Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 31, 2023

Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

RE: CCN: 245450
Cycle Start Date: August 17, 2023

Dear Administrator:

On October 31, 2023, we notified you a remedy was imposed. On October 6, 2023 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 September 29, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 17, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 31, 2023, 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 October 13, 2023. 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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

September 7, 2023

Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

RE: CCN: 245450
Cycle Start Date: August 17, 2023

Dear Administrator:

On August 17, 2023, a 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C 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: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 17, 2023, (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).

In addition, if substantial compliance with the regulations is not verified by February 17, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245450	A. BUILDING _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE LINKS CARE CENTER	815 FOREST AVENUE NORTHFIELD, MN 55057

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E 000	Initial Comments On 8/14/23 to 8/17/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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 8/14/23 to 8/17/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued. H54504506C (MN95615) H54504507C (MN95727). 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/14/2023

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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F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained.	F 000		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess, develop and implement interventions to address unplanned weight gain for 1 of 1 resident's (R13) who sustained an undesired weight gain of 41 pounds over the last 15 months. Findings include: The Centers for Disease Control and Prevention	F 692	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. "Registered Dietician (RD) reviewed	9/29/23

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F 692	Continued From page 2 (CDC) "About Adult BMI" article dated 6/3/22, indicated a body mass index (BMI) for adults (over the age of 20 years) of 30.0 and above was obese. The article also indicated people who were obese were at an increased risk for many disease and health conditions including but not limited to: death, high blood pressure, diabetes, heart disease, stroke, osteoarthritis (a degenerative joint disease), mental illnesses (depression, anxiety) and a low quality of life. R13's significant change Minimum Data Set (MDS) dated 5/17/23, indicated R13 had intact cognition, was independent for eating, required limited assistance for transferring and extensive assistance for all other activities of daily living (ADLs). R13's diagnoses included coronary artery disease (CAD, excessive plaque in the heart), diabetes, morbid obesity, deep vein thrombosis (DVT-a blood clot in the lower extremities that can travel to the lungs or heart and be fatal), high blood pressure, chronic kidney disease, atrial fibrillation (irregular heartbeat resulting in increased clot formation in the heart), Alzheimer's disease, congestive heart failure (CHF), obstructive sleep apnea, abnormal weight gain, kidney stones, heart attack, and stroke. R13's Care Area Assessment (CAA) dated 5/17/23, indicated R13 triggered for ADL function, psychosocial wellbeing, mood state, falls, nutrition, dental care, pressure ulcers, and psychotropic drug use. R13's care plan dated 7/20/23, indicated R13 enjoyed activities including playing cards, following sports, church, socializing, and music. R13 used to do woodworking, went to parties, coached kids sports and gardened. Interventions	F 692	resident R13's nutritional status on 8/17/23 and 8/18/23, discussed weight goals with resident, implemented additional interventions including assistance with menu selection and revised the Care Plan. Resident is on track with the weight loss goal. RD or designee will meet with resident weekly for 6 weeks to review current weight, menu choices and ongoing weight goal. All residents have the potential to be affected. The RD and Quality Nurse completed a review of all residents to identify potential residents who triggered for weight gain in the past 12 months. Residents who met criteria were assessed, goals determined and interventions implemented as appropriate. Weight change trigger report is reviewed weekly at Quality meeting: residents who trigger are identified, interventions are determined and implemented and or assessed for effectiveness. RD was re-educated on requirement. Results will be monitored at weekly Quality meeting for 6 weeks. Weight change trigger findings will be reported to QAPI monthly. RD and DON are responsible for ensuring compliance. Date certain: 9/29/23	

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F 692	Continued From page 3 included family visits for socialization and treats and inviting R13 to group activities. The care plan also indicated R13 was at risk for falls due to weakness and had an ADL deficit related to frailty, CHF, and CAD. R13 also had an alteration in cardiac and respiratory status and preferred to sleep in his recliner due to shortness of breath. Interventions included encouraging adequate nutrition. The care plan also indicated R13 had diabetes. Interventions included monitoring R13 for hyperglycemia including increased appetite, offering diet condiments, smaller desserts, lower sugar drinks, and reviewing choices as needed. R13's Weights and Vitals Summary indicated R13's admission weight dated 9/27/21, was 236 pounds and remained consistent until the following weights were recorded in pounds: -5/11/22, 239 -5/18/22, 243.5 -5/25/22, 246 -6/1/22, 250 -6/8/22, 251.5 (a 5.23% increase in one month) R13's Weights and Vitals Summary indicated R13's weight remained consistent from 6/8/22 to 8/21/22, when R13's weight began to steadily increase as follows: -8/16/22, 249 -8/21/22, 254.2 -8/30/22, 256 -9/9/22, 258 -10/12/22, 258 -11/16/22, 260 -12/14/22, 262 -1/4/23, 261 -2/8/23, 262 -2/21/23, 264 -3/15/23, 266 -3/22/23, 269.5	F 692		

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F 692	Continued From page 4 -4/12/23, 270 -5/3/23, 262 (a 2.96% decrease in two weeks) -5/17/23, 273 (a 4.20% increase in two weeks) -6/21/23, 275 -7/26/23, 278.5 -8/16/23, 280 (a BMI of 42.6) R13's orders dated 7/11/22, indicated to encourage R13 to walk to meals per R13's family request. R13's Nutritional Assessments indicated the following: -1/30/23, R13's weight had gradually increased over the previous quarter. R13 had been drinking more "regular" soda and extra fluids. Interventions included offering diet condiments and smaller portions of some foods with a goal for R13's weight to be stable. -current weight: 260 pounds -goal weight: 220-225 pounds -5/3/23, R13's weight had gradually increased over the previous quarter. R13 had been drinking more "regular" soda and extra fluids such as lemonade and chocolate milk. Interventions included offering diet condiments and smaller portions of some foods with a goal for R13's weight to be stable. -current weight: 262 pounds -goal weight: 220-225 pounds The assessment lacked documentation addressing R13's significant weight loss (2.96%) over the two weeks before the assessment, or the significant weight gain (4.20%) during the two weeks after the assessment. R13's nutrition note dated 11/29/22, indicated	F 692		

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F 692	Continued From page 5 R13's weight had increased the previous month from the "mid 250's to low 260's. Since mid-summer months has increased 10# [pounds]." The note indicated, although for a short time, R13 had increased his water consumption, R13 had been asking for more chocolate milk and drank occasional soda and had increased behaviors in the dining room. The note further indicated the RD spoke to the provider regarding R13's weight gain. The provider was going to prescribe sertraline for R13's behaviors and advised R13 may have "some weight change" in relation to the medication. No further interventions were indicated to manage R13's weight changes. R13's hospital discharge summary dated 3/30/23, indicated R13 was treated for shortness of breath. Recommendations included to lose weight, as extra weight made it harder to breathe. R13's mini-nutrition note dated 5/3/23, indicated R13 had no decrease in food intake or weight loss over the previous three months and had a BMI of 23 or greater but a Mini-Nutrition Score indicating R13 was at risk for malnutrition. No further interventions or assessments were indicated. R13's care conference note dated 6/8/23, indicated R13 had gradual weight gain due to the consumption of high caloric, sugary drink and the lack of water. The note stated diet powdered drinks were discussed. No further information regarding outcome, education or interventions were documented. R13's provider note dated 7/11/23, indicated R13's weight had continued to increase. The	F 692		

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F 692	Continued From page 6 provider indicated he believed it was "secondary to excess caloric intake" and minimal mobility with no evidence of fluid overload. During an observation and interview on 8/14/23 at 7:19 p.m., R13 was sitting in his room in a recliner. R13's breathing was over 20 breaths per minute, shallow with a long expiratory phase, and could be heard across the room. R13 spoke two to three words at a time and stated he became "out of breath" whenever he got up. R13 stated although he had had difficulty breathing for about a year, it had gotten worse over the last couple of weeks. R13 further stated the doctor or nurses had never talked to him about it, although the doctor told his family he needed to lose weight. During an observation and interview on 8/15/23 at 1:07 p.m., R13 was sitting in his recliner speaking three to four words at a time. R13 stated his breathing was a little "heavier" that day. R13 stated at breakfast, his friends had even asked him what was wrong, stating he seemed out of breath. During an interview on 8/16/23 at 10:03 a.m., nursing assistant (NA)-D stated she had noticed R13 having more difficulty breathing the last two weeks and had requested assistance wheeling to the dining room, when previously R13 had been able to wheel himself. During an interview on 8/16/23 at 10:28 a.m., licensed practical nurse (LPN)-B stated although she was aware R13 had increased shortness of breath for past last week and had gained weight, his oxygen saturation was 96% and he appeared stable, therefore, he was not given oxygen.	F 692		

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F 692	Continued From page 7 During an interview on 8/16/23 at 12:27 p.m., registered nurse (RN)-H who was the nurse manager for R13's unit, stated R13 had not been walking much during the last two months, possibly due to a DVT he had in his leg. RN-H stated she was aware R13 had gained weight and thought he had been working with the registered dietician (RD). During an interview on 8/16/23 at 12:51 p.m., the nurse practitioner (NP) stated although R13 had a history of CHF, she and the physician believed R13's weight gain was due to excessive caloric intake rather than an exacerbation of his CHF or fluid retention. During an interview on 8/16/23 at 1:36 p.m., the RD stated R13 was independent with eating and often asked for four cartons of chocolate milk or lemonade at meals. The RD stated she had spoken to R13 about his food choices and weight gain, although she was unable to provide documentation regarding those conversations. The RD further stated she did not know why R13 had gained so much weight over the previous year and it was probably due to "a variety of reasons." The RD also stated she had not completed a risk vs. benefit form with R13 regarding his food preferences and/or excessive caloric intake and the effect it could have on his health and breathing. During an interview on 8/17/23 at 8:47 a.m., R13 stated the RD had talked to him that morning regarding his weight. R13 stated he did not realize he had gained as much weight as he had, or that it could be contributing to his difficulty breathing. R13 stated he was going to drink water instead of chocolate milk and the RD was going	F 692		

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F 692	Continued From page 8 to assist him to fill out his menu preferences with healthier choices. R13 further stated he was very happy because he could start going to activities again and he had a family wedding to attend the following month that he wanted to be healthier for. R13 stated he would have liked to have known about his weight gain earlier and did not have a goal to gain weight after his admission to the facility on 1/5/22. During an interview on 8/17/23 at 10:17 a.m., the director of nursing (DON) stated NAs took resident weights according to their orders and relayed result to the nurse. The nurse should assess the resident's weight and notify the nurse manager and RD if a change was identified. The RD should then assess the resident, asking about their food preferences, educate them on healthy alternatives, and complete a risk vs. benefit form if the resident preferred to continue engaging in unhealthy food choices. The DON further stated the facility did not have a procedure for the management of excessive weight gain for residents as the concern was more for residents who lost weight. A facility policy regarding significant weight change was requested but not received.	F 692		
F 812 SS=E	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	F 812		9/29/23

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F 812	Continued From page 9 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 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 frozen food items were stored in a manner to reduce the risk of cross contamination and potential foodborne illness in 1 of 1 walk-in freezers using the main production kitchen. This had potential to affect all residents who could potentially consume the items. Findings include: On 8/14/23 at 1:42 p.m., an initial kitchen tour was completed with the director of culinary service (DCS) present. A single CrownTonka walk-in commercial freezer was in use, opened, and inspected. The outside of the freezer door had a white sign posted which read, "Be very careful in freezer! Floor is very [underlined] slippery!! Walk like a penguin!!" Inside, the unit had a cooling fan mounted to the top of the unit which had various black-colored, foam-wrapped piping entering the fan unit on the right side. The wrapped piping exited the back of the unit, ran along the back wall of the freezer to the opposite side, then entered the wall. However, the piping	F 812	On 8/14/23, food items were immediately assessed, any food items with ice build-up touching were discarded and not used. Food items under ice build-up were immediately relocated. Maintenance staff discussed issue with vendor, reviewed potential causes of ice build-up and began repair of any idenfiable causes including condensation on piping in ceiling above freezer. Signage was updated to clearly state that food items and food boxes cannot be stored under ice build-up in freezer. Dietary staff and Maintenance staff were re-educated on requirement. Freezer audit for proper food item storage will be documented daily and reported to Administrator weekly for 6 weeks, findings will be reported to QAPI. Director of Culinary Service is responsible for compliance. Date certain: 9/29/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245450	A. BUILDING _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE LINKS CARE CENTER	815 FOREST AVENUE NORTHFIELD, MN 55057

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F 812	Continued From page 10 had visible ice built up in numerous places including along the unit. On the left side, where the piping entered/exited the freezer into the wall, the ice build up was thick and reached down the wall past the shelving which had various food items stored; and the entire piping track had ice build-up present which, in areas, was thick enough to have ice build-up hanging down from the piping towards the food product. The floor of the freezer and the metallic shelving used also had ice build-up present on them. Immediately below the cooling unit and ice-covered piping, there were several food items stored including opened boxes of 16" frozen pizzas, one opened box of 4 ounce (oz) individual ice cream cups, and several more unopened boxes of various ice cream products. The frozen pizzas were contained in a cardboard box which was soft and somewhat mushy-feeling to touch, and were wrapped in a commercial plastic wrap which had visible ice shards laying on top of it (from the ice above); and the opened box of ice cream cups also had ice shards sitting directly on the product (i.e., lids of the ice cream cups) along with the unopened boxes. A gauge present inside the unit measured -2 degrees Fahrenheit (F). DCS acknowledged the ice build-up and explained the freezer was old and needed to likely be replaced. DCS stated the ice build-up, to their understanding, was caused when the defrost cycles activated and caused the water to come "over the drip pan" and cause the build-up. DCS stated the facility' maintenance team was aware of it and had worked on it before. DCS explained the ice build-up issue had been happening for a "couple years" now with warmer months (i.e., Summer) being worse for it. On 8/15/23 at 8:45 a.m., a return visit to the	F 812		

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F 812	Continued From page 11 kitchen was completed. The same CrownTonka walk-in freezer was observed and inspected, and the ice build-up remained as prior along with the same food items stored below; however, now an additional foil-wrapped pan which had hand-written, "Lasagna 6/15," was present next to the ice cream cups which had visible ice shards present on it along with ice stuck to the foil. At 8:59 a.m., cook (CK)-A observed and verified the various food items had ice build-up present on them. CK-A explained the ice build-up had been happening for "couple weeks" to their recall but added the issue "comes and goes." Further, CK-A stated they had never been directed or asked to not store food items below the ongoing ice build-up, and subsequent dripping and potential cross-contamination of the water or chemicals inside the piping, but added moving the food was likely a "good idea." When interviewed on 8/15/23 at 9:10 a.m., DCS stated the ice build-up issues in the walk-in freezer had been happening for "probably about two years." DCS explained an outside refrigeration company had been in to inspect the equipment and they expressed a new walk-in freezer was needed to ultimately correct the ice build-up issues but cost was a consideration. DCS stated the freezer was still holding proper temperature but explained the equipment had several defrost cycles it went through which were normal, per the manufacturer, and was where the ice build-up issue was coming from when the drip pan, used to collect the condensation, overfilled or allowed it to run over. DCS acknowledged the food items continued to be stored under the ice build-up in the freezer and expressed they felt it was just the boxes being affected and not the food items. DCS stated if ice build-up was	F 812		

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F 812	Continued From page 12 physically present or touching the food items, such as the ice cream cups, then they "would pitch" and discard those items as the ice thawing (i.e., defrost cycle) "could potentially cross contaminate the food." Further, DCS stated the environmental service director (ESD) could explain more about the freezer and it's repair needs. When interviewed on 8/15/23 at 9:22 a.m., the ESD stated an outside refrigeration company had been in and "replace it" was the recommendation. ESD explained the freezer was old and the walls were starting to concave which allowed air to enter and cause the ice build-up which had been ongoing and happening for "a long, many, many years." As a result, the maintenance team was going into the freezer a couple times each month and breaking down the ice. Further, ESD stated they had expressed to the dietary department to not store food products under the ice build-up as it could lead to freezer burned items. On 8/15/23 at 2:55 p.m., DCS was interviewed, and they explained the defrost cycles were normal for the freezer and "nothing should thaw" during them. However, DCS acknowledged the boxes felt "moist or condensed" as a result which could, potentially, be a sign the ice was going through the start of a thaw cycle before re-freezing. DCS stated they just moved all of the food items from under the ice build-up and expressed they told staff "nothing on those back racks" until the issue was fixed. Further, DCS stated they were unable to locate a manufacturer book due to the freezer's age but expressed the cooling unit was "probably original" still. When interviewed on 8/17/23 at 9:55 a.m., the	F 812		

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F 812	Continued From page 13 registered dietician (RD)-A stated they were aware the freezer had been having an ice build-up issue which had even been raised at the safety meetings. RD-A stated the ice build-up could cause unwanted wetness on the food products and any contaminated or damaged items should be discarded. RD-A stated a 'mushy' box would indicate moisture, however, expressed there wasn't much other space in the freezer to store items. RD-A reiterated if food products were smashed or appeared unfrozen, then they would be discarded and not used. However, RD-A acknowledged the ice build-up and having items stored below it did present a potential cross contamination issue. A provided Food Storage-Perishable policy, undated, identified all perishable food would be stored at proper temperature " ... and is suitably protected to guard against contamination and growth of disease causing bacteria." The policy outlined several steps to ensure refrigeration was maintained, however, lacked any guidance or direction on what, if any, steps were taken to ensure proper freezer storage given the repeated ice-build up from the dated equipment.	F 812		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245450	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 8/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE LINKS CARE CENTER	**815 FOREST AVENUE NORTHFIELD, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for 2 of 2 residents (R31 and R46) to reflect resident or guardian participation in review for MDS accuracy. Failure to code the MDS correctly could potentially lead to inaccurate federal reimbursements and inaccurate assessment and care planning of the resident. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2018, identified the purpose of the RAI process was to help ensure holistic care was provided. In addition, accurate assessment sources must include family, guardian and/or other legally authorized representative to place the resident or their family at the center of decision making. R31's quarterly Minimum Data Set (MDS) dated 6/15/23, identified severe cognitive impairment and diagnoses of bipolar disorder (a mental health condition that causes extreme mood swings), vascular dementia, delusional disorders, anxiety disorder and depression. The section labeled, "Q0100. Participation in Assessment," recorded R31, "Resident has no guardian or legally authorized representative". Review of document scanned into R31's EMR titled Conservatorship document dated April 16, 2020 established through a court order conservatorship (legally authorized representative) for R31. During interview with facility registered nurse (RN)-A On 8/15/23 at 3:08 p.m., RN-A stated R31 did have a guardian and the quarterly MDS dated 6/15/23, was coded incorrectly. R46's quarterly MD, dated 7/2/23, identified R46 with severe cognitive impairment and diagnoses of Parkinson's, dementia, depression, and delusional disorder. The section labeled, "Q0100. Participation in Assessment," recorded R31, "Resident has no guardian or legally authorized representative". Power of Attorney (POA) (legally authorized representative) document scanned into the R46's electronic medical record (EMR) with date of July 22, 1997, listed R46's spouse (FM)-A as power of attorney. During interview with FM-A on 8/15/23 at 12:52 p.m., FM-A stated she is R46's POA and has been for years. During interview with RN-A on 8/15/23 at 12:36 p.m., RN-A looked at R46's MDS and indicated the section of the MDS regarding the participation in assessment was incorrectly coded. RN-A stated importance of accurate MDS coding is important, "because it affects our reimbursement and quality measures".

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245450	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 8/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Continued From Page 1 Facility policy titled, Resident Assessment Instrument Using Minimum Data Set, CAA, Summary and Utilization Guidelines with review date of 11/16 stated communications with the resident and/or resident representative are used to complete the MDS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245450	A. BUILDING **01 - THREE LINKS CARE CENTER** B. WING _____	**08/15/2023**

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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 08/15/2023. At the time of this survey, THREE LINKS CARE CENTER 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/14/2023

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. THREE LINKS CARE CENTER is a 2 story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1974 and was determined to be of Type II (111) construction. In 2000, addition was constructed and was determined to be of Type V (111) construction.	K 000		

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K 000	Continued From page 2 Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. Resident rooms are also outfitted with battery operated smoke alarms - these are not connected to the building fire alarm system The facility has a capacity of 92 beds and had a census of 69 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress reliability per NFPA 101 (2012 edition), section(s) 19.2.1, 7.1.10. This deficient finding could have	K 211	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is	9/29/23

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K 211	Continued From page 3 an isolated impact on the residents within the facility. Findings include: On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation that in the East Wing Memory Care Unit that an exit corridor was obstructed by storage and a trash barrel An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. East Wing Memory Care Unit hallway was cleared of obstructions on 8/16/23. All hallways were inspected on 8/16/23 with no deficient findings. Staff were reminded of the requirement on 8/16/23. All staff were re-educated on requirement. A notice of the requirement was posted in the same hallway. The hallway will be inspected weekly for 10 weeks, findings will be reported to QAPI. Maintenance Director or designee is responsible for compliance. Date certain: 9/29/23	
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain facility discharge from exits per NFPA 101 (2012 edition), Life Safety	K 271	"Egress exit concrete by RM 293 and basement Crossroads were both repaired by Northstar Mudjacking on 9/8/23.	9/29/23

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K 271	Continued From page 4 Code sections 19.2.1, 7.1.6.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation that the egress exit located by RM 293 exhibited a threshold to concrete slab vertical drop of 4 inches creating a trip and fall hazard. 2. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation that the basement Crossroads egress exit exhibited a threshold to concrete slab vertical drop of 2 inches creating a trip and fall hazard. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 271	All egress exits were inspected 8/16/23 with no deficient findings. Maintenance staff were re-educated on requirement. Egress exit concrete will be inspected at least quarterly. Maintenance Director or designee is responsible for compliance. Date certain: 9/29/23	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		9/29/23

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K 353	Continued From page 5 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 5.1.1.1, 5.1.1.2, 5.2.1.1.1, 5.2.1.1.2(2), 5.2.2.2, This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation in the Boiler Room that item(s) were in contact with the sprinkler piping system resulting in loading 2. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation in RM 143 that PVC piping was in contact with the sprinkler piping system resulting in loading 3. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation in Elevator Pump Room that a PVC tray was fully supported by the sprinkler piping system resulting in loading 4. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation in Kitchen that sprinkler heads exhibited a green surface	K 353	Conduit supports were removed for Boiler RM by Guth Electric on 9/7/23. PVC piping was removed in RM 143 by Mainenance staff on 8/21/23. PVC tray was removed in Elevator Pump RM by Maintenance staff on 8/21/23. All sprinkler piping in mechanical rooms were inspected by Mainenance staff with no deficient findings. Maintenance staff were re-educated on requirement. All sprinkler piping in mechanical rooms will be inspected monthly for 3 months, findings will be reported to QAPI. Kitchen sprinkler head will be replaced by vendor by 9/29/23. All sprinkler heads were inspected by Maintenance staff on 8/23/23 with no deficient findings. Maintenance staff were re-educated on requirement. 5-year sprinkler inspection was completed on 9/1/23. 5-year inspection will be scheduled in the work order system with a date prior to end of the next 5-year cycle. Maintenance staff were re-educated on requirement. Maintenance Director or designee is	

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	245450	A. BUILDING **01 - THREE LINKS CARE CENTER** B. WING _____	**08/15/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE LINKS CARE CENTER	**815 FOREST AVENUE NORTHFIELD, MN 55057**

(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 353	Continued From page 6 substance - possible oxidation 5. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by a review of available documentation, that the most recent 5-year sprinkler system inspection was completed 02/27/2018 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	responsible for compliance. Date certain: 9/29/23	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.3, 7.2.4.4, 7.2.4.5,, 7.3.1.1.1 These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation, that fire	K 355	FE's for Atrium DR and RM 101 had a documented inspection on 8/21/23 FE list for inspection was reviewed and determined to be accurate. Maintenance staff were re-educated on requirement. All FE inspection documentation will be audited by 2 separate maintenance technicians monthly for 3 months; findings will be reported to QAPI. Maintenance Director or designee is responsible for compliance. Date certain: 9/29/23	9/29/23

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K 355	Continued From page 7 extinguishers located in the Atrium Dining Room and in RM 101 had no dates / initials noted on the hangtags for the past two months. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation that the smoke	K 374	Crossroads Activity Kitchen door was corrected 8/21/23 and self-closes All fire doors were tested by 8/23/23 with no deficient findings. Maintenance staff were re-educated on requirement. All fire doors will be tested weekly for 10 weeks; findings will be reported to QAPI.B13 Maintenance Director or designee is	9/29/23

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K 374	Continued From page 8 barrier door located at the Crossroads Activity Kitchen did not self-close and seal the opening An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	responsible for compliance. Date certain: 9/29/23	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1, and 19.7.1.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed during a review of available documentation, that no documentation was presented to confirm that fire drills were conducted for 1st shift during 1st quarter.	K 712	A 12-month calendar for fire drills was created to include: fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. Maintenance Director was re-educated on requirement. Actual fire drill dates and times will be reported to QAPI at least quarterly for monitoring of compliance. Maintenance Director or designee is responsible for compliance. Date certain: 9/29/23	9/29/23

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K 712	Continued From page 9 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.4, and NFPA 80 (2010 edition), sections 5.2, 5.2.3 This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation that the fire rated exit door in the Kitchen required more than 30-pounds of force to initiate the operation and opening of the door.	K 761	The Kitchen exit door and the Great Room exit door in the basement were repaired by 8/23/23. All fire-rated exit doors were tested by 8/23/23 and any doors found not in compliance were immediately corrected. Maintenance staff were re-educated on requirement. All fire-rated exit doors will be inspected weekly for 10 weeks; report findings to QAPI. Maintenance Director or designee is responsible for compliance. Date certain: 9/29/23	9/29/23

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K 761	Continued From page 10 2. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation that the fire rated exit door in the basement Great Room required more than 30-pounds of force to initiate the operation and opening of the door. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 761		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K 918		9/29/23

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K 918	Continued From page 11 maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1, 8.4.9, 8.4.9.2. Thls deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that 36-month - 4-hour load bank testing is occurring An interview with the Maintenance Director verified thls deficient finding at the time of discovery.	K 918	The generator had 4-hour load testing completed on 8/31/23 by Cummins Sales and Service. The 36-month 4-hour load test will be scheduled in the work order system with a date prior to end of the next 36-month cycle. Maintenance staff were re-educated on the requirement. Maintenance Director or designee is responsible for compliance. Date certain: 9/29/23	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords	K 920		9/29/23

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K 920	Continued From page 12 Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage of relocatable power taps in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: 1. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation that at the Bridge and Crossroads Nurses Station there were relocatable power taps that were daisy-chained	K 920	All workstations were inspected on 8/15/23, defiencies identified in the survey were corrected on 8/16/23. All staff were re-educated on the requirement. All workstations will be inspected monthly for 3 months; findings will be reported to QAPI. Maintenance Director or designee is responsible for compliance. Date certain: 9/29/23	

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K 920	Continued From page 13 together 2. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation that in RM 289 and in the office adjacent to Housekeeping that appliance(s) were connected to relocatable power taps 3. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation that in the Basement in RM 161 a one-to-three electrical adapter use found in use An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than	K 923		9/29/23

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K 923	Continued From page 14 or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3, 11.6.5, 11.6.5.2, 11.6.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation that in the Med Gas (O2) Storage Room there was mixed storage of cylinders. 2. On 08/15/2023 between 9:45 AM and 4:15 PM, it was revealed by observation that in the Med Gas (O2) Storage Room there was combustible storage in the form of cardboard positioned less-than 5 feet from the O2 storage vessels.	K 923	Mixed storage of cylinders was corrected on 8/16/23 with the addition of a separate metal storage rack for empty cylinders. Empty cylinders are marked. Cardboard was removed from the oxygen room on 8/16/23. Signage was posted on requirements at the oxygen room. The Maintenance Director re-educated the Northwest Respiratory Services representative on 9/13/23 on the requirement including not leaving cardboard boxes in the oxygen room. Staff were re-educated on the requirement. The oxygen room will be inspected weekly for 4 weeks; then monthly for 2 months; findings will be reported to QAPI. Director of Nursing or designee	

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K 923	Continued From page 15 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	Date certain: 9/29/23	