Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 8, 2026

Administrator
INTERFAITH CARE CENTER
811 THIRD STREET
CARLTON, MN 55718

RE: CCN: 245024
Cycle Start Date: December 03, 2025

Dear Administrator:

On January 6, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 3, 2025

Administrator
INTERFAITH CARE CENTER

811 THIRD STREET
CARLTON, MN 55718

RE: CCN:245024
Cycle Start Date: 12/03/2025

Dear Administrator:

On December 3, 2025, a survey was completed at your facility by the Minnesota Departments 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 3, 2026, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 3, 2026, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

Feel free to contact me if you have questions.

Sincerely,

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

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December 3, 2025

Administrator
INTERFAITH CARE CENTER
811 THIRD STREET
CARLTON, MN 55718

Re: Event ID: 1D956A-H1

Dear Administrator:

The above facility survey was completed on December 3, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/03/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERFAITH CARE CENTER	**811 THIRD STREET , CARLTON, Minnesota, 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
20000	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 10/15/25 through 10/16/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaints were reviewed during the survey. H50245844C (2641312).Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled	20000		12/03/2025

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/03/2025**

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20000	Continued from page 1 in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		

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F0000	INITIAL COMMENTS On 10/15/25 through 10/16/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint(s) (was/were) reviewed. H50245844C (2641312) with a deficiency issued at F602. As a result of the survey deficiencies were cited at F550, F609, F610. 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.	F0000		12/03/2025
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish	F0550	It is the policy of Inter-Faith Care Center to ensure all resident's rights are protected. Resident R1 will be allowed to refuse medications and treatments as applicable. R1's care plan was reviewed to ensure interventions are in place for staff to try if the resident is refusing a medication that is needed. RN- C no longer is employed at Inter-Faith Care Center. All facility residents have the potential to be affected by this practice, all staff have been re-educated on resident rights including the right to refuse medications. The policy on resident rights was reviewed and remains current. The Director of Nursing (DON) or designee will audit administration of medications to ensure that refusals were honored. In addition, documentation of refusals will be reviewed, and resident care plans will be updated to reflect refusals. The Interdisciplinary team will review this weekly for one month and then monthly for three months to ensure compliance. The Director of Nursing (DON) or designee will also audit any medication or treatment refusals weekly to ensure residents refusals are honored, weekly for 4 weeks and then monthly for three months to ensure compliance. Results of all audits will	12/11/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245024	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

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F0550 SS = D	Continued from page 1 and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to honor residents right to refuse medications for 1 of 3 residents reviewed (R1) when she was administered morphine after telling staff she did not want the medication. R1's Admission Record indicated she admitted to the facility on 10/24/23. Diagnosis included Malignant neoplasm of breast, hypertension, dementia, depression and anxiety. R1's Brief Interview for Mental Status dated 10/8/25, identified a score of seven which indicated severe cognitive impairment. R1's care plan dated 7/2525, identified impaired cognition and indicated she was at high risk for being exploited by others and would not be able to accurately report if abused. The care plan indicated staff would intervene on R1's behalf if abuse was suspected, witnessed or reported. The care plan identified behaviors that included calling out and refusal of medications. The care plan directed staff to allow R1 to make decisions about her treatment regime as able and to provide a sense of control and directed if R1 resisted cares or medication, reassure her, leave and return later to try again.	F0550	Continued from page 1 be reviewed by the facility Quality Assurance Performance Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245024	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/03/2025

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F0550 SS = D	Continued from page 2 An Employee Statement Form dated 10/10/25, indicated nursing assistant (NA)-B heard R1 yelling out and asked her what was wrong and the nurse, registered nurse (RN)-C, said she was going to give R1 pain medication. While trying to calm R1 down, RN-C approached R1 to give pain medication and R1 said no and kept turning her head. RN-C was yelling at NA-B and said to hold R1's hands down, then put the medication in R1's mouth. NA-B wrote, R1 called RN-C a name and said, "she gave me meds [medications] I didn't want," and asked NA-B why she didn't say anything. An Employee Statement Form written by dietary aide (DA)-A, dated 10/10/25, indicated R1 had been yelling help and seemed really upset and when asked, said "I'm sick of being tied down." DA-A reported RN-C walked by and said, "you're not tied down, ha ha ha" and laughed at R1 to her face while she was distressed. During interview on 10/16/25 at 8:38 a.m., the activities director (AD) stated DA-A had reported the incident to her on Monday or Tuesday and let her know she had filed a report on RN-C the previous Friday. The AD said DA-A was disturbed about how the RN-C had basically forced R1 to take Morphine after saying no. The AD said she had spoken to the nurse who was on-call, RN-A, who reported she had been aware of the incident. During interview on 10/16/25 at 9:45 a.m., RN-A stated she had been the nurse on call the night of the incident and said she had received a call from the scheduler that some staff were upset because of the way RN-C had administered R1's morphine. RN-A said she called the unit and talked to RN-C who said R1 had been hollering out for 15 - 30 minutes, was not re-directable and was in a lot of pain. RN-A said RN-C told her she went to administer Morphine to R1 and R1 said no and swatted her hand away. RN-A said RN-C told her she had a nursing assistant (NA) hold R1's arms out of the way to get the morphine into her mouth. RN-A said she felt RN-C was using her nursing judgement because she felt R1 needed pain medication. During interview on 10/16/25 at 11:48 a.m., the DON stated RN-A had called her on Friday evening and reported to her a staff member had been upset about the situation with RN-C and R1. The DON stated RN-A told her RN-C had held R1's hands down to give her pain medications and staff were very upset. The DON stated per facility policy, restraints were not used in the facility.	F0550		

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F0550 SS = D	Continued from page 3 Facility policy Physical Device Policy/Restraints dated 5/1/25, indicated the facility used the least restrictive device possible for the resident to ensure residents were free form physical or chemical restraints imposed for purposes of discipline or staff convenience.	F0550		
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure residents reserved the right to remain free from restraints for 1 of 3 resident (R1) when staff held her hands and administered morphine against her wishes.	F0604	It is the policy of Inter-Faith Care Center to ensure that residents are free from restraints. Resident R1 will be allowed to refuse medications and treatments as applicable. RN- C no longer is employed at Inter-Faith Care Center. All facility residents have the potential to be affected by this practice. All nursing staff have been re-educated on use of restraints. The facility policy on restraints was reviewed and remains current. Restraints will only be used in the facility under the direction of a Physician. The Director of Nursing (DON) or designee will audit medication pass administration through random observation to ensure residents aren't restrained. These will occur weekly for 4 weeks, then monthly for three months to ensure compliance. The Director of Nursing (DON) or designee will also audit any medication or treatment refusals weekly to ensure residents refusals are honored, weekly for 4 weeks and then monthly for three months to ensure compliance. Results of all audits will be reviewed by the facility Quality Assurance Performance Improvement Committee.	12/11/2025

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F0604 SS = D	Continued from page 4 R1's Admission Record indicated she admitted to the facility on 10/24/23. Diagnosis included Malignant neoplasm of breast, hypertension, dementia, depression and anxiety. R1s Brief Interview for Mental Status dated 10/8/25, identified a score of seven which indicated severe cognitive impairment. R1's care plan dated 7/2525, identified impaired cognition and indicated she was at high risk for being exploited by others and would not be able to accurately report if abused. The care plan indicated staff would intervene on R1's behalf if abuse was suspected, witnessed or reported. The care plan identified behaviors that included calling out and refusal of medications. The care plan directed staff to allow R1 to make decisions about her treatment regime as able and to provide a sense of control and directed if R1 resisted cares or medication, reassure her, leave and return later to try again. R1's Order Summary Report dated 10/17/25, identified an order for Morphine Sulfate oral solution 20 milligrams (mg) per milliliter. Give 10 mg by mouth every two hours as needed for pain. An Employee Statement Form dated 10/10/25, indicated Staff heard R1yelling out and asked her what was wrong and the nurse, registered nurse (RN)-C, said she was going to give R1 pain medication. While trying to calm R1 down, RN-C approached R1 to give pain medication and R1 said no and kept turning her head. RN-C was yelling at the staff member and said to hold R1's hands down, then put the medication in R1's mouth. The staff member wrote, R1 called RN-C a name and said, "she gave me meds [medications] I didn't want," and asked the staff why she didn't say anything. An Employee Statement Form dated 10/10/25, indicated R1 had been yelling help and seemed really upset and when asked, said "I'm sick of being tied down." The staff reported RN-C walked by and said "you're not tied down, ha ha ha" and laughed at R1 to her face while she was distressed. During interview on 10/15/25 at 3:58 a.m., nursing assistant (NA)-A stated R1 required total care and said she usually went to bed late because she liked to crawl out of bed. NA-A said R1 did not usually complain about pain but said "I think she could tell us." During interview on 10/15/25 at 4:09 p.m., trained medication aide (TMA)-A said R1 was usually very	F0604		

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F0604 SS = D	Continued from page 5 pleasant. TMA-A said he felt R1's pain was well controlled with scheduled pain medications. During interview on 10/15/25 at 4:17 p.m., licensed practical nurse (LPN)-A stated R1 was usually pretty happy and did not get upset very often. LPN-A said R1's pain was pretty well controlled, and he did not often need to use as needed medications. LPN-A said if R1 was hurting, she would tell staff, would say "ow" and became a "little more down." During interview on 10/15/25 at 4:32 p.m., dietary aide (DA)-A stated on Friday evening, October 10th 2025, around 7:00 p.m., she was on R1's unit and as she was going down the hall, R1 was sitting with a NA at the charting desk which was unusual. DA-A said the aide was holding R1's hand and comforting R1 who was yelling help, which was not unusual. DA-A stated she asked R1 what was wrong and R1 said she was "sick of being tied down here." DA-A said she talked to some of the other NA's and they told her the nurse on the unit, RN-C made one of the staff hold down R1's hands to administer medication. DA-A said the NA was very upset and said R1 told her she was scared and felt unsafe. DA-A said RN-C walked by and said no one is trying to tie you down and then laughed about it. DA-A said she had filled out a grievance form. During interview on 10/16/25 at 8:38 a.m., the activities director (AD) stated DA-A had reported the incident to her on Monday or Tuesday and let her know she had filed a report on RN-C the previous Friday. The AD said DA-A was disturbed about how the RN-C had basically forced R1 to take Morphine after saying no. The AD said she had spoken to the nurse who was on-call, RN-A, who reported she had been aware of the incident. During interview on 10/16/25 at 9:45 a.m., RN-A stated she had been the nurse on call the night of the incident and said she had received a call from the scheduler that some staff were upset because of the way RN-C had administered R1's morphine. RN-A said she called the unit and talked to RN-C who said R1 had been hollering out for 15 - 30 minutes, was not re-directable and was in a lot of pain. RN-A said RN-C told her she went to administer Morphine to R1 and R1 said no and swatted her hand away. RN-A said RN-C told her she had a NA hold R1's arms out of the way to get the morphine into her mouth. RN-A said she reported the	F0604		

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F0604 SS = D	Continued from page 6 incident to the director of nursing (DON) and the administrator that night via e-mail. RN-A stated staff should never restrain a resident. During interview on 10/16/25 at 9:57 a.m., RN-B stated R1 had behaviors at times that included yelling out, had some care refusals and would swing her arms up at times but that was about all. RN-B said R1 sometimes displayed pain in different ways but did not actually report pain. RN-B said R1 would disrobe on occasion when she had pain from the wound on her chest and if staff asked about pain, "sometimes she will say yes." RN-B said R1's pain was largely controlled by scheduled medication, and she rarely required the use of as needed medication and often did not want to take them. RN-B said if a resident did not want to take medications it was not appropriate to hold their arms down. During interview on 10/16/25 at 11:48 a.m., the DON stated RN-A had called her on Friday evening and reported to her a staff member had been upset about the situation with RN-C and R1. The DON stated RN-A told her RN-C had held R1's hands down to give her pain medications and staff were very upset. The DON stated RN-C was an agency staff nurse and was no longer working at the facility. Facility policy Physical Device Policy/Restraints dated 5/1/25, indicated the facility used the least restrictive device possible for the resident to ensure residents were free form physical or chemical restraints imposed for purposes of discipline or staff convenience.	F0604		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily	F0609	It is the policy of Inter-Faith Care Center to ensure that all allegations of abuse or neglect are reported timely. All facility staff were re-educated on abuse and neglect reporting requirements. The facility policy on abuse reporting was reviewed and remains current. All incidents are added to 24-hr monitoring, and then are reviewed during the Interdisciplinary Team meetings to ensure adequate reporting. The Director of Social Services will be responsible for verifying reporting and auditing timeliness of reporting. Incidents are reviewed monthly by the facility Quality Assurance Performance Improvement Committee that includes the facility medical director and administrator.	12/11/2025

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F0609 SS = D	Continued from page 7 injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to report an allegation of abuse to the state agency (SA) for 1 of 3 residents (R1) reviewed who was physically restrained by staff and administered medication against her wishes. R1's Admission Record indicated she admitted to the facility on 10/24/23. Diagnosis included Malignant neoplasm of breast, hypertension, dementia, depression and anxiety. R1's Brief Interview for Mental Status dated 10/8/25, identified a score of seven which indicated severe cognitive impairment. R1's care plan dated 7/2525, identified impaired cognition and indicated she was at high risk for being exploited by others and would not be able to accurately report if abused. The care plan indicated staff would intervene on R1's behalf if abuse was suspected, witnessed or reported. The care plan identified behaviors that included calling out and refusal of medications. The care plan directed staff to allow R1 to make decisions about her treatment regime as able and to provide a sense of control and directed if R1 resisted cares or medication, reassure her, leave and return later to try again. R1's Order Summary Report dated 10/17/25, identified an order for Morphine Sulfate oral solution 20 milligrams (mg) per milliliter. Give 10 mg by mouth every two hours as needed for pain. An Employee Statement Form dated 10/10/25, indicated	F0609		

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F0609 SS = D	Continued from page 8 Staff heard R1 yelling out and asked her what was wrong and the nurse, registered nurse (RN)-C, said she was going to give R1 pain medication. While trying to calm R1 down, RN-C approached R1 to give pain medication and R1 said no and kept turning her head. RN-C was yelling at the staff member and said to hold R1's hands down, then put the medication in R1's mouth. The staff member wrote, R1 called RN-C a name and said, "she gave me meds [medications] I didn't want," and asked the staff why she didn't say anything. An Employee Statement Form dated 10/10/25, indicated R1 had been yelling help and seemed really upset and when asked, said "I'm sick of being tied down." The staff reported RN-C walked by and said, "you're not tied down, ha ha ha" and laughed at R1 to her face while she was distressed. During interview on 10/16/25 at 11:48 a.m., the director of nursing (DON) stated she had been contacted over the weekend by staff who were upset about the way RN-C had administered medication to R1. The DON said the on- call nurse, RN-A reported she had spoken to RN-C. RN-C reported to RN-A, she had staff hold R1's hands to administer medication. RN-A told DON staff had been very upset. The DON stated she considered holding a resident's hands down to administer medication a restraint. The DON said the incident was not reported to the SA because RN-A had spoken to RN-C and did not feel she intended to be malicious when administering the medications. Facility policy Abuse Prevention Plan dated 2024, indicated all residents residing in the facility will be protected from Maltreatment. Suspected abuse of any kind needs to be reported IMMEDIATELY (within 2 hours) and any other suspected maltreatment needs to be reported IMMEDIATELY (within 24 hours).	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation	F0610	It is the policy of Inter-Faith Care Center to ensure that all alleged violations are thoroughly investigated. All facility staff were re-educated on abuse and neglect reporting requirements. The facility policy on abuse reporting & investigation was reviewed and remains current. The Director of Social Services and Director of Nursing are responsible for completing investigations of all reportable incidents. These individuals have all been re-educated on incident reporting and investigation. All incidents are reviewed during the Interdisciplinary Team meetings to ensure adequate reporting. The Facility Administrator will audit that all investigations are completed within five days, evidence of interviews, witness statements, conclusions and protective measures that are indicated.	12/11/2025

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F0610 SS = D	Continued from page 9 is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to thoroughly investigate an allegation of abuse for 1 of 3 residents (R1) who was physically restrained and administered morphine against her wishes. In addition, the facility failed to implement measures to protect other residents from the alleged abuse. R1's Admission Record indicated she admitted to the facility on 10/24/23. Diagnosis included Malignant neoplasm of breast, hypertension, dementia, depression and anxiety. R1s Brief Interview for Mental Status dated 10/8/25, identified a score of seven which indicated severe cognitive impairment. R1's care plan dated 7/2525, identified impaired cognition and indicated she was at high risk for being exploited by others and would not be able to accurately report if abused. The care plan indicated staff would intervene on R1's behalf if abuse was suspected, witnessed or reported. The care plan identified behaviors that included calling out and refusal of medications. The care plan directed staff to allow R1 to make decisions about her treatment regime as able and to provide a sense of control and directed if R1 resisted cares or medication, reassure her, leave and return later to try again. R1's Order Summary Report dated 10/17/25, identified an order for Morphine Sulfate oral solution 20 milligrams (mg) per milliliter. Give 10 mg by mouth every two hours as needed for pain. An Employee Statement Form dated 10/10/25, indicated Staff heard R1yelling out and asked her what was wrong and the nurse, registered nurse (RN)-C, said she was going to give R1 pain medication. While trying to calm R1 down, RN-C approached R1 to give pain medication and R1 said no and kept turning her head. RN-C was yelling at the staff member and said to hold R1's hands down,	F0610	Continued from page 9 Incidents are reviewed monthly by the facility Quality Assurance Performance Improvement Committee that includes the facility medical director and administrator.	

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F0610 SS = D	Continued from page 10 then put the medication in R1's mouth. The staff member wrote, R1 called RN-C a name and said, "she gave me meds [medications] I didn't want," and asked the staff why she didn't say anything. An Employee Statement Form dated 10/10/25, indicated R1 had been yelling help and seemed really upset and when asked, said "I'm sick of being tied down." The staff reported RN-C walked by and said "you're not tied down, ha ha ha" and laughed at R1 to her face while she was distressed. During interview on 10/16/25 at 11:48 a.m., the director of nursing (DON) stated she had been contacted over the weekend by staff who were upset about the way RN-C had administered medication to R1. The DON said the on- call nurse, RN-A reported she had spoken to RN-C. RN-C told RN-A she had staff hold R1's hands to administer medication. RN-A told DON staff had been very upset. The DON stated she considered holding a resident's hands down to administer medication a restraint. The DON stated she had not spoken with RN-C following the incident and said RN-C worked the day after. The DON said the facility had other complaints about RN-C and she was no longer working at the facility. The DON said she had not had a chance to talk to any of the staff who worked the day of the incident, nor had she followed up with R1. The DON stated typically following an allegation of abuse, the facility would investigate the incident. Facility policy Abuse Prevention Plan dated 2024, indicated All residents, alleged perpetrator(s), and staff members will protected from harm and retaliation during any and all investigations. If a staff member is considered to be an alleged perpetrator in an incident that staff member will be placed on suspension pending the investigation outcome. Other interventions could include reassignment of staff, working in pairs, separation of residents, room changes, and/or supervised visitation for residents with visitors. Staff will respond immediately to protect the alleged victim, integrity of the investigation, and examine the alleged victim for any sign of injury (physical, emotional, psychological, etc.). The policy indicated staff will investigate all incidents such as falls, bruises, medication errors, resident complaints, etc. Monday through Friday during normal business hours and all incidents will be reviewed with the following disciplines via the Inter-Disciplinary Team: nursing, social services, activities, dietary, therapies, and administration. After normal business hours, the RN Supervisor will contact Social Services Director, DON, and/or Administrator regarding all potential incidents	F0610		

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F0610 SS = D	Continued from page 11 of maltreatment if unsure of further actions to take.	F0610		