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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6CBM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00047

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245024**
2.STATE VENDOR OR MEDICAID NO.
(L2) **516740000**

3. NAME AND ADDRESS OF FACILITY
(L3) **INTERFAITH CARE CENTER**
(L4) **811 THIRD STREET**
(L5) **CARLTON, MN** (L6) **55718**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/17/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **96** (L18)
13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susan Frericks, Unit Supervisor 10/19/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/19/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1969
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/04/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 19, 2021

CMS Certification Number (CCN): 245024

Administrator
Interfaith Care Center
811 Third Street
Carlton, MN 55718

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.
Effective August 28, 2021 the above facility is certified for:

96 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 19, 2021

Administrator
Interfaith Care Center
811 Third Street
Carlton, MN 55718

RE: CCN: 245024
Cycle Start Date: July 29, 2021

Dear Administrator:

On August 18, 2021, we notified you a remedy was imposed. On September 17, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 28, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 2, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 18, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 29, 2021. 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
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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6CBM

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(L4) **811 THIRD STREET**
(L5) **CARLTON, MN** (L6) **55718**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/29/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE - NE II 09/03/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/01/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1969
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
August 18, 2021

Administrator
Interfaith Care Center
811 Third Street
Carlton, MN 55718

RE: CCN: 245024
Cycle Start Date: July 29, 2021

Dear Administrator:

On July 29, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On July 29, 2021, the situation of immediate jeopardy to potential health and safety cited at was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 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 September 2, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a 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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 2, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 2, 2021, (42 CFR 488.417 (b)).

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.

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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 29, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information,

you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Interfaith Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 29, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Terri Ament, Rapid Response
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, Licensing and Certification Program 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 January 29, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

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

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 07/29/2021

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
E 000	Initial Comments On 7/26/21, through 7/29/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/26/21, through 7/29/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F678 when the facility failed to ensure a system to identify a resident's resuscitation status was accurately reflected throughout the medical record and facility documents for 2 of 17 residents with immediate risk to resident health and safety. The IJ began on 7/28/21, and was removed on 7/29/21, when it could be verified by observation, interview and document review, the facility had accurately identified all resident's code status, updated the policy and educated staff. In addition, an extended survey was completed on 7/28/21, through 7/29/21, related to the	F 000		

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

Electronically Signed | 08/23/2021

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 07/29/2021

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

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F 000	Continued From page 1 substandard quality of care findings. The complaint H5024038C (MN74887) was found to be SUBSTANTIATED. No deficiencies were cited due to the corrective actions taken by the facility prior to the survey. The complaint H5024039C (MN74220) was found to be UNSUBSTANTIATED. The complaint H5024040C (MN73260) was found to be UNSUBSTANTIATED. The complaint H5024041C (MN72916) was found to be SUBSTANTIATED, with a related deficiency at F689. The complaint H5024042C (MN71951) was found to be UNSUBSTANTIATED.	F 000		
F 563 SS=F	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access	F 563		8/20/21

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	245024	A. BUILDING _____ B. WING _____	C 07/29/2021

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F 563	Continued From page 2 to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to allow visitors without first making an appointment. This had the potential to affect all 74 residents who resided in the facility, and their families and friends. Findings include: On 7/26/21, at 11:45 a.m. upon entering the facility a sign was noted to be posted which had the following message: All Visits must be scheduled and confirmed through the Visitation schedule line 218-***-****. NON-scheduled visits(s) will be turned away. Another posted sign had the following message: Length of visit: All visits are no more than one hour (60 minutes), even if held outside. On 7/28/21, at 8:48 a.m. nursing assistant (NA)-G was interviewed. NA-G stated families had to call a special number to schedule visits. If no one answered the phone, there were specific instructions on what information was needed to	F 563	The contradictory signage about visitation was removed from the facility entrance. A Visitation Committee was established Committee met 8/19/21 and reviewed CMS QSO-20-39-nh-revised Guidelines and MDH COVID-19 Guidance: Long-term Care Indoor Visitation for Nursing Facilities and Assisted Living-type Settings publication guidelines on visitation. Meeting included Dan Tupy East-Central Regional Ombudsman and Kathy Hogan Infection Prevention ICAR Team. Resident Survey completed determining double occupancy room residents accepting roommate visitors. If both roommates agree, visitation would be allowed in resident rooms following the CORE principles of infection Control and visitation guidelines from MDH & CMS guidelines.	

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F 563	Continued From page 3 schedule the visit. NA-G stated the visits started at 10:00 a.m., the memory care unit visitors had a special entrance to visit and stayed at the end of the hallway for visits. Visitors did not visit in resident rooms. NA-G stated other visiting areas were on the first floor. The library and dining room were used for visits. Visitors could also visit outside on the scheduled visit. The last visit of the day was scheduled for 4:30 p.m. Visits were scheduled for one hour except for the memory care unit. Visits on the memory care unit were scheduled for 30 minutes. NA-G verified there were signs on the entrance door that informed visitors could only visit by appointment. On 7/28/21, at 1:38 p.m. the ombudsman was interviewed. The ombudsman stated he received two to three calls a week about the visiting restrictions and the need to make an appointment. On 7/28/21, at 1:59 p.m. the resident council was held. R19 stated she thought the visiting rules were too restrictive. R19 stated the residents needed to be able to have visitors after business hours. An unidentified resident stated he had to visit his son outside of the front doors on one occasion. On 7/29/21, at 9:01 a.m. the activities director (AD)-A was interviewed. AD-A stated the facility had been having families make appointments prior to visiting to monitor how many families were in the building at one time. AD-A stated two to six families could visit at one time with one to three visitors. Visits were schedule for one hour. AD-A stated if families showed up without an appointment they would accommodate them. AD-A stated she did not know how many families	F 563	Visitation policy was updated on 8/20/21. Policy does not have any hour restrictions and appoints are not needed for any in-room resident visits, with the exception of more than 2 visitors and visitors that include unvaccinated children. Visitation policy containing no visiting hour restrictions and reflects in-room visits guidelines (established 8/20/21). See attached In-Room Indoor Visits policy number ACT-0039. Updated visitation guidelines were communicated to Residents and Families via Clinconnex, e mail and US postal service (if needed). The Visitation Committee will continue to meet as needed updating visitation regulations/guidance.	

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F 563	Continued From page 4 had not tried to visit based on the front door sign. AD-A stated visiting hours were restricted from 10:00 a.m. to 11:30 a.m. and then from 1:30 p.m. to 5:00 p.m. AD-A stated they would make accommodations for evening visits if asked. AD-A stated they had complaints about the restricted visiting from families and during resident council meetings. On 7/29/21, at 11:52 a.m. the director of nursing (DON) and the administrator were interviewed. The DON stated the facility had been very liberal with compassionate care visits. The administrator stated they were trying to logistically manage who was in the building, trying to apply the rules to the letter, and not put their residents at risk. The DON stated not all of their residents were vaccinated, and they were trying to keep the residents safe. The DON stated maybe they could have opened up visiting sooner, but never to their knowledge had turned any visitors away. The DON stated they were not hearing too many complaints from families, but verified they should have lifted the visiting restrictions. The facility policy In Person Contact Allowed Visits revised 6/15/21, directed all visiting parties (resident and guest) will be eligible for visits if they were 14 days past their vaccination. Guests needed to be fully vaccinated. All visits needed to be scheduled with a time and location.	F 563		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to	F 678		8/13/21

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F 678	Continued From page 5 related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a system to identify a resident's resuscitation status was accurately reflected throughout the medical record and facility documents for 2 of 17 residents (R45, R223) who had elected a do not resuscitate (DNR) status but were documented as a cardio-pulmonary resuscitation (CPR) status. This resulted in an immediate jeopardy (IJ) situation for R45 and R223 who were at risk for serious bodily injury/harm if they were given CPR when they had elected DNR. The IJ began on 7/28/21, when it was determined the facility failed to ensure resident resuscitation status documentation reflected each resident's current resuscitation preferences and physician's orders for R45 and R223. The administrator and director of nursing (DON) were notified of the IJ at 3:30 p.m. on 7/28/21. The IJ was removed on 7/29/21, but non-compliance remained at a lower scope and severity of a D, which indicated no actual harm with the potential for more than minimal harm which is not an immediate jeopardy. Findings include: R45's Admission Record printed 7/29/21, indicated R45's diagnoses included chronic kidney disease, malignant neoplasm of bladder, and personal history of cerebral infarction (stroke). R45's Providers Orders for Life Sustaining	F 678	F678 Code Status Corrective Action: 1. The code status for Resident R45 and R223 was updated by cross checking between written copy of each POLST, Resident Physician Orders and information in the electronic medical record (PointClickCare) Corrective Action As it Applies to Other Residents: 1. 100% Audit of ALL resident□s code status was completed by cross checking between written copy of each POLST, Resident Physician Orders and information in the electronic medical record (PointClickCare) ensuring all 3 contained the identical information Reoccurrence will be Prevented By: 1. Code Status was removed from each resident care guide and supplemental Code Status listings removed from the wall at each nursing station. 2. Our electronic medical record (PointClickCare and PointOfCare) was updated to include the Resident□s CODE STATUS located directly under the Resident□s photo for fast access. 3. The Code Blue Policy was updated with specific directions on where to find a resident□s Code Status: on the POLST at the front of the blue paper chart, or in	

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F 678	Continued From page 6 Treatment (POLST) signed by R45's physician and guardian dated 2/27/20, indicated R45's selected resuscitation status was DNR with limited interventions, and no intubation (DNI). R45's physician progress notes dated 5/18/21, indicated R45's resuscitation status was DNR. R45's annual Minimum Data Set (MDS) dated 6/17/21, indicated R45 had a severe cognitive impairment and required extensive assistance of staff for all activities of daily living (ADLs). R45's Order Summary Report printed 7/29/21, indicated R45 had a physician order for DNR that was initiated 2/20/20. The facility resuscitation status order listing report dated 7/15/21, located on the wall near the chart rack behind the nurse's station on Oak unit, indicated R45's code status was DNR/DNI. R45's care guide sheet (nursing assistant care plan) updated 7/27/21, indicated R45's resuscitation status was Full Code (initiate CPR). On 7/28/21, at 7:23 am. nursing assistant (NA)-D stated she was certified to do CPR, and she would check for a resident's resuscitation status either on the POLST in the chart, the sheet hanging on the wall by the charts, and could check the care guide sheet. On 7/28/21, at 7:26 a.m. licensed practical nurse (LPN)-B stated she always looked for a resident's resuscitation status in the electronic medical record (EMR), but could also check the list on the wall by the charts.	F 678	PCC or POC directly under the Resident□s photo. 4. All Nursing staff were in-serviced on the updated Code Blue Policy, where to locate the code status. The Inservice included a return demonstration for nursing staff to the trainer showing competency in locating the resident Code Status 5. New or updated Physician Orders for Code Status will be audited by Medical Records on a weekly basis by cross checking Resident Physician Orders and the written copy of each POLST in the blue paper chart. 6. Compliance audit results will be presented monthly at QA for a minimum of 6 months and thereafter as recommended by the QA Committee. Correction will be monitored by: DON, Medical Records, Nurse Managers, QA Committee	

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F 678	Continued From page 7	F 678		

On 7/28/21, at 7:49 a.m. NA-C stated she was certified to do CPR, would check the care guide sheet to find a resident's resuscitation status, and would start CPR if indicated. NA-C stated R45's resuscitation status was Full Code, so would start CPR if she found him without respirations or a heartbeat. NA-C then said she could check the wall to make sure, but noted the care guide had just been updated so she would be able to go by that.

On 7/28/21, at 9:34 a.m. NA-A stated she would check the care guide, check for a pulse and start CPR before the nurse arrived if the resident was full code.

On 7/28/21, at 9:28 a.m. registered nurse (RN)-B stated she would get help, check the EMR, or the resuscitation status list on the wall by the charts.

On 7/28/21, at 9:44 a.m. RN-A stated she made the changes on the care guide sheet. RN-A stated when the POLST was signed by the physician and returned, the nurse receiving the order would process it by entering it into the EMR, and the physician order sheet. RN-A stated medical records was updated weekly or as needed, for the updates on the resuscitation status list located on each unit on the wall near the chart rack. RN-A sated anyone who was certified in CPR would be able to do CPR in the facility. RN-A stated the staff should look at the POLST, but if not available, they could look at the resuscitation status list or the EMR. RN-A sated if a resident was found without respirations or heartbeat, she would call a "code blue", and verify the resuscitation status by looking at the POLST or the EMR. RN-A verified each resident's resuscitation status was on the care guide, but

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F 678	Continued From page 8	F 678		

may not be updated if there was a change over night. RN-A verified R45's care guide indicated he was Full Code (CPR), which was incorrect according to his POLST. RN-A verified if the NA had looked at R45's care guide, they would have initiated CPR, against his wishes. RN-A stated the facility policy directed staff to look at the EMR, the POLST or the list on the wall.

On 7/28/21, at 10:01 a.m. the director of nursing (DON) verified some NAs were certified to do CPR and stated they just had a class on resuscitation status on 4/21/21, and they were taught to look at the electronic Medication Administration Record (eMAR) and the electronic Treatment Administration Record (eTAR), the list on the wall by the chart racks, the EMR or the POLST in the event the resident was without respirations or a heartbeat. The DON stated the NAs should get the nurse, and the nurse should make the determination of whether they should start CPR. The DON verified a resident could get CPR when they did not want it if the care guide was incorrect, and staff checked it for the resuscitation status and initiated CPR.

The IJ which began on 7/28/21, was removed on 7/29/21, when the facility had revised the policy Code Blue (Cardiac Emergency) CPR Policy and Procedure, reviewed all resident records and educated staff. This was was verified through interview and document review.

The facility policy Code Blue (Cardiac Emergency) CPR dated 1/24/21, directed the staff to determine the code status of the resident who was without a pulse or respirations, which could be found in the EMAR at the top of the resident record, on the POLST in the front of the

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F 678	Continued From page 9 chart, or on the code status list on the wall by the charts. R223's Admission Record printed 7/29/21, indicated R223's diagnoses included hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) on left side, congestive heart failure (CHF), and history of COVID-19. R223's care guide sheet printed 7/28/21, indicated R223's resuscitation status was DNR. R223's POLST signed by her power of attorney (POA) on 7/20/21, indicated R223 did not want to be resuscitated in the event of her heart beat and breathing stopped. On 7/28/21, at 9:37 a.m. on the Cedar nursing unit, a list of resuscitation status for all residents was on the wall at the nurse's station. R223's resuscitation status was listed as CPR. On 7/28/21 at 9:41 a.m. R223's EMR was reviewed, and indicated R223's resuscitation status was DNR. On 7/28/21, at 9:49 a.m. NA-I was interviewed. NA-I stated she would check resuscitation status posted on the unit wall. On 7/29/21, at 10:56 a.m. the DON was interviewed. The DON verified R223's code status was incorrectly posted on the wall of the Cedar nursing unit. The DON verified R223 would have received CPR against her wishes in the event she stopped breathing and her heart	F 678		

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F 678	Continued From page 10 stopped beating.	F 678		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure difficulties with transfers using the stand-assist lift (EZ Stand) was communicated and assessed to prevent further falls for 1 of 2 residents (R39) reviewed for accidents. Findings include: R39's Admission Record printed 7/29/21, indicated R39's diagnoses included a cerebral infarction (stroke), right below the knee amputation, and Charcot's joint foot and ankle (progressive, degenerative condition which results in weakening of bones and soft tissues of the foot or ankle). R39's annual Minimum Data Set (MDS) dated 6/14/21, indicated R39 was cognitively intact, had balance deficits requiring assistance to stabilize, had range of motion deficits of both lower extremities, and required extensive assistance with transfers. R39's MDS further indicated R39 had no falls since the previous quarterly	F 689	F689 Accident Hazards/Supervision/Devices Corrective Action: 1. Resident R39 had a re-assessment of her transfer and is currently working with therapy. Corrective Action as it Applies to Other Residents: 1. A 100% Audit for All residents was conducted for any other potential changes of condition/unsafe situations by interviewing caregivers using the care guides for each resident. 2. The IFCC Direct Care Expectations were updated to include the responsibility to report changes and an expanded description of what to report. Reoccurrence will be Prevented By: 1. All IFCC Nursing Staff were educated on changes to the Direct Care Expectations including what to report, where and when to report changes.	8/26/21

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F 689	Continued From page 11 assessment. R39's care plan revised 6/22/21, indicated R39 was at risk for falls, and interventions included ensuring R39 was wearing appropriate non-slip foot wear and prosthetic leg was in place for transfers with the EZ Stand. R39's Care Guide sheet updated 7/27/21, directed staff to use two staff with transfers using the EZ stand in the bathroom, limit standing time to less than 2 minutes, and ensure the leg strap buckle was on for all transfers with the EZ Stand. R39's progress report dated 7/8/21, indicated R39 had been lowered to the floor when her right prosthetic leg slipped out of the shin pad on the EZ stand during a transfer. R39's progress report indicated the shin strap on the EZ stand was not utilized during the transfer. R39 was not injured, and her Care Guide was revised to direct the use of the shin strap during transfers with the EZ Stand. On 7/27/21, at 1:49 p.m. R39 was observed during toileting cares. Nursing assistant (NA)-B and NA-E prepared to transfer R39 with the EZ Stand. NA-E secured the shin strap around R39's lower legs, and ensured she had non-skid footwear on. R39 was lowered appropriately to limit her standing time to less than two minutes, as care planned. As R39 was transferred from the commode to the wheelchair, R39's left leg had come out the side, partially off the platform on the left, even with the shin strap appropriately secured around R39's shins. R39 was safely lowered into her wheelchair and no injury occurred.	F 689	2. All IFCC Nursing Staff are being re-educated on Safe Use of Mechanical Lifts via Relias Learning. 3. Audits of Mechanical Lift transfers will be conducted a minimum of 3 times weekly over all shifts for a minimum of 90 days. The Audit results will be presented monthly at QA for a minimum of 6 months and thereafter as recommended by the QA Committee Correction will be monitored by: DON, Nurse Managers, QA Committee	

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F 689	Continued From page 12	F 689		

On 7/27/21, at 2:05 p.m. nursing assistant (NA)-E stated R39 only used the EZ Stand when she used the commode and could only stand for about 2 minutes. NA-E verified R39 had an incident during which she was lowered to the floor when her right leg came out of the shin pad when the shin strap was not utilized. NA-E verified during the transfer with the EZ Stand on this date, R39's left leg came out, though her legs were secured with the shin strap.

On 7/29/21, at 11:05 a.m. registered nurse (RN)-A stated R39 had not been re-assessed for the use of the EZ Stand, as the shin strap had not been used, so they implemented the use of the shin strap. RN-A stated that if she had problems with the shin strap in place she would have had her re-evaluated for the safety of transfers with the EZ Stand. RN-A stated she was not aware that R39 continued to have problems with her leg sliding out of the EZ Stand shin pad and off the foot plate even with the use of the shin strap. RN-A verified none of the staff had reported this to her, but if they had she would certainly have her re-evaluated with the knowledge of continued difficulties with the EZ Stand. RN-A stated staff should be communicating any changes or difficulties, so they could be assessed.

On 7/29/21, at 1:59 p.m. director of nursing (DON) verified staff should use the shin strap for transfers with the EZ stand.

On 7/29/21, at 2:39 p.m. DON verified the staff should communicate change in condition or a change in transfers so they could be assessed.

The facility Direct Care Expectations revised 1/24/21, directed the direct care giver to report

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F 689	Continued From page 13 immediately to the team leader anything that is different from the care guide, including any accidents or incidents and any changes in the physical status.	F 689		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		8/13/21

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F 732	Continued From page 14 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the nurse staff posting was posted daily and was updated to reflect the current staffing. This had the potential to affect all 74 residents residing in the facility. Findings include: On 7/26/21, at 5:03 p.m. the nurse staff posting was reviewed. The staff posting included only staffing for the day shift, and lacked information for the evening or night shift. On 7/27/21, at 9:34 a.m. the staff posting included only staffing for the day shift, and lacked information for the evening or night shift. On 7/28/21, at 11:38 a.m. the staff posting included only staffing for the day shift, and lacked information for the evening or night shift. On 7/28/21, at 2:44 p.m. the director of nursing (DON) was interviewed. The DON verified the nurse staffing should be posted daily, with the amount of staff for each shift. On 7/28/21, at 2:54 p.m. registered nurse (RN)-C was interviewed. RN-C stated she filled out the nurse staff posting sometime after she arrived after 2:00 p.m. and then again before she left for the night. RN-C verified the staffing information for evening and night shifts was not on the nurse	F 732	F732: Posting of Nursing Hours Corrective Action: 1. The nursing hours were calculated and posted on the wall. Reoccurrence will be prevented by: 1. The Facility policy on the posting of nursing hours was written and includes data requirements and responsibilities for posting. 2. All Administrative and Licensed Nursing Staff were in-serviced on the policy 3. A copy of the policy will be located in the nursing scheduling book for reference 4. HR/Nursing Scheduler will audit compliance with the posting of nursing hours on a daily basis, report compliance to IDT and take corrective action as needed 5. Compliance with F732 Posting of Nursing Hours will be presented monthly at QA for a minimum of 6 months and thereafter as recommended by the QA Committee. Correction will be monitored by: HR/Nursing Scheduling, QA	

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F 732	Continued From page 15 staff posting.	F 732		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		8/26/21

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F 758	Continued From page 16 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure identification and monitoring of mood and behavior symptoms to determine efficacy of psychotropic medications and to monitor side effects and effectiveness of psychotropic medications for 1 of 5 residents (R26) reviewed for unnecessary medications. Findings include: R26's Admission Record printed 7/29/21, indicated R26 had diagnoses included dementia without behavior disturbances, had a problem related to social environment, was unsteady on feet, and had a history of falls. R26's Admission Minimum Data Set (MDS) dated 5/24/21, indicated R26 had moderately impaired cognition, had no behaviors, and was not on an antidepressant medication during the assessment period. R26's Order Summary Order Report printed 7/29/21, identified R26 started on Remeron (antidepressant) 15 milligrams (mg) on 6/15/21.	F 758	F758 Psychotropic Medications Corrective Action: 1. Side Effect and Target Behavior Monitoring was implemented for Resident 26 and his Care Plan was updated to include goals and interventions for depression and identification of target behaviors and monitoring related to Remeron use. Corrective Action As it Applies to Other Residents: 1. A 100% Audit was conducted of all residents using psychotropic medications to ensure appropriate Side Effect and Target Behavior Monitoring and updated Care Plan was present in the resident chart for the use of an antidepressant, antianxiety, psychotic and/or hypnotic medications. Reoccurrence will be Prevented By: 1. The psychotropic policy was written and includes Side Effect and Target	

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F 758	Continued From page 17 R26's Summary Order Report indicated R26's antidepressant side effect monitoring was not initiated until 7/28/21, and target behavior monitoring were not initiated until 7/30/21. R26's care plan initiated 6/4/21, lacked identification, goals, and interventions for R26's diagnoses of depression. R26's care plan lacked identification of target behaviors or mood symptoms, and further lacked monitoring of target behaviors and mood symptoms related to R26's Remeron order. R26's physician note dated 6/15/21, indicated R26 exhibited signs and symptoms of depression and was stared on Remeron 7.5 mg for appetite. R26's physician orders instructed to watch for side effects of Remeron and to re-evaluate in six weeks. On 7/27/21, at 3:44 p.m. registered nurse (RN)-F verified R26's electronic medication administration record (eMAR) and electronic treatment administration record (eTAR) lacked side effect or behavior monitoring for prescribed Remeron. RN-F stated he was unsure what target behaviors or side effects to monitor for R26's Remeron. On 07/28/21, at 8:48 a.m. RN-E verified identification and monitoring for side effects and target behavior for Remeron medication were not on R26's eMAR or care plan, and were added 7/27/21. RN-E stated R26 was started on Remeron for a trial period due to a decreased appetite and sadness due to major life changes and loss. RN-A stated it was important for monitoring R26's mood and possible side effects from the medication to determine the	F 758	Behavior Monitoring, Medication Review and Care Planning. 2. An Order Set was designed that provides the person entering the order in the EMR to choose the medication classification being ordered as well as being required to choose the associated Side Effect and Target Behavior Monitoring order for all documentation. 3. A weekly audit using the New Order Listing Report from the EMR will be conducted to ensure that all new medications started that week have associated Side Effect and Target Behavior Monitoring and appropriate care plan in place. 4. Compliance audit results will be presented monthly at QA for a minimum of 6 months and thereafter as recommended by the QA Committee. Correction will be monitored by: DON, MDS Coordinators, Nurse Managers, QA	

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F 758	Continued From page 18 effectiveness of the antidepressant. On 7/29/21, at 1:39 p.m. the director of nursing (DON) stated she would expect identification and monitoring of mood and behaviors along with monitoring of side effect for antipsychotic medications be identified on the residents EMR and Care Plan. The DON stated it was important as it was a way to monitor the effectiveness of the antipsychotic to ensure the resident was receiving the correct medication and dosage. A facility policy on side effect and target behavior monitoring for antipsychotropic medications was requested and not received.	F 758		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 791		8/26/21

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F 791	Continued From page 19 §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure dental concerns were followed up for 1 of 1 residents (R65) reviewed for dental services. Finding include: R65's annual Admission Data Set (MDS) dated 1/12/21, indicated R2 had intact cognition, and had no dental concerns. R65's care plan initiated 2/2/21, indicated R26 had no issues with chewing or oral pain. The facility assisted with scheduling dental appointments and with transportation to/from the dental office. R65 dentist was in Deerwood, MN.	F 791	F 791 Dental Services Corrective Action: 1. Resident R65 has an appointment scheduled with her Dentist of preference in Deerwood, MN. Corrective Action As it Applies to Other Residents: 1. A 100% Audit of all residents was completed that included a review of all dental appointments in the past year, noting of all current upcoming dental appointments as well a person-to-person interview with each resident asking if they are having oral pain and determining their preferences for dental services.	

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F 791	Continued From page 20 R65 had an upper left partial that had been made and just needed to be inserted. R65's care plan indicated R65's last appointment was in Fall 2019. R65's quarterly assessment dated 4/8/21, indicated R65 had her own teeth and they were in fair condition. The assessment further indicted R65 reported she used a dental clinic in Deerwood, MN. R65's last dental care services were the fall of 2019, prior to admission to the facility. R65 further reported she need to have a fixed partial inserted on the upper left jaw; and the piece had been created and was waiting placement. On 7/26/21, at 12:44 p.m. R65 stated she had upper left missing teeth and was fitted for a partial prior to COVID. R65 further stated staff from the facility were aware, and they had been working on getting her into see the dentist to get her partial. R65 states she had not been updated, so she did not know where things were at regarding her dental visit. On 7/28/21, at 9:08 a.m. RN-E stated she was not aware of any dental appointment for R65's partial, and verified R65's medical record lacked documentation a dental appoint had been scheduled. On 7/28/21, at 2:26 p.m. RN-D stated she completed annual, quarterly and change in condition MDS, and completed R65 quarterly assessment on 4/8/21. RN-D stated she did remember R65 stating she had a partial at her dentist and needed to have an appointment made to get her partial placed. RN-D stated she planned on calling the dentist to see if they still	F 791	2. 100% of facility residents (or their representatives) were asked if they would like an appointment set up for them at this time. Reoccurrence will be Prevented By: 1. IFCC Licensed Staff were inserviced on the regulation and expectations for obtaining routine and emergency dental services. 2. IFCC is working with HealthDrive to bring Dental Services into the facility to ensure that all residents have easy access for their oral health and dental needs. 3. Any issues or delays accessing Dental Services will be discussed weekly in IDT Meeting and presented monthly at QA for a minimum of 6 months and thereafter as recommended by the QA Committee Correction will be monitored by: Nurse Managers, MDS Coordinators, QA	

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F 791	Continued From page 21 had the partial since it had been since the fall of 2019 but had not. RN-D stated R65 had her quarterly MDS due this month and planned on following up at that time. On 7/28/21, at 2:40 p.m. R65's progress note indicated a follow up telephone call was placed to R65's dental clinic, and was informed R65 had a treatment plan in place in the Fall of 2019 to have several teeth extracted and then fitted for an upper partial and R65 had not completed the treatment plan. The progress not further indicated R65 would have to be re-evaluated for a new treatment plan and the dental office would interview R65 to see how R65 would like to proceed. On 7/29/21, at 1:43 p.m. the director of nursing (DON) stated she would expect who ever completed the dental assessment to follow up on any dental concerns. The DON further stated she would expect the follow up to be timely, which would be after the assessment and the dental need was identified, and not wait for when the next assessment was due. The facility policy Resident Care revised 5/18, directed the facility will assist residents to obtain regular and emergency dental services.	F 791		
F 843 SS=C	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved	F 843		8/20/21

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F 843	Continued From page 22 for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to develop and/or have evidence of an in-effect transfer agreement with one local Medicare participating hospital entity. This had the potential to affect all 74 residents residing in the facility who could require hospitalization on an emergent basis. Findings include: During an extended survey on 7/29/21, evidence was requested to demonstrate the facility had a transfer agreement in place with local Medicare	F 843	Transfer agreement(s) developed for Interfaith Care Center's (IFCC) primary transferring hospitals/emergency rooms; Cloquet Memorial Hospital, St. Mary's Hospital and St. Luke's. IFCC's Admissions Director has shared organization specific transfer agreements with IFCC's primary patient/resident contact at each respective organization requesting execution (authorizing signature) of the agreement.	

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F 843	Continued From page 23 participating hospitals. On 7/29/21, at 3:04 p.m. the administrator and the director of nursing (DON) were interviewed. The administrator stated they did not have a transfer agreement with a receiving hospital. The administrator stated they called 911 to transport residents to the hospital. No further information was provided.	F 843		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		8/28/21

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F 880	Continued From page 24 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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	245024	A. BUILDING _____ B. WING _____	C 07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19 related to the proper utilization of personal protective equipment (PPE) for 1 of 1 resident (R273) who was reviewed for infection control practices. In addition, the facility failed to ensure proper hand hygiene and glove use was completed during toileting cares for 1 of 2 residents (R39) observed during personal cares. Findings Include: R273's Face Sheet printed dated 7/29/2, indicated R273 was admitted to the facility on 7/14/21, and placed in quarantine. R273's quarantine period had been identified as ending 7/28/21. On 7/30/21, signage was observed on R273's door indicating R273 was on transmission-based precautions (TBP). On 7/27/21, at 1:44 p.m. R273 was observed sitting in his wheelchair, in the entryway to his room, without a mask. On 7/27/21, at 2:13 p.m. nursing assistant (NA)-H was observed donning a yellow gown, clean gloves, a surgical mask and eye protection, and entered R273's room. NA-H was interviewed when he exited the room, and stated that no one was wearing N95 masks in the quarantine rooms. The sign outside of R273's room indicated that a surgical mask was to be used. On 7/28/21, at 7:20 a.m. registered nurse (RN)-B stated newly admitted residents were kept in	F 880	F880 Corrective Action 1. Resident R273 completed TBP isolation on 7/28/21. 2. Resident R39's transfer was re-evaluated by and is currently working with therapy. Resident R39's peri-care protocol was re-assessed by nursing and her care plan updated as needed. Corrective Action as it Applies to Other Residents 1. A 100% Audit was conducted for any other residents in TBP to immediately update PPE to N-95. No other residents were affected. Reoccurrence Will Be Prevented By F880 Directed Plan of Correction POLICY/PROCEDURE/SYSTEM CHANGES 1. The IFCC Quality Assurance Committee conducted a root cause analysis to identify the problems that resulted in the deficiency and developed the correction plan 2. The Infection Control Practitioners (ICP's) and DON reviewed the policies and procedures for handwashing and gloving and Peri Care/IFCC Performance Check list for Peri-Care/Peer Review 3. The Infection Control Practitioners (ICP's) and DON reviewed the CDC Summary for Healthcare Facilities: Strategies for Optimizing the Supply of	

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F 880	Continued From page 26 isolation on droplet precautions for two weeks. RN-B further stated N95's were not required for new admission only resident who received nebulizer treatment and resident who were COVID-19 positive. On 7/28/21, at 2:00 p.m. the signage outside of R273's room indicated that R273 was on Transmission Based Droplet Precaution. The signage further indicated the specific PPE to use was gloves, gown, surgical mask and goggles. On 7/29/21, at 12:14 p.m. the director of nursing (DON) stated N95 respirators were not being used in isolation rooms for new admissions. The DON further stated she was going by the Center for Disease Control (CDC) guidelines for strategies to optimize PPE and could conserve their N95 masks in the event of a COVID-19 outbreak . The Interfaith Infection Prevention policy directed staff will use appropriate PPE when they are interacting with residents, to the extent PPE is available and per CDC guidance on conservation of PPE. R39's Admission Record printed 7/29/21, indicated R39's diagnoses included a cerebral infarction (stroke), right below the knee amputation, and Charcot's joint foot and ankle (progressive, degenerative condition which	F 880	PPE during Shortages and MDH Covid-19 Personal Protective Equipment Grid for Congregate Care Settings in regards to the use of N-95 masks during Conventional/Contingency/Crisis capacity 4. The Infection Control Practitioners (ICP's) and DON reviewed the Policy and Procedure for Transmission Based Precautions and updated Isolation Guidelines to include the appropriate use of N-95's for Transmission Based Precautions: Droplet, Known or Suspected Covid-19. TRAINING / EDUCATION 1. All IFCC staff received re-training on standard infection control practices including transmission-based precautions, Selection of Personal Protective Equipment, use of N-95's for TBP isolation and appropriate handwashing/use of gloves for peri care. 2. All IFCC nursing staff completed a performance competency skill review for Handwashing & Gloving that included changing gloves when they become soiled. 3. IFCC Direct Caregivers completed a performance competency skill review for Peri/Care that included changing gloves, sanitizing hands and donning clean gloves when contaminated. 4. ALL IFCC staff will be assigned to complete Transmission Based Precautions and PPE course on Relias	

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F 880	Continued From page 27 results in weakening of bones and soft tissues of the foot or ankle). R39's comprehensive annual Minimum Data Set (MDS) assessment dated 6/14/21, indicated R21 was cognitively intact, required extensive assistance with mobility, toilet use and personal hygiene, and was frequently incontinent of bladder. R39's MDS further indicated R39 had balance difficulties and required assistance to stabilize. R39's Care Guide sheet, updated 7/27/21, directed 2 staff to transfer R39 with the stand assist lift for toilet use and assist with toileting cares. On 7/27/21, at 1:49 p.m. R39 was transferred with a stand assist lift and 2 staff to the commode to have a bowel movement (BM). After having a BM, R39 was assisted to stand with the stand assist lift, nursing assistant (NA)-E, wiped the BM from R39's bottom with cleansing wipes, disposed of the wipes into the garbage, and pulled up R39's clean brief and pants with the same gloves on. R39 was lowered back down to the commode during cares and back up to complete dressing. NA-E then helped to transfer R39 with the stand aide assist into her wheelchair, helped move the stand aid assist lift. NA-E removed her gloves and then put away the cleansing wipes in a drawer, which she opened and closed. NA-E then sanitized her hands and donned clean gloves to remove the garbage and finish cleaning up supplies. On 7/27/21, at 2:05 p.m. NA-E verified she should have removed her gloves and sanitized or washed her hands before pulling up R39's clean	F 880	on-line training program 5. IFCC Direct Care staff will be assigned to complete a Peri Care course on Relias on-line training program. MONITORING/AUDITING 1. ICP's and DON/designee will conduct audits of handwashing /gloving during peri-care daily on all shifts for 7 days until 100% compliance is met and thereafter as directed by the QA committee 2. ICP's and DON/designee will conduct audits of Transmission Based Precautions for the correct use of PPE N-95's on all shifts 4x a week for one week then twice weekly for one week once compliance is met and thereafter as directed by the QA committee 3. ICP's and DON/designee will conduct audits on aerosolized generating procedures to ensure PPE is used. 4. Audit results will be reported to QA committee monthly for 3 months and thereafter as directed by the committee. Correction will be monitored by DON, Infection Control Practitioners, QA Committee	

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F 880	Continued From page 28 brief and pants, and before putting the wipes away. On 7/29/21, at 11:05 a.m. registered nurse (RN)-A verified staff should complete hand hygiene before and after removing gloves, and gloves should be changed after cleansing a resident's buttocks of BM as soon as there was a safe opportunity. On 7/29/21, at 1:59 p.m. director of nursing (DON) verified the expectation was for staff to sanitize hands before and after touching something that was contaminated, and to wash hands and change gloves after wiping up BM. The facility policy and procedure for Handwashing/Hand Hygiene revised 8/15, directed staff to hand sanitize with an alcohol-based hand rub containing at least 62% alcohol, or wash hands with soap and water after contact with bodily fluids, going from a contaminated body site to a clean body site during cares, after contact with resident's intact skin, and after removing gloves.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Inter-Faith Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 Edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code (NFPA 99). THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000		

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

Electronically Signed | 08/20/2021

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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Inspected as one building: Inter-Faith Care Center is a 2-story building with no basement. The building was constructed in 2000, and determined to be of Type II (222) constriction. The skilled nursing home has two assisted living facilities attached that are both of Type II (000) construction. They are both properly separated by a 2 hour fire rated barrier,	K 000		

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K 000	Continued From page 2 with 1&1/2 hour fire rated self closing doors. The building is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all resident rooms, that is monitored for automatic fire department notification. The facility has a licensed capacity of 96 beds and had a census of 74 at the time of the survey. The requirements at 42 CFR Subpart 483.70(a) are NOT MET.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K 321		8/27/21

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K 321	Continued From page 3 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 07/27/2021, at 12:40 PM during the facility tour observations revealed that the activities storage room door did not completely close and positively latch into the door frame. This deficient condition was verified by the Maintenance Supervisor.	K 321	Activities Storage Door, Latch Failure: Facility made adjustments and checked operation of activity storage door and its failure to effectively latch. Door latched properly, observed and confirmed on August 27th, 2021. Monitoring of the submitted plan of correction will be done monthly for the next 6-months through the addition of the correction onto the meeting agenda of InterFaith Care Center's (IFCC) Safety Committee. IFCC's Director of Environmental Services, Chair of IFCC's Safety Committee is the individual responsible to ensure monthly monitoring is completed. IFCC's Safety Committee Minutes are included as part of IFCC's standard Quality Assurance (QA) Meeting monthly agenda. IFCC's monthly QA minutes are a standard informational item reviewed by IFCC's Board of Director's at their every other month meeting. Review of the safety committee minutes	

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K 321	Continued From page 4	K 321	by the QA committee and then the IFCC Board will ensure IFCC's submitted corrections have in fact been completed. Approved Safety Committee Meeting Minutes will be posted for all employees to review.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition) National Fire Alarm Code, sections 14.5.3. and 14.6.2.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/27/2021 at 10:30 AM, during a review of all available fire alarm test and inspection documentation and an interview with the Regional Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that a semiannual	K 345	Semi Annual Visual Inspection: New form was created to record/log semi-annual inspections. New documentation form will used to record inspections beginning December 2021. Monitoring of the submitted plan of correction will be done monthly for the next 6-months through the addition of the correction onto the meeting agenda of InterFaith Care Center's (IFCC) Safety Committee. IFCC's Director of Environmental Services, Chair of IFCC's Safety Committee is the individual responsible to ensure monthly monitoring is completed.	8/19/21

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K 345	Continued From page 5 inspection of all initiating devices had been completed. This deficient condition was verified by the Maintenance Supervisor.	K 345	IFCC's Safety Committee Minutes are included as part of IFCC's standard Quality Assurance (QA) Meeting monthly agenda. IFCC's monthly QA minutes are a standard informational item reviewed by IFCC's Board of Director's at their every other month meeting. Review of the safety committee minutes by the QA committee and then the IFCC Board will ensure IFCC's submitted corrections have in fact been completed. Approved Safety Committee Meeting Minutes will be posted for all employees to review.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of	K 351		8/19/21

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K 351	Continued From page 6 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to install and maintain the fire sprinkler system in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.7.1.1, and NFPA 13 - 2010 edition, Section 6.2.9.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 07/27/2021 at 12:47 PM, observation revealed that there are several spare sprinkler heads that are not secured and protected from damage within the fire sprinkler spare head box located at the main sprinkler riser. This deficient condition was verified by the Maintenance Supervisor.	K 351	Spare Sprinkler Head Storage Box: A New 24 Head Cabinet for storage of spare sprinkler heads was ordered on August 28th, 2021. Sprinkler head storage cabinet has been received and spare sprinkler heads have been stored appropriately in cabinet to protect them from damage. Monitoring of the submitted plan of correction will be done monthly for the next 6-months through the addition of the correction onto the meeting agenda of InterFaith Care Center's (IFCC) Safety Committee. IFCC's Director of Environmental Services, Chair of IFCC's Safety Committee is the individual responsible to ensure monthly monitoring is completed. IFCC's Safety Committee Minutes are included as part of IFCC's standard Quality Assurance (QA) Meeting monthly agenda. IFCC's monthly QA minutes are a standard informational item reviewed by IFCC's Board of Director's at their every other month meeting. Review of the safety committee minutes	

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K 351	Continued From page 7	K 351	by the QA committee and then the IFCC Board will ensure IFCC's submitted corrections have in fact been completed. Approved Safety Committee Meeting Minutes will be posted for all employees to review.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/27/2021, at 11:00 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that 4 out of the 12 fire drill report documentation	K 712	Fire Drill Signatures on Back of Drill Form: Fire drill report updated 7/30/21 to include name and signature of individual participant. Documentation of fire drill report is located in Maintenance Supervisor Office in binder named "Fire Codes and Life Safety" Monitoring of the submitted plan of correction will be done monthly for the	8/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245024	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/27/2021**

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

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K 712	Continued From page 8 did not contain the names or signatures of the staff member who participated in the drill. This deficient condition was verified by the Maintenance Supervisor.	K 712	next 6-months through the addition of the correction onto the meeting agenda of InterFaith Care Center's (IFCC) Safety Committee. IFCC's Director of Environmental Services, Chair of IFCC's Safety Committee is the individual responsible to ensure monthly monitoring is completed. IFCC's Safety Committee Minutes are included as part of IFCC's standard Quality Assurance (QA) Meeting monthly agenda. IFCC's monthly QA minutes are a standard informational item reviewed by IFCC's Board of Director's at their every other month meeting. Review of the safety committee minutes by the QA committee and then the IFCC Board will ensure IFCC's submitted corrections have in fact been completed. Approved Safety Committee Meeting Minutes will be posted for all employees to review.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or	K 923		8/20/21

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	245024	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/27/2021**

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K 923	Continued From page 9 within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that oxygen cylinders were not being stored in accordance with NFPA 99 Standards for Health Care Facilities 2012 section 11.6.2.3 (11). This deficient condition could have an isolated impact on the residents within the facility. Findings include:	K 923	Oxygen Storage Labels for Empty/Full Containers: New Label/Signage was installed on August 27th, 2021 to identify proper location for storage of tanks in room. Straps/chains were installed on 8/13/21 to	

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	245024	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/27/2021**

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K 923	Continued From page 10 On 07/27/2021 at 11:39 AM, during the facility tour, observations revealed that there was one loose oxygen cylinder located in the oxygen storage room by the Maple unit nurses station that was not properly secured in tip resistant restraint. This deficient condition was verified by the Maintenance Supervisor.	K 923	secure freestanding oxygen tanks to prevent tanks from falling over. Storage room is located next to the nursing station on Maple Unit. Monitoring of the submitted plan of correction will be done monthly for the next 6-months through the addition of the correction onto the meeting agenda of InterFaith Care Center's (IFCC) Safety Committee. IFCC's Director of Environmental Services, Chair of IFCC's Safety Committee is the individual responsible to ensure monthly monitoring is completed. IFCC's Safety Committee Minutes are included as part of IFCC's standard Quality Assurance (QA) Meeting monthly agenda. IFCC's monthly QA minutes are a standard informational item reviewed by IFCC's Board of Director's at their every other month meeting. Review of the safety committee minutes by the QA committee and then the IFCC Board will ensure IFCC's submitted corrections have in fact been completed. Approved Safety Committee Meeting Minutes will be posted for all employees to review.	