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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0NYF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 29763

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245624**

2. STATE VENDOR OR MEDICAID NO. (L2) **969408200**

3. NAME AND ADDRESS OF FACILITY
(L3) **INTERLUDE**
(L4) **2775 CAMPUS DRIVE NORTH**
(L5) **PLYMOUTH, MN** (L6) **55441**

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 **6/30/2016** (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)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (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
___ 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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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 :
Gloria Derfus, Unit Supervisor 07/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/12/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
04/08/2015
(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.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245624

July 12, 2016

Mr. Greg Baumberger, Administrator
Interlude
2775 Campus Drive North
Plymouth, MN 55441

Dear Mr. Baumberger:

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 June 20, 2016 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

July 12, 2016

Mr. Greg Baumberger, Administrator
Interlude
2775 Campus Drive North
Plymouth, MN 55441

RE: Project Number S5624001

Dear Mr. Baumberger:

On May 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 12, 2016 that included an investigation of complaint number H5624001. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 30, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 24, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 12, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 20, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 12, 2016, effective June 20, 2016 and therefore remedies outlined in our letter to you dated May 26, 2016, will not be imposed.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245624 Y1	A. Building B. Wing Y2	6/30/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERLUDE	2775 CAMPUS DRIVE NORTH PLYMOUTH, MN 55441

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0226	Correction	ID Prefix F0241	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.15(a)	Completed
LSC	06/20/2016	LSC	05/13/2016	LSC	06/20/2016
ID Prefix F0333	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.25(m)(2)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	06/20/2016	LSC	06/20/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	7/12/2016	18623	6/30/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/12/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245624 (Y1)	A. Building 01 - INTERLUD RESTORATIVE SUITES B. Wing (Y2)	6/24/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERLUDE	2775 CAMPUS DRIVE NORTH PLYMOUTH, MN 55441

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 06/03/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 06/13/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/kfd	**DATE** 7/12/2016	**SIGNATURE OF SURVEYOR** 37009	**DATE** 6/24/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 5/11/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0NYF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 29763

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245624**

2. STATE VENDOR OR MEDICAID NO. (L2) **969408200**

3. NAME AND ADDRESS OF FACILITY
(L3) **INTERLUDE**
(L4) **2775 CAMPUS DRIVE NORTH**
(L5) **PLYMOUTH, MN** (L6) **55441**

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 **05/12/2016** (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)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

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
	50			
(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 :
Jacob Mabera, HFE NE II 06/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/06/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
04/08/2015
(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.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1081

May 26, 2016

Mr. Greg Baumberger, Administrator
Interlude
2775 Campus Drive North
Plymouth, MN 55441

RE: Project Number S5624001

Dear Mr. Baumberger:

On May 12, 2016, a standard survey was completed at your facility by the Minnesota Departments 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. In addition, at the time of the May 12, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5624001 that was substantiated.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 21, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 21, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by August 12, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 November 12, 2016 (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.

INFORMAL DISPUTE RESOLUTION

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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

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
	245624	A. BUILDING _____ B. WING _____	C 05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERLUDE	2775 CAMPUS DRIVE NORTH PLYMOUTH, MN 55441

(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
F 000	INITIAL COMMENTS The facility's plan of correction (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 form will be used as verifcation of compliance. Upon receipt of an acceptable 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. An investigation of complaint, H5624001 was completed. The complaint was substantiated. Deficiency(ies) issued at F333.	F 000	RECEIVED JUN 17 2016 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess for safe practice of self-administration (SAM) of Albuterol inhaler medication (an inhalation treatment of respiratory medication) for 1 of 2 residents (R269) observed with Albuterol inhaler medication at bedside. Findings include: During random observations on 5/9/16, at 5:31	F 176	See attached sheet for plan of correction accepted 6-17-16	6/20/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Greg Nauenberger — TITLE: Administrator — (X6) DATE: 6/16/16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245624	A. BUILDING _____ B. WING _____	C 05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERLUDE	2775 CAMPUS DRIVE NORTH PLYMOUTH, MN 55441

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F 176	Continued From page 1 p.m. in R269's room observed an albuterol HFA (Hydrofluoroalkane-a propellant in the inhaler) inhaler was observed on top of R269's night stand. When asked if she uses the albuterol HFA inhaler that was observed at bedside, R269 stated she uses the albuterol inhaler independently once or twice a day for wheezing. On 5/10/16, at 10:22 a.m. during another observation in R269's room, observed an albuterol HFA inhaler on top of R269's night stand. R269's admission Minimum Data Set dated 3/24/16, indicated R269's diagnoses included anemia, hypertension and anxiety. Review of R269's medical record revealed a SAM assessment dated 4/25/16, the evaluation part of the assessment was left blank and in the comments section of the assessment it indicated "Guest would prefer nursing staff to administer all medications during her stay." R269's care plan dated 4/24/16, was reviewed and the care plan did not address R269's SAM. R269's Order Summary Report dated 5/12/16, directed albuterol sulfate HFA Aerosol solution 108 microgram two puff inhale orally as needed for shortness of breath four times a day, with instructions "OK TO KEEP AT BEDSIDE AND SELF ADMINISTER." However, review of R269's medical record lacked an assessment to evaluate R269's ability to safely administer the medication. On 5/10/16, registered nurse (RN)-D verified the albuterol inhaler for R269 was kept at bedside and R269 self-administered the medication. RN-D acknowledged that R269 did not have a	F 176		

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F 176	Continued From page 2 SAM assessment completed to ensure that R269 was safe to administer albuterol medication that was kept at bedside. During interview on 5/10/16, at 3:15 p.m. RN-C stated that all sections of the SAM assessment needed to filled out and the evaluation section of the assessment needs to be completed with all 16 sections of the evaluation filled out. RN-C verified that R269 did not have a SAM assessment completed to ensure that R269 was safe to administer albuterol medication that was kept at bedside. On 5/12/16, at 9:37 a.m., the facility's director of nursing (DON) stated the expectation was for an assessment to be completed to assess if resident is safe to SAM. DON further stated if resident has been assessed to be safe to SAM, a physician order should be obtained for SAM and SAM included in the plan of care. Self Administration Of Medication policy modified 4/2016, directed: 1. A self administration of medication assessment has to be completed any time a resident is requesting to self administer any medications without the direct supervision of a nurse. "2. After the assessment is completed, the interdisciplinary team reviews the assessment to determine that the resident is safe to self-administer. 12. The nurse must educate the resident on the proper use of medications, which will be documented in the resident's medical record. 13. The resident's care plan must be updated to reflect self-administration of medications."	F 176		
F 226	483.13(c) DEVELOP/IMPLMENT	F 226	see attached sheet for plan of correction	5/13/16

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F 226 SS=C	Continued From page 3 ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse policy to ensure professional references were completed for 1 of 5 newly hired employees (E-1). Findings include: Reference Checks: Review of employee roster revealed E-1 was hired on 2/18/16. Review of E1's personnel record lacked evidence of professional reference checks being completed prior to the offer of employment. During interview on 5/11/16, at 10:40 a.m. the facility's culinary director (CD) acknowledged the professional references for E1 were not completed. The CD also verified that E-1 was able to have contact with the residents in the facility. When interviewed on 5/11/16, at 10:46 a.m., the facility's administrator stated the expectation is for professional references to be completed prior to offer of employment to applicants. The facility's policy titled Vulnerable Adult Abuse Prevention Plan dated 12/2014, directed	F 226		

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F 226	Continued From page 4 applicants for employment to provide consent for professional reference checks and the policy further directed obtaining professional references from former employers.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide cares and services in a dignified and respectful manner for 1 of 1 resident (R269) reviewed for dignity. Findings include: During interview on 5/9/16, at 5:34 p.m., when asked if she had been abused by anyone while at the facility, R269 stated about two days ago when a nurse was checking her blood pressure (b/p) the cuff was too tight on her arm, causing her to have pain and had asked the nurse to stop but the nurse did not stop, the nurse readjusted the b/p cuff two times and was not able to get a b/p reading. R269 further stated she felt like the nurse was blaming her for not being able to obtain b/p, R269 lifted the sleeve on her right upper arm and showed surveyor bluish/purple discoloration on her upper arm stating "did not like that she blamed me, now I have bruises. " R269 got teary and started to cry stating "I am sorry, I get teary when I think about the way she	F 241	see attached sheet for plan of correction	6/20/16

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F 241	Continued From page 5 treated me. " Observed seven dotted bluish/purple discoloration on R269's right upper arm. Review of R269's care plan dated 4/24/16, indicated R269 required one staff assistance with transfers, ambulation, bed mobility, toileting, dressing and bathing. R269's care plan indicated R269 required partial assist with grooming and set up for oral hygiene. R269's Minimum Data Set dated 4/28/16, was reviewed and revealed, R269 was cognitively intact. A review of R269's medical record revealed a progress note dated 5/9/16, the progress note indicated R269 was noted with bruising on her upper right arm, "6 dotted bruises measuring 10x1.3cm in total. Guest stated was from the electric b/p cuff and that nurse readjusted it 2 time on 5/6. Bruising came out later." During interview on 5/10/16, at 3:02 p.m. with registered nurse (RN)-C acknowledged the bruises on R269's upper arm were caused by b/p cuff. RN-C stated R269 informed her that she had asked the nurse to stop inflating the b/p cuff because it was causing her discomfort but the nurse did not stop. RN-C further stated the expectation was for nursing staff to stop checking a b/p whenever a resident asks them to and try checking b/p on a different arm. During interview with the director of nursing (DON) on 5/12/16, at 10:28 a.m. The DON stated the expectation was for nursing staff to stop a procedure if it caused discomfort to a resident and whenever a resident asks them to stop.	F 241		

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F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review facility failed to ensure that residents were free of significant medication errors involving, insulin, Coumadin and Lovenox for 3 of 11 Residents (R249, R324, R325) reviewed for medication errors. Findings Include: R249 Review of R249's medical record indicated R249 was admitted on 3/17/16. R 249's admission Minimal Data Set (MDS) indicated R249 had diagnoses that included coronary artery disease, pulmonary emboli (PE-a blockage of an artery in the lungs by a substance that has traveled from elsewhere in the body through the bloodstream), pacemaker placement and prosthetic heart valve replacement. The Hospital Discharge Summary dated 3/17/16, indicated R249 was to receive Coumadin for at least three months, through 5/13/16, for treatment of a pulmonary embolus in the right lung and with Plavix for a new coronary stent (tube placed in an artery of the heart). Coumadin (Warfarin) was an anticoagulant medication given to prevent blood clots, and the blood was periodically monitored for clotting time with a laboratory test of the protime international normalized ratio (INR) to determine the correct dosage (National Library of Medicine).	F 333	See attached sheet for plan of correction	6/20/16

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F 333	Continued From page 7 The Physician Order dated 4/4/16, instructed staff: "1.) continue Coumadin 3.5 mg[milligrams] today 4/4/16. 2) Follow up with care team tomorrow for further dosing." There was no documentation of follow up with the care team on 4/5/16. Review of Progress Notes from 4/5/16 through 4/11/16, did not indicate the physician [MD] and nurse practitioner [NP] were notified that R249 had not received any Coumadin since 4/4/16. The Physician Transitional Care Visit note dated 4/11/16, indicated the physician identified R249 had not received Coumadin for past week. New physician orders were written. The Physician Order 4/11/16, "Lovenox [a medication to prevent blood clotting] 50 mg SQ q 12 hr [subcutaneous every 12 hours] for PE start now., Coumadin 5 mg po [by mouth] daily on 4/11 4/12, INR check on 4/13/16, INR now (stat) CBC [complete blood count], BMP [basal metabolic panel] duoneb now." The Anticoagulant Record Sheet (ARS) indicated Coumadin was given for PE (pulmonary emboli-blood clot in the lung) With a desired INR (international normalized ratio, the standard used for measuring the effectiveness of Coumadin) range of two to three. The ARS indicated the INR on 4/4/16, was 2.6. The Allina Hospitals & Clinics-Laboratories report dated 4/11/16, indicated the INR was 1.1. The ARS was not completed for 4/11/16. The ARS indicated the INR on 4/13/16, was 1.3, INR on 4/15/16, was 1.5, and the INR 4/18/16, was 2.4 which was within desired range indicated. The Medication Variance Report dated 4/11/16, indicated "No INR written for F/U [follow up], not put on MD [medical doctor] communication board	F 333		

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F 333	Continued From page 8 by nurse post on call for f/u next day." Medication Variance Report indicated that the actions taken to prevent a repeat in error were: "Review Coumadin policy & teach nursing to take Coumadin orders with the next INR always. Communicate on NP board also." Review of Medication Administration Record (MAR) for April 2016, indicated registered nurse (RN)-B signed for completing "Follow up with MD/NP on 4/5 to determine further Coumadin dosing and INR one time only" Hand written note by RN-C indicated she had spoken with RN-B regarding signing for following up with NP regarding INR and Coumadin on 4/5/16, when RN-B had not called MD/NP. R325 Review of R325's medical record indicated R325 was admitted 9/1/15. R325's diagnoses listed on Admission Record printed 5/12/16, included acute embolism (a blood clot that has broken off into the blood stream) and thrombosis (blood clot) of the deep veins of left lower extremity, malignant neoplasm (cancerous tumor) of lower lobe of left lung. R325's September 2015, MAR indicated R325 was to receive Lovenox 50 mg injection every 12 hours for DVT (deep vein thrombosis), hold dose 12 hours prior to any invasive procedures. September 2015, MAR indicated RN-B gave R325 Lovenox at 8:00 a.m. on 9/11/15. Requested but did not receive copy of R325's physician orders for September. On 9/11/15, R325 had a left thoracentesis (a	F 333		

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F 333	Continued From page 9 procedure to remove excess fluid in the space between the lungs and the chest wall) to drain one liter of fluid from the lung. Medication Variance Report dated 9/11/15, indicated clinic informed facility R325 had received Lovenox prior to coming for procedure. Review of RN-B's personal record did not indicate any additional training regarding medication administration after either medication error. Facility provided a typed unsigned note dated 4/11/16, indicating nursing staff and health unit coordinators had been educated on 4/5/16, medication error and processing Coumadin orders. Note indicated RN -B was educated on 4/13/16. During interview on 5/12/16, at 10:33 a.m. RN-C said in general R249 had an INR done and the evening nurse called and got orders for Coumadin. The evening nurse did not put it on the board so the NP was not updated on need for new Coumadin orders. "We did not know that this gap was happening." R249's doctor was seeing her and realized R249 was not getting Coumadin. RN-C said "I do not want this to happen again." RN-C said the normal process for medication errors was we have a medication sheet that we fill out. "I look at who is involved, who took the order who cosigned the order, then I get out there and teach." RN-C said, "I am not aware of any other medication errors by [RN-B]." During interview on 5/12/16, at 12:05 p.m. director of nurses (DON) verified medication errors occurred. When asked what was done to ensure that errors did not reoccur. DON replied that RN-C reviewed the Coumadin policy and how to communicate on the NP board. When DON was asked if there was documentation of education completed after a medication errors	F 333		

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F 333	Continued From page 10 were identified, DON said, "I think they [nurse managers] just verbally talked with the nurses." When asked what are your systems to ensure that your patients get the right medications, DON replied, "I will have to get back to you on that." R324 R324's medical record was reviewed and revealed R324 was admitted to the facility on 5/9/16, with diagnoses that included hypertension and Type 2 diabetes mellitus. R324's care plan dated 5/9/16, indicated R324 required the assistance of one staff member with self-care including toileting, transfers and ambulation. R324's Medication administration Record printed on 5/11/16, revealed a Physician Order dated 5/9/16, for Novolog (medication used to treat diabetes) PenFill Cartridge 100 units/milliliter (ml), inject one dose subcutaneously before meals for diabetes mellitus 1-10 units subcutaneously before meals. During observation of medication administration and blood glucose monitoring on 5/11/16, at 7:20 a.m. RN-B, checked R324's blood sugar and got a blood glucose reading of 156. At 7:35 a.m. RN-B stated R324 did not require any sliding scale insulin to be administered. RN-B proceeded to draw up one unit of Novolog insulin stating R324 has an order to administer one dose of Novolog insulin before meals. RN-B was questioned as to what one dose of Novolog insulin meant and RN-B stated it meant one unit of Novolog insulin. RN-B proceeded to R324's room to administer the one unit of Novolog insulin to R324. RN-B washed her hands, donned clean gloves and proceeded to prep R324's skin for administration of insulin. At that time surveyor	F 333		

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F 333	Continued From page 11 intervened, asked RN-B not to administer the one unit Novolog insulin to R324 and that surveyor needed to discuss the Novolog insulin orders with RN-B. RN-B was questioned about consulting with another RN on duty, and after discussing with RN-E, RN-E told RN-B "would not administer anything to the resident until I get that order clarified by the NP [nurse practitioner]." RN-B clarified Novolog insulin order with nurse practitioner who was on the unit. RN-B acknowledged that resident did not need to be given any Novolog insulin and that she misinterpreted the order. RN-B further stated "I should have clarified the order instead of drawing up one unit." During interview on 5/11/16, at 1:36 p.m. RN-C stated she would expect staff to call the nurse practitioner if the order is not clear and get the orders clarified. On 5/12/16, at 9:39 a.m. the facility's director of nursing stated her expectation was for staff to clarify orders that are not clear from the provider. Medication Administration Policy dated February 2016, instructed staff: "RN's, LPN's [licensed practical nurse] and TMA's [trained medication aide] will administer medications as ordered by the attending Physician/NP." Coumadin Policy requested but not received.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441	See attached sheet for plan of correction	6/20/16

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F 441	Continued From page 12 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure clean linens were not held next to staff uniforms or replaced on the clean line cart after being taken into a	F 441		

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F 441	Continued From page 13 resident's room. In addition, the facility failed to ensure proper hand hygiene was used during eye drop administration for 1 of 1 resident (R307). Findings include: LINENS: During continuous observation by two surveyors on 5/9/16, from 5:41 p.m. to 5:55 p.m. Resident assistant (RA)-A was observed passing clean linens to rooms from a covered line cart that had the front flap open. -5:43 p.m. dietary staff passed the open linen cart with a food tray. -5:44 p.m. resident and family walked past open linen cart. -5:48 p.m. RA-A held clean towels and wash cloths against uniform when RA-A took them into room 216. -5:51 p.m. RA-A went to room 217 with a pile of towels and wash cloths and then came back out and placed several items back on the clean linen cart. -5:53 p.m. RA-A entered room 219 closet in the bathroom, placed linens in the closet and exit room without sanitizing or washing hands. -5:55 p.m. RA-B went into rooms 218 and 221 placed linens in the bathroom closet and exit the rooms without using hand sanitizer or washing hands. During interview on 5/9/16, at 6:05 p.m. RA-A said "I took too much [linens] in. I should not have put it [linens] back on the cart. I did not put it down. I try not to touch my uniform with the linens but I must have." Eye drops: During medication administration observation on	F 441		

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	245624	A. BUILDING _____ B. WING _____	C 05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERLUDE	2775 CAMPUS DRIVE NORTH PLYMOUTH, MN 55441

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F 441	Continued From page 14 5/9/16, at 5:58 p.m. licensed practical nurse (LPN)-A entered R307's room with a medication cup of pills and a vial of brimonidine 0.15% (an eye drop for the treatment of glaucoma). LPN-A repositioned R307's wheel chair, then gave the pills to R307. After R307 swallowed the pills LPN-A had R307 tilt her head back and placed one drop of brimonidine 0.15% in the right eye then the left eye. LPN-A then gave R307 a tissue. LPN-A did not wash hands or put on gloves after administering oral medications and before administering eye drops. R307's Admission Record printed 4/27/16, identified R307 had a diagnosis of unspecified glaucoma (glaucoma is a group of eye diseases resulting in injury of the optic nerve). During interview on 5/9/16, at 5:59 p.m. LPN-A said, "I should have washed my hands and worn gloves." During interview on 5/11/16, at 1:36 p.m. the director of nurses (DON) said our policy is to wash hands and put on gloves prior to giving eye drops. During interview on 5/11/16, at 1:42 pm the DON said linen pass is done holding the linens away from clothing with clean hands. Once linens go in a room the linens are considered dirty. Once staff go in a room they should sanitize their hands on the way out. Handling Clean Linen Policy dated 2015, instructed staff: 3. The nursing staff places clean linen on the covered nursing cart to pass linen. Linen must remain covered at all times until it is placed into	F 441		

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F 441	Continued From page 15 the residents' room. 5. Pass linen to a single room at a time. Carry linen away from your body and uniform. 7. Do not return clean linen from the resident's room. The line is considered contaminated once it is in a resident's room. Medication Administration Policy dated 2/16, instructed staff: 13. Infection control practices will be followed including gloves and hand washing with the administration of eye drops, nasal sprays, during medication administration hand washing will be completed when appropriate.	F 441		

F 176

Guest #269 is a 57 year old who was admitted for rehab after a joint replacement. Guest was cognitively intact and lived independently in the community with spouse. Initial Self Administration of Medication Assessment was completed on 4/25/16 indicating guest chose not to self administer at that time. On 4/26/16, the guest changed her mind and requested to self administer her inhaler. The MD was updated and an order was received to self administer the inhaler.

On 5/10/16 a Self Administer of Medication Assessment was completed for Guest #269 which indicated guest was cognitively intact and safe to self administer inhaler.

Staff education on Self Administration of Medications initiated immediately. Random audits were initiated 5/19/16 and will be completed weekly for 4 weeks. Results will be reported to the QA Committee and the need for ongoing audits and action plans will be initiated as appropriate. The Administrator, Clinical Administrator and the Clinical Coordinators will be responsible for the ongoing compliance.

Date certain for the purpose of the ongoing compliance is 6/20/16.

F 226

The referenced employee was hired on 2/18/16 and resigned on 5/2/16. The employee worked in the Culinary Department and did not provide direct guest care while employed. The Human Resources Director audited all current employee files for reference check completion and found this reference check was an isolated incident. The Human Resources Director will audit and maintain all new hire reference checks per company policy.

Presbyterian Homes and Services is exploring potential contract with an outside reference check vendor.

Date certain for the purpose of the ongoing compliance is 5/13/16.

F 241

During the Transitions Conference on 5/9/16, the Clinical Coordinator noted a bruise on Guest # 269 upper right arm. The guest stated that a couple of days before when the nurse was checking her BP, the nurse had to readjust the cuff x 2 because it was too tight on her arm. The guest stated that the bruise did not come out right away. When asked by the Clinical Coordinator if the guest felt she was abused, the guest stated "no".

The Clinical Coordinator initiated the Occurrence Policy and Procedure once the bruise was noted. The guest and nurse involved were interviewed. The nurse stated that when the guest told her that the BP cuff was too tight, she removed it per the guest's request and repositioned it.

Staff education on guest dignity and honoring their requests during cares initiated immediately. Random dignity audits were initiated 5/19/16 and will be completed weekly for 4 weeks. Results will be reported to the QA Committee and the need for ongoing audits and action plans will be initiated as appropriate. The Administrator, Clinical Administrator and the Clinical Coordinators will be responsible for the ongoing compliance.

Date certain for the purpose of the ongoing compliance is 6/20/16.

F 333

Guest #249 medication error was noted on 4/11/16 by guest's primary medical doctor. This error was self reported to the Minnesota Department of Health (MDH) immediately. Guest had a pre scheduled follow up Cardiologist appointment on 4/11/16. Progress note from Cardiologist states guest was stable.

Guest #325 medication error which occurred on 9/12/15. Guest received Lovenox on 9/15/15. Guest had pre scheduled procedure on 9/15/15. Guest went for procedure, hospital was aware she had received the Lovenox and elected to continue with procedure. Guest returned to facility post procedure stable.

Guest #324 medication error did not reach the guest and insulin order was clarified by the MD on the same day.

Nurse involved was coached and re- educated on the Administration of Medication Policy and the need for order clarification. Medication Administration audits initiated 5/19/16 and completed weekly for 4 weeks. Nurse completed education on high risk medications.

Nursing staff will be educated on high risk medications and will attend an in-service provided by Pharmacy Consultant on 6/20/16 on preventing common medication errors. Random audits were initiated 5/19/16 and will be completed weekly for 4 weeks. A Medication Administration Error Investigation Form will be completed for all medication errors. Results will be reported to the QA Committee and the need for ongoing audits and action plans will be initiated as appropriate. The Administrator, Clinical Administrator and the Clinical Coordinators will be responsible for the ongoing compliance.

Date certain for the purpose of the ongoing compliance is 6/20/16.

F 441

All nursing staff were educated on the Linen Handling Procedure immediately. The Linen Handling Procedure was addressed in The Interlude Employee newsletter on 6/8/16. Linen Handling audits were initiated on 5/19/16 and will be completed weekly for 4 weeks.

All licensed nurses were educated on the Eye Drop Administration Procedure immediately. The Medication Administration Policy and the Eye Medication Instillation Procedure was reviewed by all licensed nurses. Audits were initiated on 5/19/16 and will be completed weekly for 4 weeks.

Results of the audits will be reported to the QA Committee and the need for ongoing audits and action plans will be initiated as appropriate. The Administrator, Clinical Administrator and the Clinical Coordinators will be responsible for the ongoing compliance.

Date certain for the purpose of the ongoing compliance is 6/20/16.

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

F 624001

PRINTED: 05/26/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245624	A. BUILDING 01 - INTERLUD RESTORATIVE SUITES B. WING	05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERLUDE	2775 CAMPUS DRIVE NORTH PLYMOUTH, MN 55441

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K 000	INITIAL COMMENTS FIRE SAFETY 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 11, 2016. At the time of this survey, Interlude Restorative Suites was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	APPROVED Tom Linhoff By Tom Linhoff at 10:14 am, Jun 23, 2016 RECEIVED JUN 17 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shayla Wagner	Leader in Training	6/17/16

An, ciency 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.

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Interlude is a 2-story building with a full basement. The building was constructed in 2014 and was determined to be of Type II(111) construction. The building is has a full fire sprinkler system in accordance with NFPA 13, 1999 Ed. The facility has a fire alarm system with smoke detection in the corridors, by the smoke barrier doors, resident rooms and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 50 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly	K 050	See attached sheet for plan of correction	6/3/16

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K 050	Continued From page 2 on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 18.7.1.2. This deficient practice could affect all 47 residents. Findings include: On a facility tour between the hours of 09:30 AM and 01:30 PM on May 11, 2016, observation revealed that the facility did not test the fire alarm DACT the day after conducting silent frills. This deficient practice was verified by the Administrator at the time of inspection.	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility has failed to inspect and maintain the	K 062	See attached sheet for plan of correction	6/13/16

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K 062	Continued From page 3 sprinkler system in accordance with NFPA 13 and NFPA 25. This deficient practice could affect all 47 residents. Findings include: On a facility tour between the hours of 09:30 AM and 01:30 PM on May 11, 2016, observation revealed that the facility could not provide documentation of quarterly automatic sprinkler system flow testing. This deficient practice was verified by the Administrator at the time of the inspection.	K 062		

K050

The facility will test the fire alarm DACT the day after conducting silent fire drills as required by NFPA 101 LSC (00). A recurring task to schedule the test of fire alarm DACT following a silent drill will be entered into the electronic work order scheduling system to ensure compliance. The Engineering Services Director will maintain documentation of fire alarm DACT testing. The Safety Committee will review fire drill reports quarterly for accuracy and timeliness including fire alarm DACT testing following a silent drill.

Date certain for the purpose of the ongoing compliance is 6/3/16.

K062

The facility will conduct quarterly automatic sprinkler system flow testing and document as required by NFPA 101 LSC (00) until July 5th, 2016 when the 2012 version of NFPA 101 LSC will be enforced and semiannual flow testing will be allowed. At that time, quarterly flow testing will be discontinued and semiannual flow testing will begin. The facility conducted a sprinkler system flow test on 6/13/16. A recurring task to schedule the automatic sprinkler system flow testing will be entered into the electronic work order scheduling system to ensure compliance. The task will also be entered into the Engineering Services Directors calendar to verify that this testing was completed within the time frame required. The Engineering Services Director will maintain documentation of automatic sprinkler system flow testing.

Date certain for the purpose of the ongoing compliance is 6/13/16.