Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H50247182M
Compliance #: HL50245844C

Date Concluded: April 24, 2026

Name, Address, and County of Licensee Investigated:
Interfaith Care Center
811 3rd Street
Carlton, MN 55718-9228
Carlton County

Facility Type: Nursing Home

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation: The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation: The alleged perpetrator (AP)abused the resident when she forcibly gave the resident morphine.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was not substantiated. The resident had been hollering out for what the AP, a registered nurse, assessed as pain. The AP gave the morphine (pain relieving medication) to address the resident's pain and in preparation for pain wound cares. During the incident, the AP instructed another caregiver to hold the resident's hands so she could give the pain medication. The actions of the AP did not meet the definition of abuse.

The investigator attempted to contact multiple facility staff and the AP for interviews. The investigation included a review of the resident's record, facility internal investigation and written statements, personnel files, and staff schedules.

The resident resided in a skilled nursing facility (nursing home). The resident's diagnoses included breast cancer, dementia, anxiety and chronic pain. The resident's care plan included assistance with all activities of daily living related to pain, dementia, weakness and anxiety. Medications were ordered with the goal to be free from discomfort. The resident's assessment indicated she scored a 7/15 on the Brief Interview for Mental Status (BIMS) assessment which indicated severe impaired cognition. The care plan stated she displayed calling out behaviors and refusing medications. The interventions included offering reassurance and reattempt later.

A concern arose when one evening the resident was calling out for help. The AP attempted to give the resident morphine and the resident said no to the medication. The AP then asked an aide to hold the resident's hands while the AP gave the resident with the morphine.

The resident's medication administration record (MAR) indicated the resident had an order for morphine sulfate (concentrate) solution 20 milligrams (mg)/milliliter (mL), give 10 mg/mL every two hours as needed for pain. The AP documented the morphine was given that evening.

The resident's nursing progress notes indicated the AP documented she gave the morphine as ordered due to the resident calling out, which was an indicator she was in pain. Additionally the resident had dementia and was confused. The AP documented after the morphine was given, the resident stopped calling out and the follow up pain assessment indicated the morphine was "effective."

A caregiver was interviewed and stated found the resident hollering out for help. The caregiver stated the AP had tried to give the resident pain medication, but the resident kept refusing. The aide stated she sat with and held the resident's hand in an effort to calm her down when the AP told her to hold her hands and quickly gave her the morphine in her mouth with a syringe.

A nurse stated she believed the AP was not trying to physically restrain the resident but felt she needed to give her the morphine because the resident was in pain and needed to have a wound dressing changed.

While declining an interview, the AP agreed to give a statement. The AP's stated the resident was on hospice with comfort measures and had ordered morphine for pain. The resident's pain caused her to yell and swing out at staff. Without the morphine, she would not been able to complete the dressing change. The AP further stated she used nursing judgment, gave the ordered dose of morphine and the resident had good pain relief and did not yell out any further.

During an investigative interview, a staff member stated she witnessed the resident crying afterwards but acknowledged she did not witness the event itself.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

“Not Substantiated” means: An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Unable to interview due to cognitive impairment.
Family/Responsible Party interviewed: Declined.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: As part of the facilities plan of correction, the facility conducted audits to ensure medication refusals were honored, documentation of refusals were reviewed and care plans reflected interventions when residents refused medications. All staff were re-educated on residents rights. The AP no longer worked at the facility.

Action taken by the Minnesota Department of Health: MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term

Care Facilities, and substantiated facility noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html_

The purpose of this investigation was to determine individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email Page 5 of 5 The responsible party will be notified of their right to appeal the maltreatment findings. If maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

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 **03/04/2026**

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: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H50247182M , in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you	20000		

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

Minnesota State Department of Health

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20000	Continued from page 1 acknowledge receipt of the electronic documents.	20000		