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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: R6Y6

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 **04/24/2018** (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 :
Susie Haben, Unit Supervisor 05/14/2018 (L19)

Date:
Michaelyn Bruer, Enforcement Specialist 05/14/2018 (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
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

CMS Certification Number (CCN): 245623

May 14, 2018

Ms. Nicole Donahue, Administrator
Interlude Restorative Suites Unity
520 Osborne Road Northeast
Fridley, MN 55432

Dear Ms. Donahue:

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 April 24, 2018 the above facility is certified for or recommended 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,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 14, 2018

Ms. Nicole Donahue, Administrator
Interlude Restorative Suites Unity
520 Osborne Road Northeast
Fridley, MN 55432

RE: Project Number S5623003

Dear Ms. Donahue:

On March 29, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 15, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On April 24, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 7, 2018 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 March 15, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 24, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 15, 2018, effective April 24, 2018 and therefore remedies outlined in our letter to you dated March 29, 2018, 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.

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: R6Y6

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: **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 **03/15/2018** (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:
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 :
Mary Capes, HFE NE II — 04/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Amy Johnson, Enforcement Specialist — 04/25/2018 (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
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 delivered
March 29, 2018

Ms. Nicole Donahue, Administrator
Interlude Restorative Suites Unity
520 Osborne Road Northeast
Fridley, MN 55432

RE: Project Number S5623003

Dear Ms. Donahue:

On March 15, 2018, 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. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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;

Electronic 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
Metro A Survey Team
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: susie.haben@state.mn.us
Phone: (651) 201-3794
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 April 24, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC 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 ePoC 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 ePoC 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 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 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.

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 June 15, 2018 (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 September 15, 2018 (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 an ePoC 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,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245623	A. BUILDING _____ B. WING _____	03/15/2018

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	INITIAL COMMENTS On 3/12, 3/13, 3/14 and 3/15/18, a standard survey was completed at your facility A recertification survey was conducted 3/12, 3/13, 3/14 and 3/15/18 by the Minnesota Department of Health to determine the facility's compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 680 SS=C	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or	F 680		4/24/18

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

Electronically Signed | 04/06/2018

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 _____	03/15/2018

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 680	Continued From page 1 recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure a qualified activity director was in charge of the activity program. This had the potential to impact all 43 residents of the facility. Findings include: On 3/14/18 at 10:07 a.m. the administrator reported the facility did not have a qualified activity professional in charge of the activity program. The administrator stated the receptionist currently made out an activity schedule, and social workers on each floor conducted resident activity assessments. The administrator further stated residents were admitted for the purpose of rehabilitation and did activities on their own. A policy identifying the qualifications of an activity professional was requested but not provided.	F 680	The preparation of the following plan of correction does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was solely executed because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states: The facility has developed a policy and procedure to ensure a "qualified" professional per CMS definition will provide oversight of the activity programming for transitional care units. The Administrator and/or designee will be responsible for ensuring compliance and will audit monthly to ensure ongoing compliance. Compliance will be reviewed and discussed during facility QAPI meetings for three months. The QAPI committee will make the decision/recommendation regarding any necessary follow-up.	

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 _____	03/15/2018

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 680	Continued From page 2	F 680	Corrective action will be completed by April 24, 2018.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		4/24/18

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 _____	03/15/2018

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 758	Continued From page 3 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure antipsychotic medications were used only when there was a specific indication for use, for 1 of 2 residents (R7) reviewed who had been prescribed an antipsychotic medication. Findings include: R7's most recent minimum data set (MDS) dated 1/21/18, indicated R7 was moderately cognitively impaired. The MDS further indicated R7 was using an antipsychotic medication daily, but was not diagnosed with a psychotic disorder. R7's physician order summary report dated 3/14/18, included orders for: "Haloperidol (also referred to as Haldol- a major psychotropic medication) tablet 0.5 MG [milligrams] give 1 tablet by mouth two times a day for psychosis" with a start date of 1/14/18. R7's psychotropic drug use care area assessment (CAA) dated 1/21/18, indicated:	F 758	The facility policy for the use of Unnecessary Drugs and Psychotropic medication was reviewed and remains in effect and unchanged. With respect to R7; R7's plan of care was updated based on interview to include, "Monitor occurrence for target behavior symptoms (seeing cats on ceiling, being confused about location and thinking I am being kidnapped)" and documented per facility policy on 3/15/2018. R7 was evaluated by a medical provider on 3/15/2018. Nurse Practitioner (NP) note identifies evaluation of Haldol in HPI and Assessment/Plan related to Wernicke-Korasakoff psychosis with specific hallucinations, duration of medication and that medication had been effective and R7 declines tapering. R7 was discharged on 3/30/2018 to home. All guests receiving psychotropic medication currently in facility were reviewed on 4/3/2018 to ensure specific target behaviors are being monitored. All	

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F 758	Continued From page 4 "Triggered due to antidepressant received. Pt [patient] is on scheduled Effexor for depression and Haldol for psychosis. Pt [patient] scored 5/27 on PHQ-9 [depression screening] assessment indicating s/s [signs/symptoms] of depression. Pt is recovering from hepatic encephalopathy. Staff are monitoring targeted behaviors and s/s of drug side effect. Pt has been stable within this ARD [assessment reference date] period. Pt is at risk for psychotropic drug side effect." The CAA worksheet included no information on the resident and/or family representative's thoughts about the medication, and provided no historical or current information related to R7's specific symptoms, cause of psychosis, or historical information related to use of the Haldol. R7's psychotropic medication assessment dated 1/21/18, included: "1/14/18 Haloperidol 0.5 mg BID [twice daily] for psychosis...Monitor for target behaviors of antipsychotic: hallucinations and delusions." The assessment directed staff to document on non-pharmacological interventions used and the effectiveness of them. There were no specific symptoms identified to identify how R7 displayed delusions and hallucinations. The assessment provided no historical or current information related to R7's specific symptoms, cause of psychosis, or historical information related to the use of the Haldol.. Multiple provider progress notes were reviewed for information related to the use of the Haldol and R7's current and historical psychiatric condition. On 12/28/17, a nurse practitioner (NP) had documented, "HX of hallucinations...Haldol."	F 758	guests currently in facility and receiving anti-psychotic medications were also reviewed on 4/3/2018 to ensure historical information and specific symptoms were present to support ongoing use, and these medications will be reviewed by the primary care providers to determine if there are adequate indications present and document, or a plan for gradual dose reduction will be initiated. Medical Director consulted and verified that MD and NP, as primary care providers, are active members of the inter-disciplinary team (IDT). The facility will ensure that new admissions to the facility will have these areas addressed prior to the completion of their comprehensive care plan. Education will be provided to licensed staff, Licensed Social Workers and primary care providers by 4/24/2018 regarding Psychotropic and Unnecessary Medication Use Policy, specifically to ensure adequate indications for use of medication is present, specific symptoms are being monitored, target behaviors are being monitored and that the IDT is reviewing the ongoing need for these medications and documentation is present to support that ongoing need. Clinical Administrator and/or designee will audit 20 percent of guests weekly who use psychotropic medication per facility policy and report outcomes to QAPI Committee. The data will be reviewed and discussed during monthly QAPI	

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F 758	Continued From page 5 On 1/9/18 a NP had documented R7 had Wernicke-Korsakoff psychosis with use of Effexor and "plan: supportive cares." [Wernicke-Korsakoff syndrome is a brain disorder, due to thiamine deficiency.] On 1/22/18 a physician note indicated R7 had a diagnosis of Wernicke-Korsakoff psychosis from 5/11/14. Other physician and nurse practitioner notes were reviewed with no further information related to R7's use of the Haldol, current and historical psychiatric conditions, or specific symptoms of psychosis including notes dated: 1/13/18, 1/16/18, 1/23/18, 1/24/18, 1/29/18, 1/31/18, 2/2/18, 2/6/18, 2/15/18, 2/20/18, 2/28/18, and 3/7/18. Review of R7's Behavior Monitoring data for January, February and March 2018, revealed target behaviors including: 1.) isolation 2.) little interest in doing things 3.) hallucinations-seeing cats on the ceiling, confused about current location and thinking he's being kidnapped. 4.) delusions. The behaviors were noted as not occurring. On 3/13/18 at 9:43 a.m., R7's nurse practitioner (NP) was interviewed at the facility. The NP stated she did not want to discuss R7's medication regimen and stated, "My manager said I do not have to talk with you." The NP stated she was aware persons with Wernicke-Korsakoff could experience hallucinations related to the thiamine deficiency, and stated she had no further information related to R7's psychiatric history, specific symptoms or use of Haldol. Further, the NP stated she did not	F 758	meetings for three months. The QAPI committee will make the decision/recommendation regarding any necessary follow-up and auditing frequency. Corrective action will be completed April 24, 2018.	

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F 758	Continued From page 6	F 758		

address R7's use of psychiatric medications because historically, primary providers would not approve of changes to anti-psychotic medications however, confirmed she had not contacted R7's primary provider regarding the Haldol use. The NP acknowledged she was aware the use of Haldol had the potential for serious side effects.

On 3/13/18 at 1:19 p.m., the director of nursing (DON) stated the assessment completed for psychotropic medication use, and CAAs for psychotropic medications, were the only assessments related to R7's use of Haldol or psychiatric history related to psychosis. The DON stated he was unable to find any documentation as to when the psychosis had occurred, nor additional history regarding R7's delusions and hallucinations. At 2:31 p.m., the DON reported R7 had been on the Haldol "for awhile" and stated the providers at the nursing home would not address it since R7 was a short stay resident. The DON acknowledged the root cause of the psychosis should have been identified.

On 3/14/18 at 1:10 p.m., the social worker was interviewed and reported she was not aware of R7's history of psychosis or why he was on Haldol.

On 3/14/18 at 2:17 p.m. R7 stated he was on the Haldol due to hallucinations. R7 stated that while he was in the hospital about 2 years ago, he'd seen cats running around the ceiling and had been adamant they were there even though staff told him they were not. R7 stated he'd had no further hallucinations after starting the Haldol. R7 further stated no one had ever discussed with him the potential to discontinue the Haldol, but stated he'd be open to having that conversation.

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F 758	Continued From page 7	F 758		

On 3/15/18 at 8:39 a.m., the DON reported there was no evidence any facility staff had ever spoken with R7 about his use of Haldol. The DON again reported he was unable to find any history or current status regarding R7's specific symptoms, cause of psychosis, or historical information related to the use of the Haldol. The DON added that Haldol may be prescribed as a supportive treatment for Wernicke-Korsakoff psychosis. However, when documentation on this was requested, it was not provided. The DON stated staff were suppose to follow facility policies regarding unnecessary and/or psychiatric medications.

On 3/15/18 at 4:42 p.m., the DON stated he had amended the documentation for charting target behaviors for R7 after having spoken to the resident earlier that day. The DON stated he'd changed the Behavior Monitoring tool by adding a section for "seeing cats on the ceiling, confused about current location and thinking he's being kidnapped." The DON confirmed prior to that addition, there were no specific symptoms noted related to delusions or hallucinations.

The facility's Psychotropic and Unnecessary Medication Use Policy last revised 9/2017, included: "New Admissions: 1. Review of the use of psychotropic medications should be re-evaluated by the ARD [Assessment Reference Date] of the admission MDS [minimum data set] assessment. 2. Residents with a medication for an undocumented reason or without clear indication for the medication requires the facility to document if continuing the medication is justified by evaluating the condition, risks and existing medication regime. 3. The IDT

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F 758	Continued From page 8 [interdisciplinary team] is responsible to ensure that the physician, in collaboration with the pharmacist, re-evaluates all psychotropic medications and considers whether or not the medication can be reduced or discontinued upon admission or soon after admission. 4. The IDT will update the admission plan of care with the indication for use of psychotropic medication, and interventions within 48 hours of admission." The policy further indicated: "Specific target behaviors will be monitored for psychotropic medications. Antipsychotic medications may be prescribed for expressions or indications of distress, the IDT must first identify and address any medical, physical or psychological causes and/or social//environmental triggers. Doses must be administered at the lowest possible dose for the shortest time period. 2. Diagnoses alone do not necessarily warrant the use of of an antipsychotic medication. Antipsychotic medications may be indicated if: a. Behavioral symptoms present a danger to the resident or others. b. Expressions or indications of distress that are significant distress to the resident. c. If not clinically contraindicated, multiple non-pharmacological approaches have been attempted but did not relieve the symptoms which are present a danger or significant distress and/or d. GDR [gradual dose reduction] was attempted but clinical symptoms returned. "	F 758		

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	245623	A. BUILDING **01 - BENEDICTINE LIVING CENTER FRIDLEY** B. WING _____	**03/14/2018**

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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 FORM WILL BE USED AS VERIFICATION OF 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Interlude Restorative Suites of Fridley was found not 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/06/2018

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.

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K 000	Continued From page 1 Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or 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 Restorative Suites of Fridley is a 3-story building without a 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 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 licensed capacity of 50 beds and had a census of 43 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT METas evidence by:	K 000		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain smoke barriers shall be constructed to a ½ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.6. This deficient practice could allow smoke to travel throughout smoke compartments affecting the exiting capabilities of 8 patients and an undetermined amount of staff and visitors. Findings include: During the facility tour between 8:30 am and	K 372	The facility will maintain smoke barriers as required in the NFPA 101 Life Safety Code (2012) section 19.3, 8.5 and 8.7. The Environmental Services Director and/or designee will be responsible for ensuring the integrity of the smoke barriers to maintain a safe path of egress. The cross corridor doors identified in the TCU atrium will be repaired to ensure they close to prevent smoke from traveling throughout smoke compartments, as required by the NFPA 101 Life Safety Code (2012). An entry will be made in the electronic	4/24/18

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K 372	Continued From page 3 12:30 pm on 03/14/2018 observations revealed the cross corridor doors in the TCU Atrium did not close when tested. This deficient condition was confirmed Maintenance Director and Administrator.	K 372	work order system to ensure monthly and required yearly inspections of the smoke barrier doors are conducted. The Environmental Services Director and/or Designee will be responsible to ensure these door inspections are completed in a timely manner. Corrective action will be completed April 24, 2018.	