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	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Interfaith Care Center	811 Third Street Carlton, MN 55718

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to honor residents right to refuse medications for 1 of 3 residents reviewed (R1) when she was administered morphine after telling staff she did not want the medication.R1's admission Record indicated she admitted to the facility on [DATE]. Diagnosis included Malignant neoplasm of breast, hypertension, dementia, depression and anxiety. R1's Brief Interview for Mental Status dated 10/8/25, identified a score of seven which indicated severe cognitive impairment.R1's care plan dated 7/2525, identified impaired cognition and indicated she was at high risk for being exploited by others and would not be able to accurately report if abused. The care plan indicated staff would intervene on R1's behalf if abuse was suspected, witnessed or reported. The care plan identified behaviors that included calling out and refusal of medications. The care plan directed staff to allow R1 to make decisions about her treatment regime as able and to provide a sense of control and directed if R1 resisted cares or medication, reassure her, leave and return later to try again.An Employee Statement Form dated 10/10/25, indicated nursing assistant (NA)-B heard R1 yelling out and asked her what was wrong and the nurse, registered nurse (RN)-C, said she was going to give R1 pain medication. While trying to calm R1 down, RN-C approached R1 to give pain medication and R1 said no and kept turning her head. RN-C was yelling at NA-B and said to hold R1's hands down, then put the medication in R1's mouth. NA-B wrote, R1 called RN-C a name and said, she gave me meds [medications] I didn't want, and asked NA-B why she didn't say anything.An Employee Statement Form written by dietary aide (DA)-A, dated 10/10/25, indicated R1 had been yelling help and seemed really upset and when asked, said I'm sick of being tied down. DA-A reported RN-C walked by and said, you're not tied down, ha ha ha and laughed at R1 to her face while she was distressed.During interview on 10/16/25 at 8:38 a.m., the activities director (AD) stated DA-A had reported the incident to her on Monday or Tuesday and let her know she had filed a report on RN-C the previous Friday. The AD said DA-A was disturbed about how the RN-C had basically forced R1 to take Morphine after saying no. The AD said she had spoken to the nurse who was on-call, RN-A, who reported she had been aware of the incident.During interview on 10/16/25 at 9:45 a.m., RN-A stated she had been the nurse on call the night of the incident and said she had received a call from the scheduler that some staff were upset because of the way RN-C had administered R1's morphine. RN-A said she called the unit and talked to RN-C who said R1 had been hollering out for 15 - 30 minutes, was not re-directable and was in a lot of pain. RN-A said RN-C told her she went to administer Morphine to R1 and R1 said no and swatted her hand away. RN-A said RN-C told her she had a nursing assistant (NA) hold R1's arms out of the way to get the morphine into her mouth. RN-A said she felt RN-C was using her nursing judgement because she felt R1 needed pain medication.During interview on 10/16/25 at 11:48 a.m., the DON stated RN-A had called her on Friday evening and reported to her a staff member had been upset about the situation with RN-C and R1. The DON stated RN-A told her RN-C had held R1's hands down to give her pain medications and staff were very upset. The DON stated per facility policy, restraints were not used in the facility.Facility policy Physical Device Policy/Restraints dated 5/1/25, indicated the facility used the least restrictive device possible for the resident to ensure residents were free form physical or chemical restraints imposed for purposes of discipline or staff convenience.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure residents reserved the right to remain free from restraints for 1 of 3 resident (R1) when staff held her hands and administered morphine against her wishes. R1's admission Record indicated she admitted to the facility on [DATE]. Diagnosis included Malignant neoplasm of breast, hypertension, dementia, depression and anxiety. R1s Brief Interview for Mental Status dated 10/8/25, identified a score of seven which indicated severe cognitive impairment.R1's care plan dated 7/2525, identified impaired cognition and indicated she was at high risk for being exploited by others and would not be able to accurately report if abused. The care plan indicated staff would intervene on R1's behalf if abuse was suspected, witnessed or reported. The care plan identified behaviors that included calling out and refusal of medications. The care plan directed staff to allow R1 to make decisions about her treatment regime as able and to provide a sense of control and directed if R1 resisted cares or medication, reassure her, leave and return later to try again.R1's Order Summary Report dated 10/17/25, identified an order for Morphine Sulfate oral solution 20 milligrams (mg) per milliliter. Give 10 mg by mouth every two hours as needed for pain.An Employee Statement Form dated 10/10/25, indicated Staff heard R1yelling out and asked her what was wrong and the nurse, registered nurse (RN)-C, said she was going to give R1 pain medication. While trying to calm R1 down, RN-C approached R1 to give pain medication and R1 said no and kept turning her head. RN-C was yelling at the staff member and said to hold R1's hands down, then put the medication in R1's mouth. The staff member wrote, R1 called RN-C a name and said, she gave me meds [medications] I didn't want, and asked the staff why she didn't say anything.An Employee Statement Form dated 10/10/25, indicated R1 had been yelling help and seemed really upset and when asked, said I'm sick of being tied down. The staff reported RN-C walked by and said you're not tied down, ha ha ha and laughed at R1 to her face while she was distressed.During interview on 10/15/25 at 3:58 a.m., nursing assistant (NA)-A stated R1 required total care and said she usually went to bed late because she liked to crawl out of bed. NA-A said R1 did not usually complain about pain but said I think she could tell us.During interview on 10/15/25 at 4:09 p.m., trained medication aide (TMA)-A said R1 was usually very pleasant. TMA-A said he felt R1's pain was well controlled with scheduled pain medications. During interview on 10/15/25 at 4:17 p.m. , licensed practical nurse (LPN)-A stated R1 was usually pretty happy and did not get upset very often. LPN-A said R1's pain was pretty well controlled, and he did not often need to use as needed medications. LPN-A said if R1 was hurting, she would tell staff, would say ow and became a little more down. During interview on 10/15/25 at 4:32 p.m., dietary aide (DA)-A stated on Friday evening, October 10th 2025, around 7:00 p.m., she was on R1's unit and as she was going down the hall, R1 was sitting with a NA at the charting desk which was unusual. DA-A said the aide was holding R1's hand and comforting R1 who was yelling help, which was not unusual. DA-A stated she asked R1 what was wrong and R1 said she was sick of being tied down here. DA-A said she talked to some of the other NA's and they told her the nurse on the unit, RN-C made one of the staff hold down R1's hands to administer medication. DA-A said the NA was very upset and said R1 told her she was scared and felt unsafe. DA-A said RN-C walked by and said no one is trying to tie you down and then laughed about it. DA-A said she had filled out a grievance form. During interview on 10/16/25 at 8:38 a.m., the activities director (AD) stated DA-A had reported the incident to her on Monday or Tuesday and let her know she had filed a report on RN-C the previous Friday. The AD said DA-A was disturbed about how the RN-C had basically forced R1 to take Morphine after saying no. The AD said she had spoken to the nurse who was on-call, RN-A, who reported she had been aware of the incident. During interview on 10/16/25 at 9:45 a.m., RN-A stated she had been the nurse on call the night of the incident and said she had received a call from the scheduler that some staff were upset because of the way RN-C had administered R1's morphine. RN-A said she called the unit and talked to RN-C who said R1 had been hollering out for 15 - 30 minutes, was not re-directable and was in a lot of pain. RN-A said RN-C told her she went to administer Morphine to R1 and R1 said no and swatted her hand away. RN-A said RN-C told her she had a NA hold R1's arms out of the way to get the morphine into her mouth. RN-A said she reported the incident to the director of nursing (DON) and the administrator that night via e-mail. RN-A stated staff should never restrain a resident. During interview on 10/16/25 at 9:57 a.m., RN-B stated R1 had behaviors at times that included yelling out, had some care refusals and would swing her arms up at times but that was about all. RN-B said R1 sometimes displayed pain in different ways but did not actually report pain. RN-B said R1

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to report an allegation of abuse to the state agency (SA) for 1 of 3 residents (R1) reviewed who was physically restrained by staff and administered medication against her wishes.R1's admission Record indicated she admitted to the facility on [DATE]. Diagnosis included Malignant neoplasm of breast, hypertension, dementia, depression and anxiety. R1's Brief Interview for Mental Status dated 10/8/25, identified a score of seven which indicated severe cognitive impairment.R1's care plan dated 7/2525, identified impaired cognition and indicated she was at high risk for being exploited by others and would not be able to accurately report if abused. The care plan indicated staff would intervene on R1's behalf if abuse was suspected, witnessed or reported. The care plan identified behaviors that included calling out and refusal of medications. The care plan directed staff to allow R1 to make decisions about her treatment regime as able and to provide a sense of control and directed if R1 resisted cares or medication, reassure her, leave and return later to try again.R1's Order Summary Report dated 10/17/25, identified an order for Morphine Sulfate oral solution 20 milligrams (mg) per milliliter. Give 10 mg by mouth every two hours as needed for pain.An Employee Statement Form dated 10/10/25, indicated Staff heard R1 yelling out and asked her what was wrong and the nurse, registered nurse (RN)-C, said she was going to give R1 pain medication. While trying to calm R1 down, RN-C approached R1 to give pain medication and R1 said no and kept turning her head. RN-C was yelling at the staff member and said to hold R1's hands down, then put the medication in R1's mouth. The staff member wrote, R1 called RN-C a name and said, she gave me meds [medications] I didn't want, and asked the staff why she didn't say anything.An Employee Statement Form dated 10/10/25, indicated R1 had been yelling help and seemed really upset and when asked, said I'm sick of being tied down. The staff reported RN-C walked by and said, you're not tied down, ha ha ha and laughed at R1 to her face while she was distressed.During interview on 10/16/25 at 11:48 a.m., the director of nursing (DON) stated she had been contacted over the weekend by staff who were upset about the way RN-C had administered medication to R1. The DON said the on- call nurse, RN-A reported she had spoken to RN-C. RN-C reported to RN-A, she had staff hold R1's hands to administer medication. RN-A told DON staff had been very upset. The DON stated she considered holding a resident's hands down to administer medication a restraint. The DON said the incident was not reported to the SA because RN-A had spoken to RN-C and did not feel she intended to be malicious when administering the medications. Facility policy Abuse Prevention Plan dated 2024, indicated all residents residing in the facility will be protected from Maltreatment. Suspected abuse of any kind needs to be reported IMMEDIATELY (within 2 hours) and any other suspected maltreatment needs to be reported IMMEDIATELY (within 24 hours).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to thoroughly investigate an allegation of abuse for 1 of 3 residents (R1) who was physically restrained and administered morphine against her wishes. In addition, the facility failed to implement measures to protect other residents from the alleged abuse.R1's admission Record indicated she admitted to the facility on [DATE]. Diagnosis included Malignant neoplasm of breast, hypertension, dementia, depression and anxiety. R1s Brief Interview for Mental Status dated 10/8/25, identified a score of seven which indicated severe cognitive impairment.R1's care plan dated 7/2525, identified impaired cognition and indicated she was at high risk for being exploited by others and would not be able to accurately report if abused. The care plan indicated staff would intervene on R1's behalf if abuse was suspected, witnessed or reported. The care plan identified behaviors that included calling out and refusal of medications. The care plan directed staff to allow R1 to make decisions about her treatment regime as able and to provide a sense of control and directed if R1 resisted cares or medication, reassure her, leave and return later to try again.R1's Order Summary Report dated 10/17/25, identified an order for Morphine Sulfate oral solution 20 milligrams (mg) per milliliter. Give 10 mg by mouth every two hours as needed for pain.An Employee Statement Form dated 10/10/25, indicated Staff heard R1yelling out and asked her what was wrong and the nurse, registered nurse (RN)-C, said she was going to give R1 pain medication. While trying to calm R1 down, RN-C approached R1 to give pain medication and R1 said no and kept turning her head. RN-C was yelling at the staff member and said to hold R1's hands down, then put the medication in R1's mouth. The staff member wrote, R1 called RN-C a name and said, she gave me meds [medications] I didn't want, and asked the staff why she didn't say anything.An Employee Statement Form dated 10/10/25, indicated R1 had been yelling help and seemed really upset and when asked, said I'm sick of being tied down. The staff reported RN-C walked by and said you're not tied down, ha ha ha and laughed at R1 to her face while she was distressed.During interview on 10/16/25 at 11:48 a.m., the director of nursing (DON) stated she had been contacted over the weekend by staff who were upset about the way RN-C had administered medication to R1. The DON said the on- call nurse, RN-A reported she had spoken to RN-C. RN-C told RN-A she had staff hold R1's hands to administer medication. RN-A told DON staff had been very upset. The DON stated she considered holding a resident's hands down to administer medication a restraint. The DON stated she had not spoken with RN-C following the incident and said RN-C worked the day after. The DON said the facility had other complaints about RN-C and she was no longer working at the facility. The DON said she had not had a chance to talk to any of the staff who worked the day of the incident, nor had she followed up with R1. The DON stated typically following an allegation of abuse, the facility would investigate the incident.Facility policy Abuse Prevention Plan dated 2024, indicated All residents, alleged perpetrator(s), and staff members will protected from harm and retaliation during any and all investigations. If a staff member is considered to be an alleged perpetrator in an incident that staff member will be placed on suspension pending the investigation outcome. Other interventions could include reassignment of staff, working in pairs, separation of residents, room changes, and/or supervised visitation for residents with visitors. Staff will respond immediately to protect the alleged victim, integrity of the investigation, and examine the alleged victim for any sign of injury (physical, emotional, psychological, etc.). The policy indicated staff will investigate all incidents such as falls, bruises, medication errors, resident complaints, etc. Monday through Friday during normal business hours and all incidents will be reviewed with the following disciplines via the Inter-Disciplinary Team: nursing, social services, activities, dietary, therapies, and administration. After normal business hours, the RN Supervisor will contact Social Services Director, DON, and/or Administrator regarding all potential incidents of maltreatment if unsure of further actions to take.