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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KTCE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 29890

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245623**

2.STATE VENDOR OR MEDICAID NO.
(L2) **103600300**

3. NAME AND ADDRESS OF FACILITY
(L3) **INTERLUDE RESTORATIVE SUITES UNITY**
(L4) **520 OSBORNE ROAD NORTHEAST**
(L5) **FRIDLEY, MN** (L6) **55432**

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 08/17/2021 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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 :
Jamie Perell, Unit Supervisor 08/19/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 08/19/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/18/2015
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 19, 2021

CMS Certification Number (CCN): 245623

Administrator
Interlude Restorative Suites Unity
520 Osborne Road Northeast
Fridley, MN 55432

Dear Administrator:

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

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 10, 2021 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 19, 2021

Administrator
Interlude Restorative Suites Unity
520 Osborne Road Northeast
Fridley, MN 55432

RE: CCN: 245623
Cycle Start Date: July 8, 2021

Dear Administrator:

On July 29, 2021, we notified you a remedy was imposed. On August 17, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 10, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 13, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 29, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 8, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KTCE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L3) **INTERLUDE RESTORATIVE SUITES UNITY**
(L4) **520 OSBORNE ROAD NORTHEAST**
(L5) **FRIDLEY, MN** (L6) **55432**

4. TYPE OF ACTION: **2** (L8)

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3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/08/2021** (L34)

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

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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)
06/30

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To (b) :

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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 :
Brandon Martfeld, HFE NE 08/09/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 08/13/2021 (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)

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3. Both of the Above :

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03/18/2015
(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

Electronically Submitted
July 29, 2021

Administrator
Interlude Restorative Suites Unity
520 Osborne Road Northeast
Fridley, MN 55432

RE: CCN: 245623
Cycle Start Date: July 8, 2021

Dear Administrator:

On July 8, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On July 8, 2021, the situation of immediate jeopardy to potential health and safety cited at F678 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 13, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 13, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 13, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Interlude Restorative Suites Unity is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 8, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Jamie Perell, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 8, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a

request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

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

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety

445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245623	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERLUDE RESTORATIVE SUITES UNITY	**520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 7/6/21, to 7/8/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/6/21, through 7/8/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H5623011C (MN73861) The survey resulted in an Immediate Jeopardy (IJ) at F678 when R21, who was alert 15 minutes prior, was found without a pulse or respirations, and CPR was not initiated. It was also determined R127, who had a full-code status, was found without a pulse and respirations and CPR was not initiated. The administrator and director of nursing (DON) were informed of the IJ on 7/7/21, at 1:55 p.m. The IJ was removed on 7/8/21, 10:54 a.m. but noncompliance remained at the lower scope and severity level of D - isolated scope and severity level, which indicated no actual harm with	F 000		

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

Electronically Signed | 08/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245623	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERLUDE RESTORATIVE SUITES UNITY	**520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432**

(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	Continued From page 1 potential for more than minimal harm that is not IJ. The above findings constituted substandard quality of care, and an extended survey was conducted from 7/7/21, through 7/8/21. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to initiate cardiopulmonary resuscitation (CPR) in accordance with physician orders and resident wishes for 2 of 2 residents (R21, R172) who required emergency care. This resulted in an immediate jeopardy (IJ) situation when R21 and R172 who were found with absent pulse/respirations, CPR was not performed, and	F 678	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited and is also noted to be construed as an admission against interest of the Facility,	8/10/21

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INTERLUDE RESTORATIVE SUITES UNITY	**520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432**

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F 678	Continued From page 2 R21 and R172 died. In addition, the facility failed to ensure policy, related to withholding CPR, was based on current American Heart Association (AHA) standards of practice. The IJ began on 6/2/21, at 6:00 a.m. when R21, who was alert 15 minutes prior, was found without a pulse or respirations, and CPR was not initiated. On 6/20/21, at 6:04 a.m. R127 was also found without a pulse or respirations, and CPR was not initiated. The administrator and director of nursing (DON) were informed of the IJ on 7/7/21, at 1:55 p.m. The IJ was removed on 7/8/21, 10:54 a.m. but noncompliance remained at the lower scope and severity level of D - isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include: Facility policy titled Code Status: Physician's Order for Life Sustaining Treatment Policy dated 10/19, directed "On all witnessed arrests, CPR is initiated if ordered, if the arrest was not witnessed and the resident was dead in the nurse's clinical judgement (either rigor mortis is present or following signs are present: no palpable, observable, or audible apical pulse and no respirations) the nurse will not initiate CPR." R21's Face Sheet printed on 7/8/21, indicated R21's diagnosis included asthma and chronic kidney disease. R21's physician orders dated 5/14/21, indicated R21 was a "Full Code" status. R21's Provider Orders for Life-Sustaining	F 678	its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency The facility Cardiopulmonary Resuscitation (CPR) Policy and the Code Status and Physician□s Order for Life Sustaining Treatment Policy has been updated to reflect the language in F678 and according to the American Heart Association. R21 and R172 have expired as noted in the findings. Verbal and written education was initiated on 7/7/21 and will be provided to all nurses prior to them working their next scheduled shift to ensure all current and future guests at Interlude of Fridley have their advanced directives respected and followed per CMS F678 and in accordance with the American Heart Association. The Clinical Administrator and/or designee completed audits daily from 7/8/2021- 7/15/2021. The audit consists of two scenario based questions of a witnessed and unwitnessed event, and review of the five instances when you would not be required to initiate CPR on a full code resident who is found	

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F 678	Continued From page 3 Treatment (POLST) dated 5/17/21, directed to attempt resuscitation / CPR (cardiopulmonary resuscitation). R21's June 2021 Medication Administration Record (MAR) indicated R21 was administered a dose of Tramadol (pain medication) at 5:45 a.m. on 6/2/21, by registered nurse (RN)-A. R21's progress notes dated 6/2/21, at 7:47 a.m. indicated R21 was last seen by RN-A at 5:45 a.m. and R21 was conversing. The progress notes further indicated, at approximately 6:00 a.m. a laboratory technician went to draw R21's labs. R21 was found not breathing. The laboratory technician notified RN-A "right away." RN-A attempted to find a "pulse, heart sounds, or breathing", however, was unable to locate. R21's fingers were noted to be "mottled" and she was "warm to touch." The progress note lacked indication CPR was initiated. When interviewed on 7/7/21, at 8:08 a.m. RN-A stated she spoke with R21 at 5:45 a.m. on 6/2/21, when she administered medication. RN-A stated a laboratory technician came to draw R21's labs during the morning and informed her R21 had died. RN-A stated she was shocked as it had not been long since she last saw R21. RN-A stated she returned to R21's room at approximately 6:00 a.m. and R21 "was already dead." RN-A stated R21 was lying down with her eyes closed and mouth open. RN-A stated R21's fingertips were pale, but "not really cold." RN-A stated she was unable to locate a radial or neck pulse, shook R21, and called her name with no response. RN-A stated she then called the supervisor who verified R21 was breathless and pulseless. RN-A confirmed she reviewed R21's code status and	F 678	unresponsive with no pulse and no respirations. The QAPI committee met, reviewed the audits, and determined to change the audit frequency to weekly until our QAPI committee meeting on 8/24/2021. The QAPI committee will continue to make the decision/recommendation regarding any necessary follow-up and auditing frequency. Corrective Action will be completed by 08/10/2021	

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F 678	Continued From page 4	F 678		

was aware R21 was a full-code, however, did not initiate CPR. RN-A stated, "There were no signs of life" which included the absence of pulse and breathing. RN-A stated according to facility policy she was unable to perform CPR if someone was found dead with no pulse or breathing. RN-A stated after R21's death, she received an email regarding the facility CPR policy and instructed to read it, however, did not recall any changes to the policy related to CPR.

R172's Face Sheet printed on 7/8/21, indicated R172's diagnosis included hyperkalemia and chronic kidney disease.

R172's physician orders dated 4/2/21, indicated R172 was a "Full Code" status.

R172's POLST dated 4/5/21, directed to attempt resuscitation / CPR (cardiopulmonary resuscitation).

R172's progress notes dated 6/20/21, at 8:25 a.m. indicated R172 was found "unresponsive" at 6:04 a.m. by a nursing assistant while doing rounds. R172's pupil was fixed and not reactive to light. Two writers were unable to locate a "pulse, chest movement or heart sounds." R172's extremities were cold and mottled. R172 was last seen by the writer at 4:00 a.m. and was "sleeping" in bed. The progress note lacked indication CPR was initiated.

When interviewed on 7/7/32, at 10:12 a.m. RN-A stated she had last seen R127 alive around 3:00 a.m. to 4:00 a.m. when she walked past R127's room. RN-A stated R127 was "breathing" at that time. RN-A stated, during morning rounds, she was notified by a nursing assistant of an

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F 678	Continued From page 5	F 678		

"emergency" in R127's room. RN-A stated she ran to R127's room and "he was down." RN-A stated R127's arm was hanging off the right side of the bed, his eyes were slightly open, and there was "some discoloration." RN-A stated she called another nurse, and together, they checked R127's pulse. RN-A stated they then checked R127's code status and confirmed R127 was a "full-code." RN-A stated R127 did not have a pulse, lacked heart sounds, and was not breathing. RN-A described R127 as "gone." RN-A confirmed CPR was not performed on R127.

When interviewed on 7/7/21, at 9:05 a.m. RN-B stated CPR needed to be initiated when a resident did not have a pulse and a resident was observed going "unconscious in front of you." RN-B stated if a resident, who was full-code, was found unresponsive CPR was not initiated if the resident lacked respirations, pulse, chest movement, did not respond to touch, and was stiff. RN-B was unable to recall the facility policy related to CPR.

When interviewed on 7/7/21, at 9:43 a.m. and 11:01 a.m. the director of nursing (DON) stated the facility expectation was to initiate CPR on witnessed cardiac arrests. The DON stated facility policy "clearly states" CPR would not be initiated if a cardiac arrest was not witnessed. The DON stated this was, "not necessarily a common thing" and believed the facility previously used guidance from the AHA. The DON stated she was unsure where guidance in facility policy was obtained from. The DON stated staff should follow facility policy related to CPR.

When interviewed on 7/7/21, at 12:02 p.m. medical doctor (MD)-D stated he was unable to

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F 678	Continued From page 6	F 678		

think of an instance in which CPR would not be initiated for a resident who had a full-code status, unless there was a policy which determined a resident had already died.

When interviewed on 7/7/21, at 11:05 a.m. nurse practitioner (NP)-C stated the only time CPR should not be initiated was if a resident's code status was "do not resuscitate", or clinical signs of death such as rigor were present. NP-C stated rigor would usually set in after four to six hours. NP-C stated she would expect staff to initiate CPR if a resident was pulseless and not breathing. NP-C stated if a resident was last seen alive 15 minutes prior to a cardiac arrest, she would expect CPR initiation.

When interviewed on 7/7/21, at 11:15 a.m. the facility medical director stated facility policy indicated nurses may exercise judgement regarding the initiation of CPR in the event a cardiac arrest was unwitnessed, if in their view, the resident had been dead for some time. The medical director stated he was unaware R21 was last seen well 15 minutes prior to their cardiac arrest and "probably" would had attempted CPR in that circumstance.

When interviewed on 7/7/21, at 1:31 p.m. the regional clinical director stated she did not know why facility policy directed not to initiate CPR for unwitnessed cardiac arrests. The regional clinical director stated the corporate and the vice-president were reviewing the policy. The regional clinical director stated she recommended modifying policy to include AHA definitions so there were no interpretations.

The 2010 American Heart Association Guidelines

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F 678	Continued From page 7 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care; Part 3: Ethics, included: "Criteria for not starting CPR in all OHCA (out of hospital cardiac arrest). While the general rule is to provide emergency treatment to a victim of cardiac arrest, there are a few exceptions where withholding CPR might be appropriate, as follows: 1. Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril. 2. Obvious clinical signs of irreversible death (e.g., rigor mortis, dependent lividly [a bluish discoloration of lowest part of body], decapitation, transection, or decomposition). 3. A valid, signed, and dated advanced directive indicating that resuscitation is not desired, or a valid, signed, and dated DNAR (do not attempt resuscitation) order. The IJ that began on 6/2/21, at 6:00 a.m. was removed on 7/8/21 at 10:54 a.m. when the facility developed and implemented a systemic plan which was verified through interview and document review. The plan included: - The facility CPR and POLST policies were updated on 7/8/21, in accordance with AHA guidelines. - Verbal and written education related to the facility CPR and POLST policy was provided to 11 nursing staff prior to their scheduled shift on 7/7/21. - The facility notified remaining staff education must be completed prior to their next scheduled shift on 7/8/21. - Audits of licensed nurses' understanding of the CPR and POLST policies would be conducted for one week by the facility.	F 678		

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F 755	Continued From page 8	F 755		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired medications were removed from medication carts	F 755	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of	8/10/21

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F 755	Continued From page 9 for 4 of 4 carts reviewed for medication storage. This had the potential to affect 11 of 40 residents who were administered these medications. Findings include: On 7/6/21, at 3:10 an observation was conducted of the Rhapsody unit medication cart with registered nurse (RN)-G. The following medications were found to be expired and verified by RN-G: - Ibuprofen 200 milligram (mg) tablets were opened and had a manufacturer expiration date of 6/21. - Ferosol (iron) tablets were opened and had a manufacturer expiration date of 5/21. RN-G stated the nurse should check dates all medication bottles prior to administration. RN-G stated night shift staff usually reviewed medication carts for expired medications as they had more time. RN-G removed the expired medications from the medication cart at this time. On 7/6/21, at 3:15 p.m. an observation was conducted of the Symphony unit medication cart with RN-F. The following stock medications were found to be expired and verified by RN-F: - Ferosol (iron) tablets was opened and had a manufacturer expiration date of 5/21. - Acetaminophen tablets were opened and had a manufacturer expiration date of 5/21. RN-F verified R3, R5, R231, R232, R233, R236, R237, R271, R272, R273, and R274 were prescribed and administered this medication while in the facility. On 7/6/21, at 3:30 p.m. an observation was conducted of the Lyric unit medication cart with	F 755	Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited and is also noted to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency The facility policy titled Storage and Expiration Dating of Medications, and Biologicals was reviewed and remains unchanged. The expired medications had the potential to affect 11 residents on the day it was noted. The noted medications were removed and destroyed per our policy. The provider team of the affected residents were updated and residents were noted to not have adverse effects. An audit of all the medications in the facility was completed on 7/16/2021 to ensure all expired medications were discarded. All licensed staff will be trained on the Storage and Expiration Dating of Medications, and Biologicals policy to ensure we are following requirements per F755. The Clinical Administrator and/or designee will complete weekly audits until	

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F 755	Continued From page 10 RN-E. The following stock medications were found to be expired and verified by RN-E: - Benadryl (antihistamine) and had a manufacturer expiration date of 6/7/21. RN-E verified R5 was prescribed and had been administered this medication while at the facility. - Tums tablets was opened and had a manufacturer expiration date of 6/21. - Ferosol (iron) tablets was opened and had an expiration date of 5/19/21. On 7/6/21, at 3:45 p.m. an observation was conducted of the Melody unit medication cart with RN-E. - Fish oil capsules were opened and had a manufacturer expiration date of 2/21. When interviewed on 7/7/21, at 9:25 a.m. RN-J stated nurses should check dates on medications as part of the procedure when giving medications. RN-J stated it was the night nurse's responsibility to review medication carts for expired medications. When interviewed on 7/7/21, at 2:00 p.m. the consulting pharmacist stated medications such as ibuprofen, ferosol, and fish oil would lose their effectiveness one year after being past manufacturer expiration dates. The consulting pharmacist stated it was not recommended to take ibuprofen after an expiration date because the potency decreases over time and a resident may not get enough active ingredients to effectively manage pain. When interviewed on 7/7/21, at 10:00 a.m. the director of nursing (DON) stated she was made aware all four medication carts had expired stock medications. The DON stated it was the	F 755	our QAPI committee meeting on 8/24/2021 to ensure compliance. The QAPI committee will then make the decision/recommendation regarding any necessary follow-up and auditing frequency to ensure ongoing compliance. Corrective Action will be completed by 08/10/2021	

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F 755	Continued From page 11 responsibility of the nurse to check expiration dates prior to administering medications as part of the eight rights of medication administration. The DON stated the first step was to ensure a medication was not out of date. The DON stated night shift usually conducted cart audits and reviewed all medications to ensure medications were not expired. The DON indicated 11 residents total were taking the expired stocked medications. Facility policy titled Storage and Expiration Dating of Medications, and Biologicals revised date 10/28/19, directed the facility should ensure medications and biologicals that have been retained longer than recommended by manufacturer are destroyed or returned to the pharmacy	F 755		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		8/10/21

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F 812	Continued From page 12 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired food items were removed from the facility kitchen and disposed of. This had the potential to affect all 40 residents who resided at the facility and consumed food from the kitchen. Findings include: On 7/6/21, at 11:55 a.m. a kitchen tour was conducted with culinary director (CD)-A. In a refrigerator, a plastic container labeled "alfredo 6/10" and a large bucket of cooked pasta dated "5/8" was noted. At 12:24 p.m., cook (C)-A confirmed the alfredo sauce and pasta were expired and needed to be thrown away. C-A stated he was unaware of when the food items were last used. During an interview on 7/8/32, at 10:00 a.m. CD-A stated left over food items should be disposed of after three days and the alfredo sauce and cooked pasta should had been thrown away to prevent possible food borne illness. Facility Labeling and Dating policy (Ready to Eat and/or Potentially Hazardous Food) dated 8/2019, directed leftover food was to be discarded after three days from the day it was prepared.	F 812	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited and is also noted to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency The facility Labeling and Dating Policy was reviewed and remains unchanged. The expired food that was noted during the survey was discarded immediately. An audit of the whole building was completed on 7/30/2021 to ensure all expired food was discarded. All staff training will be completed to review the Labeling and Dating Policy to ensure understanding of the policy, so our residents do not come in contact with potentially hazardous food. The Culinary Director and/or designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245623	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERLUDE RESTORATIVE SUITES UNITY	**520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432**

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F 812	Continued From page 13	F 812	complete audits twice per week until our QAPI committee meeting on 8/24/2021 to ensure compliance. The QAPI committee will then make the decision/recommendation regarding any necessary follow-up and auditing frequency to ensure ongoing compliance. Corrective Action will be completed by 08/10/2021	
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure soiled cooling racks were separated from clean items and dishware was in good condition. This had the potential to affect all 40 residents who resided at the facility and consumed food from the kitchen. Findings include: During a kitchen tour conducted on 7/8/21, at 9:31 a.m. two cooling racks which were coated in a brown, sticky, grease-like substance were noted to be stacked on top of clean cooking racks. C-A confirmed the finding and stated, "That's not clean at all." C-A removed the cooking racks and placed them in a dirty sink. Four small plastic soup bowls were found to have scratches which exposed a while color around the inner rims. Dietary aide (DA)-A scratched plastic off a	F 921	The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited and is also noted to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any of the facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency	8/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245623	A. BUILDING _____ B. WING _____	C 07/08/2021

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INTERLUDE RESTORATIVE SUITES UNITY	**520 OSBORNE ROAD NORTHEAST FRIDLEY, MN 55432**

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F 921	Continued From page 14 bowel with her fingernail and stated all the bowls were like that because of the dishwashing machine. C-A also stated the plastic on the bowels chipped off because of the dishwasher, but did not believe it was a health concern. During an interview on 7/8/32, at 10:00 a.m. culinary director (CD)-A stated it was a concern pieces of plastic could flake off from bowels and into a resident's food. CD-A stated dirty items such as cooking racks should not had been stored with clean items to prevent cross-contamination.	F 921	The facility Dishes and Equipment Air Drying Policy was reviewed and remains unchanged. An audit of all our soup bowls were completed on 7/30/2021 and damaged bowls were thrown away and replaced with new bowls. Culinary staff training on the Dishes and Equipment Air Drying Policy will be completed to review expectations for making sure all dishes are in good condition, and expectations to ensure cooling/cooking racks are stored in a safe and sanitary manner. The Culinary Director and/or designee will complete weekly audits until our QAPI committee meeting on 8/24/2021 to ensure compliance. The QAPI committee will then make the decision/recommendation regarding any necessary follow-up and auditing frequency to ensure ongoing compliance. Corrective Action will be completed by 08/10/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245623	A. BUILDING **01 - BENEDICTINE LIVING CENTER FRIDLEY** B. WING _____	**07/07/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/07/2021. At the time of this survey, Interlude Restorative Suites Unity was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Interlude Restorative Suites Unity is a 3-story building without a basement. The building was constructed in 2015 and was determined to be of Type II(111) construction. The building has a full fire sprinkler system and 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 capacity of 50 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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