the facility Corrective Action As It Applies to Other Residents a. A 100% Audit of resident weights was conducted for Significant Change by the nurse managers including baseline weight, current weight and all notifications/interventions and actions taken were documented in each resident□s EMR. 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 permanent IDT team weekly review. b. The facility policy on MDS was written to include IDT Member roles and the definition of Significant Change. c. The facility policy on Inter-Disciplinary Team (IDT) was permanently updated to include Significant Changes as an area to be reviewed weekly d. All Interdisciplinary team (IDT) members who complete departmental assessments will be educated on the MDS policy including emphasis on	

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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, toileting, 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. 3/18/21, 190.2 lbs. 3/27/21, 182.4 lbs.- indicating a weight loss of -14% since 3/9/21 4/3/21, 184.4 lbs. 4/11/21, 166.4 lbs. indicating a 30 lbs. weight loss since 3/9/21 4/17/21, 163.8 lbs. 4/24/21, 142 lbs. indicating a 52 lbs. weight loss since admission on 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 did not have a SCSA completed when he experienced an unplanned weight loss of five percent or more in the past month, or 10 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 unplanned weight loss. RN-A verified R1's diagnosis of dysphagia should have	F 637	identification Significant Change e. Resident weights will be audited weekly by the unit managers including baseline weight and current weight over time using the Weight Summary Report generated by Point Click Care (PCC). Any significant findings will be used to identify residents potentially needing a Significant Change Assessment. Audits and actions taken will be presented at the Interdisciplinary Team (IDT) meeting on a weekly basis. f. The Interdisciplinary Team (IDT) will audit compliance with the Nursing Weekly Weight Review / Significant Change Status Review and Audit findings will be reported to QA monthly for 6 months and as recommended by the QA Committee thereafter. Correction will be Monitored by: DON, RAI-MDS Coordinator, Nurse Managers	

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F 637	Continued From page 3	F 637		

been on R1's admission MDS which indicated R1 had a swallowing difficulty /disorder and had not been properly identified on R1's admission assessment completed on 3/16/21. RN-A stated there was not a facility policy specifically related to guidance on completing MDS, the facility followed the most current Resident Assessment Instrument manual from CMS.

On 6/9/21, at 11:39 p.m. the director of nursing (DON) stated that the facility would discuss if a resident was appropriate for a SCSA during weekly IDT meetings. The DON stated if a resident experienced an unplanned weight loss of five percent or more in the past month, or 10 percent or more in less than a six months' timeframe a significant change MDS would be required.

The Resident Assessment Instrument (RAI) manual dated October 2019, indicated the purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care. The manual indicated a (SCSA) comprehensive assessment is to be completed on the 14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)

The RAI manual included the definition of a significant change as a decline or improvement in a resident's status that:
A "significant change" is a major decline or improvement in a resident's status that:
1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline

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F 637	Continued From page 4 is not considered "self-limiting"; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan.	F 637		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to complete accurate and ongoing weight monitoring and nutritional assessment for 1 of 3 residents (R1) reviewed for weight loss. This resulted in actual harm to R1, who experienced a 25% weight loss in 6 weeks.	F 692	F 692: Nutrition/Hydration Status Maintenance Resident R1 discharged from the facility Corrective Action As It Applies to Other Residents a. A 100% Audit of resident weights was	7/5/21

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F 692	Continued From page 5 Findings include: R1's admission record printed 6/9/21, indicated R1's diagnoses included cerebral vascular accident (CVA, commonly known as a stroke) with left side weakness, dysphagia (difficulty swallowing) and dementia 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, toileting, 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 Care Area Assessment (CAA) dated 3/19/21, indicated R4 was a nutrition risk related to recent stroke that has caused dysphagia, left sided weakness/hemiplegia and left side neglect and diabetes among other disease processes. R1's care plan initiated 3/18/21, identified R1 had the potential for alteration in nutrition related to diagnosis which included CVA with left sided neglect, dysphagia, and diabetes that affect appetite. The care plan indicated goals which included to keep R1's weight stable, maintain current weight and R1 would consume 75% of meals and fluids. The care plan further instructed staff to perform weekly weights, monitor food and fluid intakes and document after each meal, Registered Dietician (RD) to monitor weights upon admission, annually and with significant changes. Dietary Manager (DM) to monitor weights weekly with focus for weight loss/gain at	F 692	conducted for significant change by the nurse managers including baseline weight, current weight and all notifications/interventions and actions taken were documented in each resident□s EMR. b. Audit findings were reviewed by the Registered Dietician (RD), the Dietary 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 permanent IDT team weekly review. b. The roles of the Dietician, Dietary Manager (CDM), RAI-MDS staff and nurse managers were clarified in regards to resident Nutrition Hydration assessment, weight loss and gain, IDT review and ongoing monitoring. c. The Certified Dietary Manager (CDM) under the guidance of the Dietician will review weight loss and gains weekly with the IDT team and the Weight Summary Report and Nurse Manager Weekly Weight Review will be sent to the Dietitian weekly for review. d. Admission, Annual and Significant Change Nutritional assessment will be completed by the Dietician and reviewed by the MDS assessor to ensure items is section K are assessed and calculated	

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F 692	Continued From page 6 interdisciplinary team (IDT) meeting. Dietary Manager to analyze weights for quarterly assessments and MDS. R1's care plan also identified R1 was at risk for changes in weight and appetite related to diagnosis of depression and administration of antidepressant medications. R1's admission Nutrition Assessment dated 3/19/21, lacked R1's current weight but had been noted to have a low caloric carbohydrate (LCC) diet with regular textures. The assessment indicated R1 had recently been progressed from tube feedings to oral nutritional intake during recent hospital stay. The assessment also indicated R1 was independent at meals but requires supervision and cues. Recorded intakes have been 75-100% with IBW (ideal body weight) 160-196 lbs. and directed staff to monitor weight and intake per protocol. R1's Physician Orders initiated 3/13/21, included weight to being taken 1 time weekly on Saturdays. Check previous weights and reweigh if off +/- 5 pounds. Progress notes to be made noting weights, what scale used, if on wheelchair and if foot rests were in place. On 4/6/21, a Physician Visit form indicated R1 had some weight loss which was likely related both to his stroke and to the medications he had been started on recently. On 4/20/21, at 12:28 p.m. a progress note indicated R1's meal intake had been quite variable throughout stay and had been mostly inadequate. Writer reached out to dietary manager to update on this and request someone discuss with resident what his dietary preferences are and see what we can do to personalize his	F 692	accurately e. A Quarterly Nutrition Review will be completed by the Dietician / Certified Dietary Manager (CDM) and reviewed by the MDS assessor to ensure items is section K are assessed and calculated accurately. f. All facility licensed staff were educated on the facility Weight Policy including roles, responsibilities, significant weight loss / gains and notifications. g. Resident weights will be audited weekly by the unit managers for significant change including baseline weight and current weight over time using the Weight Summary Report generated by Point Click Care (PCC). Audits and actions taken will be presented at the Interdisciplinary Team (IDT) meeting on a weekly basis. h. The Interdisciplinary Team (IDT) will audit compliance with the Nursing Weekly Weight Review and Audit findings will be reported to QA monthly for 6 months and as recommended by the QA Committee thereafter Correction will be Monitored by: DON, RAI-MDS Coordinator, Nurse Managers, QA Committee	

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	245024	A. BUILDING _____ B. WING _____	C 06/09/2021

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dining experience.

On 4/21/21, at 9:26 p.m. a progress note indicated R1 had a decline in his eating, eating 25% or less most of the time.

On 4/23/21, at 9:03 a.m. a progress note indicated R1 had significant weight loss of 30 pounds (lbs) since admission to the facility. R1 reported poor appetite. Fluid intake poor as well. Discussed medications that may have caused decreased appetite. Discussed a potential decrease in stimulant medication and options such as appetite stimulation medication with R1. The note indicated R1's MD was updated.

On 4/23/21, at 2:41 p.m. a progress note indicated R1's MD replied back with OK to start supplement shakes 2 times daily and Marinol (appetite stimulation) 2.5 milligrams (mg) 2 times daily, as well decreasing Methylphenidate (appetite stimulant) to 5 mg twice daily. The note indicated R1's insurance had not approved stimulant medication, and medication had not been started prior to readmission to the hospital on 4/25/21.

On 4 /25/2021, at 8:50 a.m. a progress note indicated R1 had difficulty swallowing morning medications and swallowing water. The note indicated both water and pills ran out of R1's mouth. R1 was noted to have been weaker and having some difficulty with balance and was leaning to the left more than usual. R1 did not appear to be in pain. When asked if R1 felt he should be evaluated at the emergency room (ER), R1 replied, "No, I'm not going anywhere." R1 was reevaluated 15 minutes later and was offered ER again and R1 refused. Facility

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continued to monitor. R1 refused breakfast.

On 4/25/21, at 1:50 p.m. a progress note indicated R1 had been having increased difficulties following direction and increased weakness. R1 was requesting to go to hospital, and was transferred out.

R1's weight record from the electronic health record (EHR) 3/9/21, to 4/24/21, indicated:
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. indicating a 52 lbs. weight loss, or 25% since admission on 3/9/21.

R1's meal intake records from the EHR from 3/9/21, to 4/25/21, and weekly total combined three daily meal (breakfast, lunch, and dinner) averages included:
3/9/21, through 3/16/21, 81% combined average meal intake for all 7 days.
3/16/21, through 3/22/21, 78% combined average meal intake for all 7 days.
3/23/21, through 3/29/21, 56% combined meal average intake for all 7 days.
3/30/21, through 4/5/21, 30% combined meal average intake for all 7 days.
4/6/21, through 4/12/21, 28% combined meal average intake for all 7 days.
4/13/21, through 4/20/21, 32% combined meal average intake for all 7 days.
4/21//21, through 4/25/21, 15% combined meal average intake for all 5 days.

On 6/9/21, at 9:01 a.m. the facility MDS

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coordinator, registered nurse (RN)-A was interviewed and stated all resident's weights were reviewed weekly to identify weight loss and discussed at the interdisciplinary team (IDT)weekly meetings. RN-A stated she had not always attended all IDT meetings. RN-A stated if a residents would have unplanned weight loss as a team, they would discuss interventions such as maybe they needed a supplement. RN-A stated the nurse managers were responsible for collecting the information related to weight loss, and would investigate what the causes might be for the weight loss. RN-A stated the nurse managers were responsible for contacting the registered dietician, updating the physician, and notifying the dietary manager. RN-A stated she had not been made aware of R1's significant weight loss, but her expectation was that she would have been notified by the nurse managers. RN-A verified significant unplanned weight loss could contribute to changes in cognition, skin integrity and overall weakness/decline.

On 6/9/21, at 9:39 a.m. dietary manger (DM)-A was interviewed and stated a resident's weight loss was reviewed and discussed at the IDT weekly meetings. DM-A stated she had attended all IDT meetings. DM-A stated she met with all residents the day of admission to complete an assessment, and find out what the residents food preferences were. DM-A stated she personally did not review residents' weights for either weight loss or weight gain. DM-A stated she also had not been reviewing intake of meal percentages. 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

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residents were having weight loss. DM-A stated she would then initiate other food options and or a nutritional supplement. DM-A stated she had not 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 with 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 email they had been aware of R1's weight loss and were looking at possible medication changes with adding an appetite stimulant. RD-A stated she would expect to be notified unplanned weight loss 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-A verified the email correspondence between herself, and the facility nurse managers had been 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 IDT meetings were held weekly, and all residents' weights were being reviewed at that time. RN-A stated the nurse managers discussed

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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 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 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 percent or more in less than a six months' timeframe she would expect the nurse managers to have notified the registered dietician, dietary manager, and primary physician. The DON stated the facility had not been sending the weekly weights to the dietician to review but should have been doing so. The DON stated it was important to identify unplanned weight loss early to prevent further decline in the residents condition.

A facility policy related to Weight Monitoring and

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F 692	Continued From page 12 Nutrition was requested but not received.	F 692		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its	F 801		7/1/21

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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. §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 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: Based on interview and document review, the facility failed to ensure the dietary manager was	F 801	F 801 Qualified Dietary Staffing	

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F 801	Continued From page 14 certified and credentialed to oversee food preparation and service in the kitchen. This had potential to affect all 77 residents and facility staff who consumed food from the kitchen. Findings include: On 6/9/21 at 9:39 a.m. dietary manager (DM)-A stated that she was not a certified dietary manager. DM-A stated she recently finished the education, and had been signed up to take her test related to becoming a certified DM and obtaining her ServSafe certification. On 6/9/21, at 10:18 a.m. registered dietician (RD)-A was interviewed. RD-A stated the acting DM-A had not completed her test to become a certified DM. RD-A stated she was currently providing approximately 4 hours a month to the facility as a registered dietician, and worked as needed. RD-A stated she had not been to the facility since the pandemic; however, she had been checking in with the acting non-certified DM-A. RD-A stated she was always available to the facility via phone or email. On 6/9/21, at 11:57 a.m. the administrator stated that DM-A was put in the position of DM in January 2020, after the previous DM had resigned. The administrator stated that DM-A finished the education and had been signed up to take her test related to DM-C ServSafe certification. The administrator stated he had signed off on paperwork regarding the certified dietary manager training that week. The facility's dietary manager position description dated 1/23/19, included the requirement that dietary director must be a graduate of an	F 801	1. The facility Dietary Manager completed the Certified Dietary Manager certification program through NDU and successfully passed the PSI examination for Certified Dietary Manager (CDM) 6-18-2021. 2. The Facility Registered Dietician (RD) is available in-person on site in the facility 4 hours weekly and as needed. The RD is also readily available via telephone or e mail. 3. Facility Administrative Staff including the Administrator, DON, Human Resources On-Boarding staff and the Certified Dietary Manager (CDM) were educated on qualification requirements for a dietary manager. Correction will be Monitored by: Administrator, DON	

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F 801	Continued From page 15 approved Dietary Manager's course that meets State and Federal requirements. The policy further indicated this requirement must be met within one year from date of hire.	F 801		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

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,

Kamala 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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/8/21, through 6/9/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT found to be in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5024037 (MN73360) Licensing orders were issued at: 4658.0525 Subp 7 0956 4658.0605 Subp 2 0980 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 state form. 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	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive reassessment using the Resident Assessment Instrument (RAI) process and Significant Change in Status Assessment (SCSA) for 1 of 1 residents (R1) following a significant unplanned weight loss. The RAI indicates an unplanned weight loss of five percent or more in the past month, or 10 percent or more in the past six months. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified the MDS as an assessment tool which facilities are required to use. The manual provided instructions to ensure accurate and complete coding for each section of	2 550	CORRECTED	7/5/21

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2 550	Continued From page 3 the assessment as follows: Section K: Swallowing/Nutritional Status Indicated, "The items in this section are intended to assess the many conditions that could affect the residents' ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately." R1's admission record printed 6/9/21, indicated R1's diagnoses included stroke, dysphagia (difficulty swallowing) weakness, and dementia 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, toileting, 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. 3/18/21, 190.2 lbs. 3/27/21, 182.4 lbs.- indicating a weight loss of -14% since 3/9/21 4/3/21, 184.4 lbs. 4/11/21, 166.4 lbs. indicating a 30 lbs. weight loss since 3/9/21 4/17/21, 163.8 lbs. 4/24/21, 142 lbs. indicating a 52 lbs. weight loss since admission on 3/9/21.	2 550		

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2 550	Continued From page 4 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 did not have a SCSA completed when he experienced an unplanned weight loss of five percent or more in the past month, or 10 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 unplanned weight loss. RN-A verified R1's diagnosis of dysphagia should have been on R1's admission MDS which indicated R1 had a swallowing difficulty /disorder and had not been properly identified on R1's admission assessment completed on 3/16/21. RN-A stated there was not a facility policy specifically related to guidance on completing MDS, the facility followed the most current Resident Assessment Instrument manual from CMS. On 6/9/21, at 11:39 p.m. the director of nursing (DON) stated that the facility would discuss if a resident was appropriate for a SCSA during weekly IDT meetings. The DON stated if a resident experienced an unplanned weight loss of five percent or more in the past month, or 10 percent or more in less than a six months' timeframe a significant change MDS would be required. The Resident Assessment Instrument (RAI) manual dated October 2019, indicated the purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care. The manual indicated a	2 550		

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2 550	Continued From page 5 (SCSA) comprehensive assessment is to be completed on the 14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days) The RAI manual included the definition of a significant change as a decline or improvement in a resident's status that: A "significant change" is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting"; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable procedures and policies to ensure the timely and accurate capture of resident information pertaining to the Minimum Data Set (MDS); then educate staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value	2 965		7/5/21

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2 965	Continued From page 6 must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to complete accurate and ongoing weight monitoring and nutritional assessment for 1 of 3 residents (R1) reviewed for weight loss. This resulted in actual harm to R1, who experienced a 25% weight loss in 6 weeks. Findings include: R1's admission record printed 6/9/21, indicated R1's diagnoses included cerebral vascular accident (CVA, commonly known as a stroke) with left side weakness, dysphagia (difficulty swallowing) and dementia 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, toileting, 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 Care Area Assessment (CAA) dated 3/19/21, indicated R4 was a nutrition risk related to recent stroke that has caused dysphagia, left sided weakness/hemiplegia and left side neglect and diabetes among other disease processes.	2 965	CORRECTED	

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2 965	Continued From page 7 R1's care plan initiated 3/18/21, identified R1 had the potential for alteration in nutrition related to diagnosis which included CVA with left sided neglect, dysphagia, and diabetes that affect appetite. The care plan indicated goals which included to keep R1's weight stable, maintain current weight and R1 would consume 75% of meals and fluids. The care plan further instructed staff to perform weekly weights, monitor food and fluid intakes and document after each meal, Registered Dietician (RD) to monitor weights upon admission, annually and with significant changes. Dietary Manager (DM) to monitor weights weekly with focus for weight loss/gain at interdisciplinary team (IDT) meeting. Dietary Manager to analyze weights for quarterly assessments and MDS. R1's care plan also identified R1 was at risk for changes in weight and appetite related to diagnosis of depression and administration of antidepressant medications. R1's admission Nutrition Assessment dated 3/19/21, lacked R1's current weight but had been noted to have a low caloric carbohydrate (LCC) diet with regular textures. The assessment indicated R1 had recently been progressed from tube feedings to oral nutritional intake during recent hospital stay. The assessment also indicated R1 was independent at meals but requires supervision and cues. Recorded intakes have been 75-100% with IBW (ideal body weight) 160-196 lbs. and directed staff to monitor weight and intake per protocol. R1's Physician Orders initiated 3/13/21, included weight to being taken 1 time weekly on Saturdays. Check previous weights and reweigh if off +/- 5 pounds. Progress notes to be made noting weights, what scale used, if on wheelchair and if foot rests were in place.	2 965		

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2 965	Continued From page 8 On 4/6/21, a Physician Visit form indicated R1 had some weight loss which was likely related both to his stroke and to the medications he had been started on recently. On 4/20/21, at 12:28 p.m. a progress note indicated R1's meal intake had been quite variable throughout stay and had been mostly inadequate. Writer reached out to dietary manager to update on this and request someone discuss with resident what his dietary preferences are and see what we can do to personalize his dining experience. On 4/21/21, at 9:26 p.m. a progress note indicated R1 had a decline in his eating, eating 25% or less most of the time. On 4/23/21, at 9:03 a.m. a progress note indicated R1 had significant weight loss of 30 pounds (lbs) since admission to the facility. R1 reported poor appetite. Fluid intake poor as well. Discussed medications that may have caused decreased appetite. Discussed a potential decrease in stimulant medication and options such as appetite stimulation medication with R1. The note indicated R1's MD was updated. On 4/23/21, at 2:41 p.m. a progress note indicated R1's MD replied back with OK to start supplement shakes 2 times daily and Marinol (appetite stimulation) 2.5 milligrams (mg) 2 times daily, as well decreasing Methylphenidate (appetite stimulant) to 5 mg twice daily. The note indicated R1's insurance had not approved stimulant medication, and medication had not been started prior to readmission to the hospital on 4/25/21.	2 965		

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2 965	Continued From page 9 On 4 /25/2021, at 8:50 a.m. a progress note indicated R1 had difficulty swallowing morning medications and swallowing water. The note indicated both water and pills ran out of R1's mouth. R1 was noted to have been weaker and having some difficulty with balance and was leaning to the left more than usual. R1 did not appear to be in pain. When asked if R1 felt he should be evaluated at the emergency room (ER), R1 replied, "No, I'm not going anywhere." R1 was reevaluated 15 minutes later and was offered ER again and R1 refused. Facility continued to monitor. R1 refused breakfast. On 4/25/21, at 1:50 p.m. a progress note indicated R1 had been having increased difficulties following direction and increased weakness. R1 was requesting to go to hospital, and was transferred out. R1's weight record from the electronic health record (EHR) 3/9/21, to 4/24/21, indicated: 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. indicating a 52 lbs. weight loss, or 25% since admission on 3/9/21. R1's meal intake records from the EHR from 3/9/21, to 4/25/21, and weekly total combined three daily meal (breakfast, lunch, and dinner) averages included: 3/9/21, through 3/16/21, 81% combined average meal intake for all 7 days. 3/16/21, through 3/22/21, 78% combined average meal intake for all 7 days. 3/23/21, through 3/29/21, 56% combined meal	2 965		

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average intake for all 7 days.
3/30/21, through 4/5/21, 30% combined meal average intake for all 7 days.
4/6/21, through 4/12/21, 28% combined meal average intake for all 7 days.
4/13/21, through 4/20/21, 32% combined meal average intake for all 7 days.
4/21//21, through 4/25/21, 15% combined meal average intake for all 5 days.

On 6/9/21, at 9:01 a.m. the facility MDS coordinator, registered nurse (RN)-A was interviewed and stated all resident's weights were reviewed weekly to identify weight loss and discussed at the interdisciplinary team (IDT)weekly meetings. RN-A stated she had not always attended all IDT meetings. RN-A stated if a residents would have unplanned weight loss as a team, they would discuss interventions such as maybe they needed a supplement. RN-A stated the nurse managers were responsible for collecting the information related to weight loss, and would investigate what the causes might be for the weight loss. RN-A stated the nurse managers were responsible for contacting the registered dietician, updating the physician, and notifying the dietary manager. RN-A stated she had not been made aware of R1's significant weight loss, but her expectation was that she would have been notified by the nurse managers. RN-A verified significant unplanned weight loss could contribute to changes in cognition, skin integrity and overall weakness/decline.

On 6/9/21, at 9:39 a.m. dietary manger (DM)-A was interviewed and stated a resident's weight loss was reviewed and discussed at the IDT weekly meetings. DM-A stated she had attended all IDT meetings. DM-A stated she met with all residents the day of admission to complete an

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2 965	Continued From page 11	2 965		

assessment, and find out what the residents food preferences were. DM-A stated she personally did not review residents' weights for either weight loss or weight gain. DM-A stated she also had not been reviewing intake of meal percentages. 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 nutritional supplement. DM-A stated she had not 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 with 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 email they had been aware of R1's weight loss and were looking at possible medication changes with adding an appetite stimulant. RD-A stated she would expect to be notified unplanned weight loss 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-A verified the email correspondence between

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2 965	Continued From page 12	2 965		

herself, and the facility nurse managers had been 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 IDT meetings were held weekly, and all residents' weights were being reviewed at that time. RN-A stated the nurse managers discussed 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 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 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 percent or more in less than a six months' timeframe she would expect the nurse managers to have notified the registered dietician, dietary

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2 965	Continued From page 13 manager, and primary physician. The DON stated the facility had not been sending the weekly weights to the dietician to review but should have been doing so. The DON stated it was important to identify unplanned weight loss early to prevent further decline in the residents condition. A facility policy related to Weight Monitoring and Nutrition was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could review and/or revise policies and procedures related to identifying weight loss and monitor nutritional intake/meal percentages. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
2 980	MN Rule 4658.0605 Subp. 2 Director of dietary service; Director Subp. 2. Director of dietary service. If a qualified dietitian is not employed full time, the administrator must designate a director of dietary service who is enrolled in or has completed, at a minimum, a dietary manager course, and who receives frequently scheduled consultation from a qualified dietitian. The number of hours of consultation must be based upon the needs of the nursing home. Directors of dietary service hired before May 28, 1995, are not required to complete a dietary manager course.	2 980		6/30/21

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2 980	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the dietary manager was certified and credentialed to oversee food preparation and service in the kitchen. This had potential to affect all 77 residents and facility staff who consumed food from the kitchen. Findings include: On 6/9/21 at 9:39 a.m. dietary manager (DM)-A stated that she was not a certified dietary manager. DM-A stated she recently finished the education, and had been signed up to take her test related to becoming a certified DM and obtaining her ServSafe certification. On 6/9/21, at 10:18 a.m. registered dietician (RD)-A was interviewed. RD-A stated the acting DM-A had not completed her test to become a certified DM. RD-A stated she was currently providing approximately 4 hours a month to the facility as a registered dietician, and worked as needed. RD-A stated she had not been to the facility since the pandemic; however, she had been checking in with the acting non-certified DM-A. RD-A stated she was always available to the facility via phone or email. On 6/9/21, at 11:57 a.m. the administrator stated that DM-A was put in the position of DM in January 2020, after the previous DM had resigned. The administrator stated that DM-A finished the education and had been signed up to take her test related to DM-C ServSafe certification. The administrator stated he had signed off on paperwork regarding the certified dietary manager training that week.	2 980	CORRECTED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00047	A. BUILDING: _____ B. WING _____	C 06/09/2021

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

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2 980	Continued From page 15 The facility's dietary manager position description dated 1/23/19, included the requirement that dietary director must be a graduate of an approved Dietary Manager's course that meets State and Federal requirements. The policy further indicated this requirement must be met within one year from date of hire. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could develop, review, and/or revise policies and procedures to ensure the Dietary Manager has the proper qualifications for the position. The Administrator or designee could educate all appropriate staff on the policies and procedures. The Administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 980		