Electronically delivered
September 10, 2021

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

RE: CCN: 245623
Cycle Start Date: August 23, 2021

Dear Administrator:

On August 23, 2021, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On August 19, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires 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 § 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 effectiveAugust 23, 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.

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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.

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 electronic 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.

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 08/23/2021

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	INITIAL COMMENTS On 8/23/21, an abbreviated survey was completed at your facility by the Minnesota Department of Health (MDH). The facility was found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5623013C (MN75879) was substantiated with a deficiency cited at F689 past non-compliance and does not require a plan of correction. The survey resulted in an immediate jeopardy (IJ) at F689. The IJ began on 8/13/21, when a R1 eloped from the facility and crossed a busy street into a residential area. The administrator and DON were notified of the IJ on 8/23/21, at 4:09 p.m. The facility implemented corrective action by 8/19/21, and F689 is being issued at past non-compliance. Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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

Electronically Signed

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F 689	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure safety interventions for elopement were implemented following exit seeking behaviors for 1 of 1 residents (R1) reviewed for elopement. This failure resulted in an immediate jeopardy (IJ) when R1 eloped from the facility and crossed a busy street into a residential area 8/13/21. The facility had implemented corrective action so the deficient practice is being issued at past non-compliance. The IJ began on 8/13/21, when R1 eloped from the facility and crossed a busy street into a residential area. The administrator and DON were notified of the IJ on 8/23/21, at 4:09 p.m. The facility implemented corrective action on 8/19/21, prior to the start of the survey and was issued as past non-compliance. Findings include: R1's Admission Record printed 8/24/21, included diagnosis of hemiplegia (paralysis of one side of the body) following a cerebral infarction (stroke) affecting the left side, weakness, difficulty with walking and unsteadiness on feet. R1's admission Minimum Data Sheet (MDS) dated 7/12/21, indicated R1 had moderate cognitive impairment, required extensive assist with locomotion on the unit, and one person physical assist with locomotion off unit. R1's Elopement Risk Assessment dated 7/7/21, indicated R1 was not at risk for elopement. R1's care plan initiated 7/12/21, indicated R1 was	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

at risk for elopement due to history of attempts to leave the facility unattended. R1's care plan lacked interventions for R1's risk for elopement.

R1's care plan updated on 8/13/21, indicated elopement interventions were added including initiating a door security system on the unit, and R1 was put on hourly safety checks and an elopement risk assessment was completed.

On 8/5/21, at 9:34 p.m. a progress note indicated R1 had attempted to exit the floor multiple times on this shift.

On 8/5/21, at 4:23 p.m. a progress note indicated R1 was wandering into the hallways in the morning, and attempted to leave the unit three times. The door was closed at the hallway to the unit to provide a barrier.

On 8/13/21, a progress note indicated R1 was not in his room at 6:00 p.m. After an initial search of the room and the unit was completed, the missing persons protocol was implemented. R1 was located off campus, in a residential area around 7:00 p.m. R1 was brought back to the facility, and no injuries were noted.

On 8/13/21, at 7:54 p.m. a progress note indicated R1's care plan was updated to include a door security system on the unit.

On 8/13/21, a facility Resident Occurrence Report indicated cameras were reviewed and R1 went outside the facility at 5:45 p.m. and was found at approximately at 6:50 p.m. in a nearby residential area. R1 had used the sidewalk and crosswalk.

On 8/24/21, at 1:05 p.m. registered nurse (RN)-A

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F 689	Continued From page 3	F 689		

was interviewed and stated that nursing assistant (NA)-A notified her that R1 was not in his room at about 6:00 p.m. A search was started including the missing persons protocol. As soon as RN-A was updated R1 was returning to the facility, the door alarm was initiated. RN-A stated previously, R1 had attempted to leave the unit and the doors to the hallway were closed.

On 8/4/21, at 1:57 p.m. RN-B was interviewed and stated before R1's elopement on 8/13/21, R1 had attempted to leave the unit several times, and it was decided to close the doors to deter R1 from going off the unit.

On 8/24/21, at 3:18 p.m. the DON was interviewed and stated closing the doors on the unit after R1 attempted to leave on 8/5/21, was appropriate, and was effective at the time. The DON stated a staff members friend had alerted the facility R1 was seen away from the facility out in a neighborhood. R1 was picked up by the DON and brought back to the facility.

The facility policy Wandering and Elopement dated 4/19, directed the facility promotes the least restrictive environment for all resident while recognizing the potential of residents wandering from the facility. The facility will utilize monitoring and alarm systems; sign in and out logs on all units/households, and maintain pictures of all residents. This facility will also maintain a response plan for implementation in the event of a missing resident.

The past noncompliance immediate jeopardy began on 8/13/21. The immediate jeopardy was removed and the deficient practice corrected by 8/19/21, after the facility implemented a systemic

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F 689	Continued From page 4 plan that included the following actions: When R1 was returned to the facility at 6:50 p.m. by the DON, a skin assessment was completed that indicated no injuries. The double doors between the unit and the area located by the elevators had the alarm system initiated. Hourly checks of R1 were started and documented. The care plan was updated, as well as the nursing assistant task sheets, reflecting the elopement risk for R1. Staff were educated on the elopement policy. The corrective actions were verified though documentation review and staff interviews.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 10, 2021

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

Re: Event ID: C9I111

Dear Administrator:

The above facility survey was completed on August 23, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with 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

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	29890	A. BUILDING: _____ B. WING _____	C 08/23/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/23/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5623013C (MN75879) was substantiated at past non-compliance. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		