August 23, 2019

Administrator
Interfaith Care Center
811 Third Street
Carlton, MN 55718

RE: Project Number H5024017C, H5024018C, H5024019C, H5024020C, H5024021C and H5024022C

Dear Administrator:

On August 8, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy 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 October 27, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 27, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 27, 2019.

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 $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 27, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Interfaith Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 27, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
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
Phone: (218) 302-6151
Fax: (218) 723-2359

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 8, 2020 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services

determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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 08/08/2019

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INTERFAITH CARE CENTER	**811 THIRD STREET CARLTON, MN 55718**

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F 000	INITIAL COMMENTS On 8/7/19 through 8/8/19 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5024018C and H5024020C. The following complaint(s) were found not to be substantiated: H5024019C, H5024017C, H5024022C, and H5024021C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		8/29/19

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

Electronically Signed | 08/29/2019

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F 684	Continued From page 1 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure timely identification, notification of physician, and implementation of appropriate treatment for 1 of 3 residents (R5) reviewed for non-pressure related skin conditions. This failure resulted in actual harm for R5 when the wound deteriorated and became infected. The facility had immediately implemented corrective action 7/29/19, as a result the deficient practice is being issued at past non-compliance. Findings include: R5's quarterly Minimum Data Set (MDS) dated 5/15/19, included severe cognitive impairment with a diagnosis of dementia. R5 required extensive staff assistance for most activities of daily living (ADL's). R5's care plan revised 8/8/19, indicated R5 was at risk for pressure related skin breakdown, required assistance with ADLs, and directed staff to inspect skin daily with routine cares and observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse. In addition, staff were to conduct weekly skin inspections by the nurse on bath days. R5's care plan further directed nursing staff to follow facility protocols for the prevention and treatment of skin breakdown, and administer treatments as ordered and monitor for effectiveness. R5's facility incident report dated 7/29/19,	F 684	Past noncompliance: no plan of correction required.	

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F 684	Continued From page 2	F 684		

included, "On 7/29/19, resident was noted to have an Allevyn gentle border dressing [a type of dressing with a gel adhesive which maintains a moist environment] on rt [right] shin with redness and warmth of skin below dressing. Allevyn was removed and a 2.6 cm [centimeter] x [by] 1.7 cm abrasion was present on rt shin. Wound was 75% moist, pink dermal tissue and 25% slough [dead tissue] tissue with moderate purulent [pus] drainage, foul odor noted. Wound bed flush with surrounding skin. Area of redness surrounding wound 15.3 cm x 4.9 cm, skin slightly warm. RN [registered nurse] cleansed wound with NS [normal saline], applied gauze and wrapped with kerlix [gauze wrap]. Resident reported mild pain to area. There was no treatment order in residents TAR [treatment administration record] for the abrasion. RN updated MD [medical doctor] and requested treatment orders. Family updated along with Nurse manager, administrator and DON [director of nursing]." A follow up report dated 8/5/19, included, "Abrasion originally discovered 7/17/19, Skin event/risk management report was not completed and MD not updated within 24 hrs [hours] of discovery. Treatment initiated 7/17/19 was not a part of facility skin care protocol. Treatment orders were not implemented in TAR." The report went on to identify a dressing change completed after R5's shower on 7/20/19, and the nurse who changed the dressing had not added to the TAR, nor contacted the MD. The report indicated another nurse changed the dressing on 7/26/19, and also did not update MD or add to TAR. It was added to a 24 hour report book. Then on 7/29/19, the wound appeared infected with foul odor, slough and purulent drainage. The physician was notified, the wound was cultured, it was added to

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F 684	Continued From page 3 the TAR, and an antibiotic was initiated. The wound culture showed MRSA (methicillin-resistant staphylococcus aureus- an antibiotic resistant bacteria). Nurses were educated, the policy was reviewed, and the facility placed intervention of the nurse manager reviewing the 24 hour book every day to ensure skin incidences would be documented properly, proper treatments initiated and appropriate personnel/contacts updated. R5's progress notes dated 7/17/19, lacked documentation of a skin abrasion on the right shin. R5's progress note dated 7/19/19, indicated R5's dressing was clean, dry and intact (CDI), and R5 offered no complaints of pain of the right shin. R5's progress note dated 7/20/19, indicated R5 had no signs of pain or infection of the right shin and the dressing was CDI, and a new Allevyn was applied after her shower. There were no progress notes regarding assessment of the wound again until 7/26/19. R5's progress notes lacked further documentation regarding the right shin abrasion, until 7/26/19, when R5's right shin abrasion was observed to be red and painful. R5's abrasion was cleaned and a new Allevyn dressing was applied. R5's progress note dated 7/27/19, indicated R5's dressing was intact and R5 had no complaints of pain.	F 684		

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F 684	Continued From page 4 R5's progress note dated 7/29/19, at 8:25 p.m. documented the right shin abrasion (originally identified on 7/18/19), measured 1.5 cm x 2 cm when identified, and on 7/26/19, an Allevyn dressing was applied over the area. R5's progress note indicated on 7/29/19, a nursing assistant (NA) alerted a nurse of redness located below the dressing that had not been present a few days prior. The dressing was removed and revealed R5's wound measured 2.6 centimeters (cm) x 1.7 cm with a moderate amount of foul smelling, purulent drainage. R5 had slightly warm, redness around the wound measuring 15.3 cm x 4.9 cm and extended down the leg toward R5's foot. R5 complained of some increased pain to the area. R5's physician was sent a fax notification and treatment orders requested. R5's progress notes dated 8/1/19, indicated R5's redness around the right shin wound had not increased in size, but had not improved, remained slightly warm and tender to touch with a minimal amount of tan, bloody drainage, but was no longer foul smelling. R5's physician was faxed an update and orders for a culture were requested. R5's progress note dated 8/2/19, indicated a culture had been obtained from R5's right shin wound, and new treatment orders were obtained. R5's progress note dated 8/4/19, indicated the physician was notified of R5's wound culture results being MRSA positive, and an order was received Bactrim DS. R5's progress note indicated R5 was on, "precautions" (to prevent the spread of MRSA to other residents and staff).	F 684		

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F 684	Continued From page 5 R5's right shin remained reddened and painful with a scant amount of drainage. R5's progress note dated 8/6/19, indicated R5's right shin wound was improving. R5's interdisciplinary team (IDT) progress note dated 8/7/19, indicated the IDT had met on 8/2/19, to review R5's skin incident discovered on 7/29/19. The notes indicated on 7/29/19, a NA noted R5 to have an Allevyn dressing on right shin, with red and warm skin below the dressing. The NA informed the supervisor who assessed, cleansed and dressed R5's right shin wound, and updated the physician and R5's resident representative. The IDT reviewed the physician orders and resident condition, contact precautions had been implemented and an investigation was initiated. The IDT reviewed the investigation which revealed an abrasion on R5's right shin was identified on 7/17/19, and R5 had no pain or concerns at that time, but was unable to identify the cause of the abrasion at that time. The registered nurse (RN) had added R5's wound to the 24 hour report to be monitored for 9 shifts, but did not document in R5's progress notes, initiate a skin event or risk management report. R5's right shin wound was monitored until the p.m. on 7/20/19, when a new Allevyn dressing was applied. The investigation indicated there was no treatment in the treatment administration record for the Allevyn dressing. On 7/26/19, R5 was added back on the 24 hour report book, and progress notes indicated R5's right shin abrasion was red and painful, and a new Allevyn dressing was applied after cleansing the wound. The physician and resident representative were not updated. On 7/29/19,	F 684		

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F 684	Continued From page 6 R5's right shin wound had worsened, and at that time the RN followed the facility protocol for initiating treatment and change of condition reporting. The physician and family representative were notified and R5 was then started on an appropriate treatment, and R5's right shin wound improved. R5's IDT notes indicated the facility had educated the nurses. On 8/7/19, at 2:10 p.m. R5 was sitting in the day area by the bird aviary with a dressing on her right leg. R5's room doorway had a sign posted for precautions. On 8/8/19, at 11:22 a.m. RN-B performed a dressing change according to physician orders on R5's right shin. R5's dressing had a small amount of green purulent drainage without odor. RN-C stated R5's skin surrounding the open area was reddened and said it was slightly warm. RN-B stated R5's wound was improving. On 8/8/19, at 12:09 p.m. RN-A stated R5's wound had not been reported to the physician, and it was put on the 24 hours report for 3 days and then fell off report. R5's wound was not identified as a concern until 7/29/19, though a dressing had been put on R5's right shin wound on 7/26/19. RN-A stated a skin event report and risk management report should have been done and the treatment put on the TAR, when it was identified. RN-A stated the nurses involved were re-educated, and a unit education is planned, as well. RN-A stated R5 had developed an MRSA infection in the wound and stated the infection most likely would not have happened if it had been treated and followed up on appropriately.	F 684		

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F 684	Continued From page 7 On 8/8/19, at 1:28 p.m. director of nursing, DON stated two nurses put dressings on R5's right shin wound, didn't identify it, and didn't follow protocol, and didn't have orders for the Allevyn dressing. The DON stated they had developed a new employee checklist which included the wound care protocol on the checklist. The facility policy and procedure for Addendum to Change of Condition/Incident Report Policy dated 8/16, directed staff to follow the incident report procedure for all skin tears, investigate the incident and staff statements, follow 24 hour change of condition policy, notify family, physician, administrator, DON, nurse manager, complete the white skin sheet, document in the electronic medical record (EMR) until healed. The facility Skin Procedure dated 5/15, directed staff to assess skin daily with ADLs and report to floor nurse any area of concern. The nurse was directed to assess skin weekly on bath day, and update skin sheets. The facility policy and procedure for Change in condition revised 4/15, directed staff to put all changes in condition on the 24-hour report for follow up, including any change in skin integrity, which was to be assessed and reported to physician in a timely manner either verbally or written, and family. Although the facility failed to ensure R5's wound was identified and care implemented in a timely manner. On 7/29/19, when the infected wound was identified, the facility immediately sought medical care for the resident, initiated an error report and met with nurses involved. Education	F 684		

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F 684	Continued From page 8 for all nurses involved was provided. Facility policies for treatment, condition change and risk management were reviewed. The facility initiated nurse manager review of the 24 hour book every day to ensure skin incidences were documented properly, proper treatments initiated and appropriate personnel/contacts updated. The facility's corrective action was verified during the onsite survey on 8/8/19 as having been implemented 7/29/19 therefore, this deficient practice is being cited at Past Non-compliance.	F 684		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were free of significant medication errors for 2 of 3 residents (R6 and R8) observed who received daily dose of insulin. This deficient practice resulted in actual harm for R6, when he became dizzy, lightheaded, experienced altered level of consciousness and required administration of intravenous (IV) glucose and oral glucose to normalize his blood sugar. Findings include: R6's quarterly Minimum Data Set (MDS) assessment dated 7/18/19, indicated R6 had diagnoses which included type two Diabetes Mellitus, atrial fibrillation and seizure disorder. The MDS indicated R6 had moderate cognitive impairment and required assist with activities of	F 760	Correction for Residents Affected: R6 and R8's physician's orders for insulin were reviewed and updated to include specific, individualized, resident centered administration parameters. Correction as it Applies to other Residents: 100% Audit was conducted of all physician's insulin orders to ensure they included specific, individualized, resident centered administration parameters. An "order set" was added to the EMAR that allows for resident specific interventions including high and low blood glucose administration parameters and administration with meals.	9/13/19

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	245024	A. BUILDING _____ B. WING _____	C 08/08/2019

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 760	Continued From page 9 daily living, and supervision for eating. Further, the MDS indicated R6 received a daily dose of insulin. R6's care plan, dated 5/7/19, indicated R6 had diabetes. R6's goals included to be free from any signs and symptoms of hypoglycemia (low blood sugar). Interventions included to observe for signs and symptoms of altered glucose metabolism, administer anti-diabetic medication as ordered by the physician, and blood glucose checks as ordered by the physician. During interview on 8/8/19, at 9:09 a.m. R6 stated on 7/25/19, he had told facility staff he would be going out shopping with his son for a recliner for his wife. R6 stated the staff gave him insulin even though he would not be having lunch until after returning to the facility. R6 stated while at the furniture store he became tired and fell asleep in a chair and his son called the ambulance. R6's Emergency Department(ED) Note, dated 7/25/19, indicated R6 had been in a store shopping with his son, when he became faint, dizzy, lightheaded, sat down in a chair and began staring into the distance. Emergency Medical Services (EMS) was called, and upon arrival R6's blood sugar was found to be 28. EMS administered IV dextrose (D50) and oral glucose in the form of lemonade. He was transferred to the ED for evaluation. In the ED his blood sugar had increased to 98, and it was reported R6 had been administered 8 units of insulin before lunch, yet accidentally forgot to eat lunch today after receiving his insulin, as his son picked him up to go shopping. R6 was discharged back to the	F 760	All facility licensed staff were re-inserviced on following physician's orders, fully understanding each insulin order and medication error procedures. Prevention of reoccurrence: The facility policies and procedures for medication administration including insulin administration were reviewed and updated as needed. All facility licensed staff were re-inserviced on following physician's orders, fully understanding each insulin order and medication error procedures. All facility licensed staff were re-inserviced on the most current pharmacy manual and where to locate information when needed. Monitoring: A review of Insulin orders has been added permanently to the agenda of the Interdisciplinary weekly meeting. This includes review of administration parameters, accuracy in following orders and recommendations for physician review. Findings will be reported to QA monthly by DON/designee. Medication & Treatment completion will be monitored using the Medication Administration Audit Report from our	

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F 760	Continued From page 10 nursing home with instructions to monitor glucose carefully, ensuring he does not miss any meals. R6's Physician's Orders dated 7/11/19, indicated R6 was prescribed a NovoLOG insulin pen (fast acting insulin) to be administered 8 units with meals at 8:00 a.m., 12:00 p.m., and 6:00 p.m. R6's Medication Administration Record (MAR) July 2019, listed on 7/25/19 R6 had been administered 8 units of NovoLOG insulin at 12:00 p.m. A progress note dated 7/25/19, at 4:41 p.m. indicated R6's son called the facility to report he had called 911 and was waiting for an ambulance to arrive because R6 had become somnolent. The son stated the ambulance arrived and his blood sugar was found to be 28. The ambulance service transported R6 to a local hospital emergency room (ER) per the son's request. The progress note further indicated R6's medical chart was reviewed and it revealed R6's last blood glucose was done right before lunch when his blood sugar was 188, he received his scheduled 8 units of Novolog. This AM at breakfast he was 169 (blood sugar) and received Novolog 8 units along with his Lantus 15 units. Computer documentation revealed that he ate 100% at both meals. However, the son had arrived to pick the resident up before he'd eaten. On 8/8/19, at 1:27 p.m. an interview was conducted with the director of nursing (DON). The DON stated she was made aware of the medication administration error at the time it occurred. DON indicated when she reviewed R6's record, she found the facility staff had also	F 760	EMAR that identifies all missed medications or treatments. Nurse Managers will review the report daily at AM meeting for 90 days followed by weekly for 90 days and report findings to QA committee to determine compliance and need for further monitoring.	

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F 760	Continued From page 11	F 760		

inaccurately documented R6 had eaten 100% of the noon meal, even though he was not in the facility for lunch. DON confirmed she considered the medication error for R6 a significant medication error. Further, DON stated if the facility had followed the physician's orders and documented appropriately, R6 may not have experienced a hypoglycemic episode which lead to being treated in the ER.

R8's quarterly MDS dated 6/12/19, included he was cognitively intact, had a diagnosis of diabetes and received insulin daily.

R8's physician orders directed blood glucose monitoring four times a day. Novolog (fast acting insulin) 12 units with meals and Lantus insulin daily. There was an order to hold the Novolog insulin if blood glucose was less than 130.

R8's insulin administration and blood glucose records indicated on 7/29/19, at 7:00 a.m. R8's blood sugar reading was 108, and R8's Novolog insulin was administered despite the order to hold the insulin if blood sugar under 130. R8's blood sugar result on 7/29/19, at 11:00 a.m. was 174 and R8's progress notes did not show any adverse effects of receiving the insulin in error.

On 8/7/19, at 2:15 p.m. R8 was sitting in his room in a wheelchair. R8 stated his blood sugars have been in the 100's recently and have been stable. R8 stated his blood sugars were running high, but they adjusted his insulin and stated he had no low blood sugars. R8 stated he eats regularly, but not too much.

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F 760	Continued From page 12 On 8/7/19, at 3:49 p.m. DON verified the Medication administration notes and Medication Administration Record indicated R8 received insulin on 7/29/19, at 7:46 a.m. and R8's blood sugar was below 130 at 108, so should not have received insulin. On 8/8/19, at 8:58 a.m. R8 was eating breakfast and stated he has eaten the same breakfast every day for the past 5 years. R8 ate all his breakfast and drank all his liquids. On 8/8/19, registered nurse (RN)-B stated R8's blood sugar was 154 that morning and received his insulin. RN-B stated she gives insulin 15 minutes before eating or within 15 minutes after eating. RN-B stated R8 showed symptoms of hypoglycemia at times, and then she checks his blood sugar. RN-B stated if it is a resident who does not always eat well, she will make sure they eat before giving the insulin. RN-B stated R8 has parameters to hold insulin if it is under 130, so would hold it if it were below 130. The facility's 7/2018 policy, Medication and Treatment Errors, directed staff to recognize errors as any variation in administration of medication from the physician's orders. The facility 8/8/19 training, Insulin Administration, directed nursing staff, "NOT to administer short/fast acting insulin to a resident until you know they are going to eat." The direction further accentuated the importance of fully understanding and implementing each insulin order.	F 760		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 23, 2019

Administrator
Interfaith Care Center
811 Third Street
Carlton, MN 55718

Re: State Nursing Home Licensing Orders - Complaint Number H5024017C, H5024018C, H5024019C, H5024020C, H5024021C and H5024022C

Dear Administrator:

A complaint investigation was completed on August 8, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited violation. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
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
Phone: (218) 302-6151
Fax: (218) 723-2359

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/7/19-8/8/19 an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found not to be in compliance with the MN state licensure. The following complaints were found to be	2 000		

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2 000	Continued From page 1 substantiated: H5024020C H5024018C The following complaint(s) were found not to be substantiated: H5024019C H5024017C H5024022C H5024021C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that	21545		9/13/19

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21545	Continued From page 2 usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were free of significant medication errors for 2 of 3 residents (R6 and R8) observed who received daily dose of insulin. This deficient practice resulted in actual harm for R6, when he became dizzy, lightheaded, experienced altered level of consciousness and required administration of intravenous (IV) glucose and oral glucose to normalize his blood sugar. Findings include:	21545	Correction for Residents Affected: R6 and R8's physician's orders for insulin were reviewed and updated to include specific, individualized, resident centered administration parameters. Correction as it Applies to other Residents: 100% Audit was conducted of all physician's insulin orders to ensure they included specific, individualized, resident	

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21545	Continued From page 3 R6's quarterly Minimum Data Set (MDS) assessment dated 7/18/19, indicated R6 had diagnoses which included type two Diabetes Mellitus, atrial fibrillation and seizure disorder. The MDS indicated R6 had moderate cognitive impairment and required assist with activities of daily living, and supervision for eating. Further, the MDS indicated R6 received a daily dose of insulin. R6's care plan, dated 5/7/19, indicated R6 had diabetes. R6's goals included to be free from any signs and symptoms of hypoglycemia (low blood sugar). Interventions included to observe for signs and symptoms of altered glucose metabolism, administer anti-diabetic medication as ordered by the physician, and blood glucose checks as ordered by the physician. During interview on 8/8/19, at 9:09 a.m. R6 stated on 7/25/19, he had told facility staff he would be going out shopping with his son for a recliner for his wife. R6 stated the staff gave him insulin even though he would not be having lunch until after returning to the facility. R6 stated while at the furniture store he became tired and fell asleep in a chair and his son called the ambulance. R6's Emergency Department(ED) Note, dated 7/25/19, indicated R6 had been in a store shopping with his son, when he became faint, dizzy, lightheaded, sat down in a chair and began staring into the distance. Emergency Medical Services (EMS) was called, and upon arrival R6's blood sugar was found to be 28. EMS administered IV dextrose (D50) and oral glucose in the form of lemonade. He was transferred to	21545	centered administration parameters. An "order set" was added to the EMAR that allows for resident specific interventions including high and low blood glucose administration parameters and administration with meals. All facility licensed staff were re-inserviced on following physician's orders, fully understanding each insulin order and medication error procedures. Prevention of reoccurrence: The facility policies and procedures for medication administration including insulin administration were reviewed and updated as needed. All facility licensed staff were re-inserviced on following physician's orders, fully understanding each insulin order and medication error procedures. All facility licensed staff were re-inserviced on the most current pharmacy manual and where to locate information when needed. Monitoring: A review of Insulin orders has been added permanently to the agenda of the Interdisciplinary weekly meeting. This includes review of administration parameters, accuracy in following orders and recommendations for physician review. Findings will be reported to QA	

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21545	Continued From page 5	21545		

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(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) COMPLETE DATE
21545	Continued From page 6 no low blood sugars. R8 stated he eats regularly, but not too much. On 8/7/19, at 3:49 p.m. DON verified the Medication administration notes and Medication Administration Record indicated R8 received insulin on 7/29/19, at 7:46 a.m. and R8's blood sugar was below 130 at 108, so should not have received insulin. On 8/8/19, at 8:58 a.m. R8 was eating breakfast and stated he has eaten the same breakfast every day for the past 5 years. R8 ate all his breakfast and drank all his liquids. On 8/8/19, registered nurse (RN)-B stated R8's blood sugar was 154 that morning and received his insulin. RN-B stated she gives insulin 15 minutes before eating or within 15 minutes after eating. RN-B stated R8 showed symptoms of hypoglycemia at times, and then she checks his blood sugar. RN-B stated if it is a resident who does not always eat well, she will make sure they eat before giving the insulin. RN-B stated R8 has parameters to hold insulin if it is under 130, so would hold it if it were below 130. The facility's 7/2018 policy, Medication and Treatment Errors, directed staff to recognize errors as any variation in administration of medication from the physician's orders. The facility 8/8/19 training, Insulin Administration, directed nursing staff, "NOT to administer short/fast acting insulin to a resident until you know they are going to eat." The direction further accentuated the importance of fully understanding and implementing each insulin order.	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00047	A. BUILDING: _____ B. WING _____	C 08/08/2019

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21545	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The administrator, DON, and consulting pharmacist could review and revise policies and procedures for appropriate medication administration , including insulin administration and educate staff. The DON or designee, could audit medication administration and take those results to the Quality Assurance Performance Improvement (QAPI) committee for a set amount of time to determine compliance and the need for further monitoring. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21545		