

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OH2W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 29763

1. MEDICARE/MEDICAID PROVIDER NO. (L1) INITIAL		3. NAME AND ADDRESS OF FACILITY (L3) INTERLUDE (L4) 2775 CAMPUS DRIVE NORTH (L5) PLYMOUTH, MN (L6) 55441		4. TYPE OF ACTION: 1 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2. STATE VENDOR OR MEDICAID NO. (L2)		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY 02 (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NE/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NE/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE	
6. DATE OF SURVEY 04/08/2015 (L34)		8. ACCREDITATION STATUS: — (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) 09/30	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10. THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: — 2. Technical Personnel — 6. Scope of Services Limit — 3. 24 Hour RN — 7. Medical Director — 4. 7-Day RN (Rural SNF) — 8. Patient Room Size — 5. Life Safety Code — 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12)			
12. Total Facility Beds 50 (L18)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 50 (L37) (L38) (L39) (L42) (L43)			
13. Total Certified Beds 50 (L17)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)			

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

See Attached Remarks

17. SURVEYOR SIGNATURE Kathy Sass, HFE NE II (L19)		Date : 04/08/2015	18. STATE SURVEY AGENCY APPROVAL Shellae Dietrich, Certification Specialist (L20)		Date: 04/09/2015
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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 (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 INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination OTHER 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE: (L28)		29. INTERMEDIARY/CARRIER NO. (L31)		30. REMARK: Sent to CMS/(RO) _____ As an attachment in ACO. Emailed CMS on 04/10/2015	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	

C&T REMARKS - CMS 1539 FORMSTATE AGENCY REMARKS

CCN: Initial

An initial certification survey completed on April 8, 2015 found Interlude in compliance with health and life safety code requirements for Long Term Care Facilities. Certification recommended effective April 8, 2015, since all requirements were met.

Attached are the following documents: Health CMS-2567, Life Safety Code CMS-2567, CMS-2786R and crucial data extract, CMS-671, CMS-672, CMS-1561, Office for Civil Rights confirmation email, Transfer Agreement, CMS-855 including the approval letter from National Government Services dated December 9, 2014.

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

PRINTED: 04/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29763	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/08/2015
NAME OF PROVIDER OR SUPPLIER INTERLUDE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 An Initial Certification survey was conducted on April 7 through 8, 2015, by surveyors of this department. The facility was found to be in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. Certification is recommended.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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

FL 29763001

Printed: 02/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29763	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PHS WEST HEALTH INC B. WING _____		(X3) DATE SURVEY COMPLETED 02/09/2015
NAME OF PROVIDER OR SUPPLIER INTERLUDE			STREET ADDRESS, CITY, STATE, ZIP CODE 3005 CAMPUS DRIVE PLYMOUTH, MN 55447		
(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	
K 000	INITIAL COMMENTS FIRE SAFETY An Initial Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Interlude was found 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. 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 0 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

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