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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 51IO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00564

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245450**

2.STATE VENDOR OR MEDICAID NO.
(L2) **770343100**

3. NAME AND ADDRESS OF FACILITY
(L3) **THREE LINKS CARE CENTER**
(L4) **815 FOREST AVENUE**
(L5) **NORTHFIELD, MN** (L6) **55057**

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) **02/01/2017**

6. DATE OF SURVEY **03/16/2020** (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)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **92** (L18)

13.Total Certified Beds **92** (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
	92			
(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 :
Sarah Grebenc, Unit Supervisor — 03/23/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 03/23/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1987
(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.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/11/2020
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 23, 2020

CMS Certification Number (CCN): 245450

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

Dear Administrator:

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

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

Effective March 8, 2020 the above facility is certified for:

92 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 92 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 23, 2020

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

RE: CCN: 245450
Cycle Start Date: January 17, 2020

Dear Administrator:

On February 7, 2020, we notified you a remedy was imposed. On March 16, 2020 the Minnesota Department(s) 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 March 8, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 6, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 7, 2020, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 6, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 8, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@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: 51IO

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(L2) **770343100**

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(L3) **THREE LINKS CARE CENTER**
(L4) **815 FOREST AVENUE**
(L5) **NORTHFIELD, MN** (L6) **55057**

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) **02/01/2017**

6. DATE OF SURVEY **01/17/2020** (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)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **92** (L18)

13.Total Certified Beds **92** (L17)

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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
	92			
(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 :
Sarah Grebenc, Unit Supervisor — 02/26/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 03/10/2020 (L20)

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

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

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3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
09/01/1987
(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.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
February 7, 2020

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

RE: 245450
Cycle Start Date: January 17, 2020

Dear Administrator:

On January 17, 2020, a survey was completed at your facility by the Minnesota Department(s) 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 6, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 6, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 6, 2020.

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

This Department is also recommending that CMS impose a civil money penalty. 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)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 6, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Three Links Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 6, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro D 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: sarah.grebenc@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by July 17, 2020 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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.

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@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
	245450	A. BUILDING _____ B. WING _____	C 01/17/2020

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 1/13/20, through 1/17/20, during a recertification survey. The facility is in compliance with Appendix Z, Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 1/13/20, through 1/17/20, a standard survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not to be in compliance with the federal requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5450040C Deficiencies issued at F609, F689. H5450041C Deficiencies issued at F609, F689. H5450042C Deficiencies issued at F609, F689, F744. H5450043C Deficiencies issued at F609 The following complaints were found to be unsubstantiated H5450039C 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,	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/17/2020

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.

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 01/17/2020

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
F 000	Continued From page 1 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 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident	F 565		3/8/20

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 01/17/2020

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
F 565	Continued From page 2 representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promptly respond to and resolve grievances for long call light wait time for 3 of 10 residents (R52, R54, R75) who participated in the resident council and for R59 and R8 who were not present. Findings include: On 1/14/20, at 10:00 a.m. a resident council meeting was held with residents R12, R24, R26, R29, R41, R45, R49, R52, R54, R75, the ombudsman, and member of the survey team in attendance. The resident council president, R54 stated the resident council met monthly and members of leadership and staff attended. When asked if the facility considered the views and recommendations of the residents, there was agreement the facility responded to concerns brought up in meetings. However, R54, R75, and R52 indicated they had brought up the long call light waits in previous meetings as a problem. R54 stated the call light issue was ongoing and while it is better at times, it remained a concern. R54 continued "Call times are an on and off problem. A lot depends on who is working and how much help they have. The toughest time is getting up and bed time". R52 and R75 added they experienced long wait times to get help from the staff. On 1/16/20, at 9:22 a.m. R54 clarified that the	F 565	F000 Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same Preparation, submission and implementation of this plan of correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed the alleged deficiencies and licensing violations. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and compliance with all applicable state and federal regulatory requirements and it constitutes the facility□s compliance. F565: Upon notification, a Suggestion, concern, and grievance form and individual plans	

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F 565	Continued From page 3 call light concerns remained a current and ongoing issue. R54 repeated that it "really depends on the time and who is working". R54 added that he was told the facility was trying to hire float staff but indicated the float position was not consistently filled. R54 stated he "tries to catch the staff in the hallway as they go past his room because the use of the call light can get a mixed response". On 1/16/20, at 9:37 a.m. R75 stated the call light issue was a problem and while it was better this week than last week, there were still concerns. R75 took a note pad from his nightstand and read it aloud. "On 1/7/19, I put call light on at 12:08 a.m. and at 12:28 a.m. I got myself into the wheelchair and transferred myself onto the toilet. I then put my light on the bathroom at 12:30 p.m. and staff came at 12:48 p.m. to take me off the toilet". R75 explained, "I don't like to s*** my pants and if no one shows up, I have to do it myself and one day last week I sat on the s***** for over 25 minutes before they showed up to help me off". On 1/16/20, at 10:00 a.m. R52 stated that he has experienced long wait times and this past week he waited at least one time for 45 minutes for staff to come and help him. R52 further stated that there were at least a couple of times when he waited up to 25 minutes for a staff person to respond to his call light. R52 stated that the worst time for him is in the evening at change of shift. Review of Resident Council (RC) meeting minutes revealed:	F 565	for follow-up were created for R8, R59, R52 and R54. R75 is no longer a resident at our facility, therefore steps could not be made for corrective action for this individual. Follow up will be done weekly with resident/representative by social services and clinical coordinator with R8, R59, R52 and R54. Interventions will be implemented following a quality improvement PDSA (Plan, Do, Study, Act) cycle until both residents verbalize satisfaction with the results. A resident centered care plan has been implemented and communicated to staff for R8, R59, R52 and R54 to address routine preferences. A resident council record and summary form will be written and implemented to assist in clearly outlining the needs and requests that the resident council group is communicating and discussing during each monthly resident council meeting. The form will include documentation for prompt response and rationale for each grievance, concern, suggestion, and recommendation of the group. An agenda item will be added to the resident council meeting and will be implemented at each meeting to address follow up information from the month□s previous meeting. Follow up will be clearly identified in the newly resident council minutes form. A new role titled, Quality of Life Coordinator, has been implemented and will oversee resident council to ensure proper follow up to each concern and assist in communication of concerns	

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F 565	Continued From page 4 The 9/27/19, RC minutes indicated one member stated "call light time is a problem". The 10/30/19, RC minutes indicated one member stated call lights were not answered timely. This was an "ongoing problem", and there was a long wait time in the mornings. A second member stated "someone will answer my call light and say "I'll go find someone", but they leave and no one comes". The leadership response indicated additional morning and evening positions had been approved and posted with no applicants as of yet. A nursing assistant class started and Human Resources worked hard to hire new employees. The 11/13/19, RC meeting minutes indicated the issue with call lights being answered timely was again raised by residents. One stated it took 1.5 hours to get up that morning. A second member stated he got himself into the chair himself because his call light went unanswered for half an hour. The residents were told nursing leadership would be asked to come to the December meeting. It is also noted that nursing leadership was looking into "Arial call light response escalation to improve overall response time". The 12/18/19, RC meeting minutes indicated residents reported continued "gaps" in response times to call lights. This was noted to be primarily in the morning and evenings. A member wanted to know if the call lights were answered in sequence. In response, a certified nursing assistant (CNA) /trained medical assistant (TMA) address the issue and noted the call lights were answered in the order that they were activated.	F 565	to the appropriate departments. This is a one person role. This role will also communicate resident council findings and follow up at the monthly quality assurance meeting. A revised call light policy will be written and implemented. Call light wait time rounding/audits will be completed weekly for four weeks and once a month for 3 months, at random times of day until acceptable practice is observed. Findings will be reported on in IDT quality meeting. A PIP including the plans to address call light wait times summarized above will be reported on at the monthly Quality Assurance Meeting until acceptable practices are observed and a sustainability plan is in place. Education of policies, forms, and expectations will be completed for all staff. The administrator or designee will be responsible for compliance on this tag by March 8, 2020.	

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F 565	Continued From page 5 During an interview with the Life Enrichment Director on 1/15/20, at 9:49 a.m. she verified call lights have come up as an issue in resident council. She followed up with leadership and leadership reports back to the members. The Life Enrichment Director clarified R54 wanted the call lights answered in sequence and that leadership is looking into a system that will provide better response times. On 1/16/20, at 8:37 a.m. the director of nursing (DON) stated that since she started at this location she has developed an action plan and she has took beginning steps and collected information for improvement in call light response times. She stated when she gets a call light complaint that she will pull the call light reports and evaluate them and do a root cause analysis. DON confirmed that some of the call lights are on longer than others, but that there are also call lights with short response times. Further, she was going to provide education to the staff related to call lights. DON stated the "aerial" system can do a hierarchy alert and explained that staff have "walkies" that alert them to the lights. During an interview on 1/13/20, at 3:49 p.m. R8 stated the most significant issue with living at the facility was the long wait time to get a response to the call light. R8 stated, "it was because the unit was chronically short staffed" and that although she was continent, she had to use incontinence briefs because staff didn't respond to her call light in time to help her to the bathroom. R8 indicated it consistently took more than half an hour for someone to answer her call	F 565		

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F 565	Continued From page 6	F 565		

light and by then it was too late to make it to the bathroom. R8 stated she reported this concern several times to several different people, including the nurse manager RN-D. R8 also stated the long call light response time was particularly problematic when she needed pain medication.
R59 stated on 1/13/20, at 3:44 p.m. she had to wait long times in the mornings for staff to answer her call light. R59 stated she had to wait for her pain pills. R59 stated she stayed mostly in bed and needed staff assistance for positioning, transfers and with activities of daily living (ADLs).

Supervisor Registered Nurse (RN)-B stated on 1/17/20, at 8:52 a.m. R59 "rings the call light a lot of times, she wants pain medications. RN-B stated she had pulled the call light report and R59 had pushed her call light button 168 times in 7 days. RN-B verified on the Associated Clinic Psychology assessment dated 1/3/20, R59 had told psychologist her concern at the facility was for long call light waits.

The Quality Assurance Performance Improvement (QAPI) committee notes dated 11/26/19, indicated there were continual complaints on Resident Council regarding call light wait time. The minutes also indicated staff were coming in and turning off resident call light without providing assistance. QAPI minutes dated 12/18/19, did not address call light wait times or staff not responding to resident call light.

Call light policy requested and not provided.

Call light logs were requested for R52, R54, R75 and not provided.

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F 565	Continued From page 7 Facility policy Arial Wireless Communication System (no date) indicated every nursing department member will use the communication system for resident communication and staff to staff communication. This is done through the use of call stations and portable radios that floor staff have on their person throughout the shift. Facility policy Suggestion, Concern, or Grievance Form, dated November 2019, indicated the form is used by staff members to document an individual's suggestion, concern or grievance. The director of social services or designee is responsible for this process. Resident Council policy last updated 12/19, indicated: Within the resident council, the members have the opportunity to express their concerns or grievance, contribute ideas and make recommendations regarding the facility's functions.	F 565		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		3/8/20

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F 584	Continued From page 8 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean living environment was provided for 4 of 4 residents (R1, R21, R31, R58) reviewed for environmental concerns. Findings include: R1's quarterly Minimum Data Set (MDS) dated 12/6/19, indicated R1's cognition was intact. R1's	F 584	F584 Upon notification of the living environments of R1, R21, R31, and R58, a deep clean schedule for all four of the resident□s room was implemented to immediately correct cleanliness. Oversight of the deep clean schedule will be done by the housekeeping services supervisor. Routine quality checks in the	

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F 584	Continued From page 9 diagnoses included difficulty walking and history of falling. During an observation on 1/13/20, at 2:01 p.m. it was noted that R1's room was extremely cluttered with empty containers and pop can on the over the bed table, several afghans on the floor, a shoe box in the pathway to the recliner, and papers scattered on two bedside tables, and the desk, Additionally, the linoleum floor was visibly dirty and there was a thick layer of dust on the desk, dresser, and bedside table. There were two scrunched up Kleenex under the bed. The door was held open by a rag tie between the door handle and a handle on the dresser. Observation on 1/14/20, at 3:35 p.m. revealed the room in the same condition and a urinal was noted on the bedside table. During an interview on 1/15/20, at 8:03 a.m. R1 stated his room was a mess and that he needed more room. R1 indicated he could independently get out of bed into his wheelchair and thought there was plenty of space to get out of the room. Five empty pop cans were on R1's over the bed table and he stated they had been there a couple of days. R1 indicated that the room was "not as clean as it should be". R1 indicated they sweep once in a while, but thought they should do it every day". R1 stated the paper bag on the floor contained Christmas presents and the shoes in the box were too small, and his daughter planned to return them. It was noted that urinal and Kleenex under the bed were still there. Two garbage cans were in the room, one of which was overflowing.	F 584	long term care area is also currently being done by the housekeeping services supervisor. A documentation form will be written and implemented by housekeeping services for room cleaning completion and resident refusal of services. If any resident refuses housekeeping services, social services will be made aware. The housekeeping services supervisor will educate all of the housekeeping staff on room cleanliness expectations, standards, and policies. Regional director of the housekeeping services company will do an internal review of all cleaning processes. All staff will have education completed on room cleanliness expectations and process on the Maintenance Care system to create tasks when housekeeping needs are identified. Audits will be done by the Environmental Services Director, weekly for 4 weeks, then monthly for 3 months, of completion of housekeeping tasks addressed in the Maintenance Care system until acceptable practice is seen. A quality control inspection housekeeping checklist will be completed Monday through Friday daily for two weeks, then weekly for two months. IDT safety rounding will be implemented bi-weekly. Observations and follow-up will be reported on in the monthly safety committee meeting. The safety	

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F 584	Continued From page 10 R21's quarterly MDS dated 10/20/19, indicated mild cognitive impairment and listed diagnoses that included quadriplegia and multiple sclerosis. During an observation on 1/13/20, at 2:53 p.m. it was noted that the carpet had crumbs all through the room. On 1/14/20, at 12:35 p.m. the carpet had still not been vacuumed. On 1/15/20, at 12:15 p.m. the carpet has still not been vacuumed. R31's quarterly MDS dated 12/7/19, indicated mild cognitive impairment and listed diagnoses that included Parkinson's and repeated falls. During an observation of R31's room on 1/13/20, at 3:18 p.m. it was noted the carpet had three areas with crumbs crushed into the carpet. The garbage can was overflowing. On 1/14/20, at 9:28 a.m. the carpet had the same areas of crumbs, but the garbage had been emptied. On 1/15/20, at 12:33 p.m. it was noted the carpet had still not been vacuumed and that the over the bed table was dirty and sticky. Nursing assistant (NA)-F verified the dirty carpet and table. R58's quarterly MDS dated 10/12/19, indicated mild cognitive impairment and listed diagnoses that included dementia. During an observation on 1/13/20, at 2:13 p.m. it was noted the room was cluttered and the carpet	F 584	committee with report further to QAPI if trends indicate a need for a PIP. Education of policies, forms, and expectations will be completed for all staff. The administrator or designee will be responsible for compliance on this tag by March 8, 2020.	

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F 584	Continued From page 11 had crumbs an debris all over. On 1/14/20, at 9:38 a.m., the clutter was no longer evident, however, the carpet had still not been vacuumed. On 1/15/20, at 12:15 p.m. the carpet has still not been vacuumed. Housekeeping aide (HK)-A was interviewed on 1/16/20, at 7:27 a.m. and stated each wing had one housekeeper on day shift. Daily responsibilities were outlined as: clean each room, sweep and mop the bathroom floors, clean the sink and toilet, empty garbage, vacuum carpets and light dusting of all surfaces. HK-A stated the over the bed tables were washed off using an antiseptic agent. On 1/16/20, at 7:39 a.m. housekeeping manager (HK)-B was interviewed. HK-B indicated that housekeeping was a contracted service. HK-B stated the expectation was that every room was cleaned daily and included cleaning of toilet and sink, mop and vacuum the floors, wipe off of all surfaces, and light dusting. HK-B indicated that housekeeping staff do not straighten up items in the rooms. During a walk through of the unit, HK-B verified the dirty floors and surfaces of each of the rooms identified. HK-B stated the condition of the rooms was not acceptable.	F 584		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		3/8/20

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F 609	Continued From page 12 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to timely report to the State Agency (SA) and/or administrator for 2 of 2 residents (R29, R73) reviewed for resident to resident altercation and for 3 of 6 residents (R9, R35, R67) reviewed for abuse. Findings include: F29's Fall Report dated 1/8/20, at 5:15 p.m. identified R29 fell in the dining room after R29 and another resident attempted to sit in the same	F 609	F609 Preparation, submission and implementation of this plan of correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed the alleged deficiencies and licensing violations. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and	

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F 609	Continued From page 13 chair. The other resident was noted to have "pushed" R29 in the chest area, which caused R29 to lose her balance and fall onto her right side. R29 was noted to limp and stated her hip and upper leg were sore, bruises noted to R29's right elbow measured 9 centimeter (cm) long by 3 cm by 3 cm, right hip measured 4 cm by 2.5 cm and right front knee measured 3 cm by 4 cm and was almost noted as swollen. The facility investigative filed submitted 1/8/20, at 9:11 p.m. indicated R73 pushed R29 when both R73 and R29 attempted to sit in the same chair. When R73 "pushed" R29 "in the chest area" R29 "was unable to regain her balance falling to her right side." R29's quarterly Minimum Data Set (MDS) dated 12/23/19, identified R29 had moderately impaired cognition and diagnoses which included dementia and anxiety. The quarterly MDS indicated R29 had no behaviors during the reference period and required extensive assistance from one staff for ADLs (activities of daily living). R73's quarterly MDS dated 12/26/19, identified R73 had severe cognitive impairment and diagnoses which included dementia and anxiety. The quarterly MDS indicated R73 had physical behavioral symptoms one to three days during the reference period. The MDS further indicated R73 required extensive assist of two staff with ADLs. R29's and R73's medical records lacked evidence of timely notification to the administrator and/or SA of the incident on 1/8/20.	F 609	compliance with all applicable state and federal regulatory requirements and it constitutes the facility□s compliance. Upon notification of concern reporting files were reviewed for R29, R73, R9, R35, and R67 with the current staff responsible for creating OHFC reports to assess immediate areas for improvement and correction. The resident protection policy will be reviewed and revised to outline the reporting structure required to make timely reports to OHFC, as stated in in regulation 483.12. Furthermore if the designated reporters (DON and ADON) are found to be unavailable an alternate contact plan will be written and implemented. A timeliness of reporting audit according to the resident protection policy will be done by the Director of Nursing each time a report is submitted. If a practice is found to be incongruent with standards, education will be done regarding the time requirements of state agency reporting until acceptable practices are reached. A summary of vulnerable adult reports and time audits will be reported on at the monthly QAPI meeting by the Director of Nursing. Education of policies, forms, and expectations will be completed for all staff. All nurses, nurse supervisors, and	

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F 609	Continued From page 14 The administrator, the director of nursing (DON) and registered nurse (RN)-A were interviewed on 1/17/20, at 11:18 a.m. RN-A stated it was her understanding the facility had to report the incident within two hours if major injury suspected and 24 hours if serious bodily injury was not suspected. RN-A explained she attempted to contact the facility supervisor whom was in the facility, however was unable to reach her until 9:00 p.m. which was why the report was not submitted until 9:11 p.m. RN-A indicated she updated DON and administrator at that time. DON stated R73 did not have intent when he pushed R29. The administrator indicated the incident was not reported within two hours as there was no new injury. RN-B was interviewed on 1/17/20, at 12:27 p.m. and explained around dinner time R73 and R29 had an altercation. RN-B stated she was in the dining room five minutes earlier and R73 and R29 were at two different tables then I left and when I returned NA-A notified RN-B R29 fell. RN-B stated R73 extended his arm to "say this is my chair" and when R73 made contact with R29; R29 lost her balance and fell. RN-B stated R73 did not appear to be upset, however seemed "surprised." RN-B stated R73 intended to sit in the chair and "was like with his arm no I am sitting here." RN-B confirmed she completed R29's fall incident reported and acknowledged "he did push her it was a not this is my chair it was enough with his hand to make" R29 off balance and fall. R9's quarterly MDS dated 11/2/19, indicated history of a stroke, diagnoses hemiplegia,	F 609	nurse managers will be educated on their particular responsibilities for reporting to the DON, ADON, and alternative designee. The administrator or designee will be responsible for compliance on this tag by March 8, 2020	

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Parkinson's, and dementia with Lewy bodies and that R9 was cognitively intact. Additionally indicated R9 needed one person assist with transferring, mobility, toileting, dressing, and personal hygiene.

R9 reported an allegation of abuse to RN-D on 11/11/19, at 9:32 p.m. R9's facility investigation report indicated that on 11/11/19, at 9:32 p.m. R9 expressed concern to RN-D, the evening shift supervisor, about interactions with NA-G. R9 stated NA-G was very short with her and yelled at her. NA-G did not treat her kindly and did not show empathy or caring. R9 indicated that NA-G said, "I told you to put the light on, it's my job, I'll get fired if you fall or something". NA-G acted like he was forced to help her and R9 felt demeaned. R9 requested to not have NA-G care for her.

There was no documentation regarding this incident in nursing progress notes.

The facility submitted the report of these allegations to the SA on 11/12/19, at 2:38 p.m. which was 17 hours after the allegations were reported to the nursing supervisor.

R35's quarterly MDS dated 11/17/19, indicated diagnoses including anxiety, depression, dementia, and convulsions. R35 was cognitively intact. R35 reported an allegation of abuse to RN-D on 11/11/19, at 9:32 p.m. R35's facility investigation file indicated that R35 reported to RN-D that NA-G had no patience and was rushed during cares and threw a towel across the room while providing care for her. The towel was not thrown at her and did not make contact with her. R35 requested NA-G not provide care for

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F 609	Continued From page 16 her. During an interview on 1/15/20, at 10:08 a.m. R35 stated that NA-G was harsh and rough when transferred from the wheel chair to the recliner. She stated was not hurt and she did not say anything to him. R35 indicated that NA-G cared for her frequently on weekends. NA-G told her "if she didn't behave yourself you would be put downstairs (higher level of care)" and R35 felt threatened by that. R35 said to him "please don't hurt me". R35 stated she reported the interaction to the nurse, but did not remember who. DON was interviewed on 1/17/20, at 8:54 a.m. and stated the allegations were reported to the evening nursing supervisor, RN-D on 11/11/19. RN-D sent the report to DON via email on 11/12/19, at 1:30 p.m. DON stated the expectation is that any report regarding abuse or mistreatment would be communicated via immediate direct, personal contact and a report would be sent to the SA within two hours of the allegations being made. DON stated RN-D would have been counseled regarding the delay in communicating the allegations, however, she was no longer employed at the facility. DON stated NA-G was immediately suspended. DON verified that the incident occurred on 11/11/19, at 9:32 p.m. but the report was not submitted to the SA until 11/12/19, at 2:38 p.m. more than 17 hours after incident was first reported. The facility Resident Protection Program Policy dated 3/2019, indicated the definition of verbal abuse was language that willfully included disparaging and derogatory terms made to a resident. The policy indicated if the event	F 609		

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involved abuse or resulted in serious bodily injury the report must be made no later than two hours after the allegation was made.

R67's face sheet, undated, included a diagnosis of dementia with behaviors.

R67's admission Care Area Assessment worksheet dated 2/14/19, indicated staff needed to anticipate all needs, provide for all cares, cue and redirect R67 as needed.

R67's quarterly MDS dated 5/23/19, indicated severely impaired cognition. Additionally indicated, R67 required extensive assist with ADLs and needed supervision with eating.

R67's care plan dated 12/14/19, indicated R67 had dx that included dementia and was at risk for injury related to self-transfers, self-ambulation, habit of wandering unit daily in wheelchair and resistance to staff assistance with cares multiple times.

R67's incident progress note dated 8/14/19, at 7:29 p.m. indicated R67 was involved in a physical incident with R136. Just prior to dinner R136 extended a hand and wanted R67 to get up and walk and follow him. Although R67 was able to walk, she refused. R136 became upset that she wouldn't walk and took her by her right arm and began to drag her down the hall stating that he had to save her from "them". R67 indicated she was afraid and yelled out.

The facility investigative file submitted 8/14/19, at 8:40 p.m. stated the incident occurred at 5:50

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p.m. The investigative file indicated R136 wanted R67 to walk and follow him. R67 refused. Then, R136 pulled R67 by her arm in her wheelchair down the hall. The file lacked evidence of a timely notification to SA.

When interviewed on 1/14/20, at 9:20 a.m. family member (FM)-C stated I don't remember how soon I was notified after that incident. For sure, within the day, staff will call me at home and let me know if there's an incident.

When interviewed on 1/16/20, at 10:31 a.m. care coordinator RN-A stated reporting of abuse depends on circumstances. If major injury right away to within two hours. We still try to report within 24 hours even if no injury. Regarding the incident on 8/14/19, RN-A stated the incident was not reported within two hours because there was no injury or harm.

When interviewed on 11/16/19, at 11:43 a.m. DON stated since this incident was witnessed and no intent by the resident to cause harm I don't think it fell within the two hour range.

LPN-C was interviewed via telephone on 1/16/20, at 4:36 p.m. and recalled being the nurse during the incident. R136 was pushing R67 in her wheelchair. I reported that he wanted R67 to walk with him. R136 had 1:1 after that to ensure safety. R136 had a decline and interventions were put in place. Right away I called the supervisor. We ended up calling 911 and sent R136 to the hospital due to behaviors that escalated. LPN-C stated abuse has to be reported right away.

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F 609	Continued From page 19 The Resident Protection Program Policy dated 3/2019, indicated resident to resident abuse may not cause serious harm. If it was willful (meaning the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish) or causes serious harm it should be reported. The policy indicated if the event involved abuse or resulted in serious bodily injury the report must be made no later than two hours after the allegation was made.	F 609		
F 689 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate supervision when 1 of 1 resident (R29) was pushed by another resident (R73) resulting in a fall. This resulted in actual harm for R29 who suffered a pelvic fracture as a result of the fall. In addition, the facility failed to ensure the safety of 1 of resident (R10) who had fallen and failed to provide needed education to employee who had not followed the care plan. Additionally, the facility failed to provide an environment free from a tripping hazard to ensure the safety of 1 of 1 resident (R29) who was at risk for falls.	F 689	F689 Preparation, submission and implementation of this plan of correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed this alleged deficiencies and licensing violations. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and compliance with all applicable state and federal regulatory requirements and it	3/8/20

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F 689	Continued From page 20 Findings include: Family member (FM)-B was interviewed on 1/16/20, at 1:01 p.m. and stated R29's life changed after R73 "pushed" R29 causing R29 to sustain two detached fractures of the upper and lower pubic rami bone (pelvic fracture). FM-B explained it took over a week to confirm the fractures due to a portable x-ray completed at the facility showing a past fracture. FM-B stated R29 began to have pain after the fall 1/8/20, which did not improve so R29 was taken to the hospital where they diagnosed a current fracture. FM-B stated R29 was now scared of R73 and had told FM-B "I am scared, I am scared of him." FM-B stated she was told both R73 and R29 were trying to sit in the same chair when R73 pushed R29. FM-B stated she wanted the facility to lay out a care plan to reassure FM-B that R73 would not "push my mom" again. FM-B stated the hospital's social worker had suggested R29 move closer to the desk so the staff could "watch better." FM-B stated, "I just need to know what the plan is." F29's Fall Report dated 1/8/20, identified R29 fell in the dining room after R29 and another resident attempted to sit in the same chair. The other resident was noted to have "pushed" R29 in the chest area, which caused R29 to lose her balance and fall onto her right side. R29 was noted to limp and stated her hip and upper leg were sore. In addition, bruises were noted to R29's right elbow which measured 9 centimeter (cm) long by 3 cm by 3 cm, right hip measured 4 cm by 2.5 cm, and right front knee bruising measured 3 cm by 4 cm and was almost noted as swollen. The report indicated nursing assistant	F 689	constitutes the facility□s compliance. Upon notification of risks to R29 regarding supervision of R73, the facility reviewed and implemented the revised resident centered behavior care plan for each resident. R73 is on frequent checks as able to observe any behavior risk to others. Review of R73□s medical record indicates no documentation or observation, since the incident on 1/8/2020 that has indicated any behavioral expression creating risk towards other residents. Resident□s behavioral expressions of combativeness with cares has improved in number of episodes in the last 30 days. This follows the implementation of non-pharmacological interventions and an increase in R73□s antidepressant. Facility will continue behavior tracking record of R73 to assess if non-pharmacological and pharmacological interventions are meeting care plan goals. Residents who display behaviors that pose a risk of injury or a resident to resident altercation risk will be reported on at the BHT (behavioral health team) weekly meeting to review needs and behavioral plan. ACP (Associated Clinic of Psychology) consult referrals are made based on need at this meeting. The BHT will complete audits of behavior documentation and ensure an IDT behavior plan for behavioral expressions	

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F 689	Continued From page 21 (NA)-A witnessed the incident. The facility investigative filed submitted 1/8/20, indicated R73 pushed R29 when both R73 and R29 attempted to sit in the same chair. When R73 "pushed" R29 "in the chest area" R29 "was unable to regain her balance falling to her right side." FM-A was interviewed via telephone on 1/17/20, at 8:59 a.m. and stated she was not aware R73 pushed another resident and indicated R73 would get agitated when asked to do something. Nursing assistant (NA)-C was interviewed on 1/17/20, at 9:21 a.m. and stated R73 would hit, swing out and push staff when providing personal cares. NA-C was unaware R73 had any issues with another resident and was only aware of altercations with staff however, indicated R73 could "switch moods quickly." R73 was observed on 1/17/20, at 9:27 a.m. seated calm in recliner in common area with magazine in hand. Attempts to interview R73 at that time were unsuccessful. Licensed practical nurse (LPN)-A was interviewed on 1/17/20, at 9:28 a.m. and stated R73 would push and hit staff during cares and indicated staff were to offer him a stuffed dog to hold to decrease the incidence of pushing and hitting. LPN-A stated she was not aware R73 had hit or pushed another resident and was only aware of altercations with staff. The Nurse Practitioner (NP) was interviewed via telephone on 1/17/20, at 9:37 a.m. and stated R29's x-ray completed at the facility showed a	F 689	that have the identified potential to have a negative result to the resident themselves or others is implemented. Audits will be done once weekly for two weeks. Then once monthly for two months until an acceptable practice is attained. Upon notification of the tripping hazard risk to R29 maintenance completed a safety risk assessment of the device that as noted by a surveyor. When maintenance completed this safety assessment the area was free and remains free of tripping hazards. IDT safety rounding in all care areas will be implemented bi-weekly to observe for such hazards. Observations and follow-up will be reported on in the monthly safety committee meeting. The safety committee will report further to QAPI if trends indicate a need for a PIP. Upon notification of the failure by staff to follow the care plan on 11/27/2019 for R10 which resulted in a fall, all staff in the care area educated on current care plan for R10. The nursing assistant that did not follow R10□s care plan that lead to a fall on 11/27/29 will have corrective action follow up and will have education on fall risk and following the plan of care. The falls and accident policy will be reviewed, updated, and implemented to outline expectations of education for all staff to follow the care plan and consider additional interventions to keep resident from previously identified risk. Also the	

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F 689	Continued From page 22 subacute right pelvic fracture however, NP indicated this did not correlate with R29's acute onset of pain. NP stated on 1/10/20, she called the x-ray company who again indicated a subacute fracture which possibly happened five to twelve weeks prior. NP indicated on 1/15/20, R29's pain and bruising correlated with an acute fracture and she called R29's family and it was decided R29 would be transferred to the hospital. NP explained a computed tomography (CT) was completed at the emergency room which showed an acute fracture, believed to be a result of R29's fall after having been pushed by R73. R29 was interviewed on 1/17/20, at 10:01 a.m. and was unable to answer questions. At that time, R29 was observed lying calmly in bed with her wheelchair and walker at her bedside. R73's Behavioral Symptoms Care Area Assessment dated 3/28/19, identified R73 wandered on the unit into other resident rooms, yelling and threatening staff and raised his hand towards staff and directed staff to reapproach, use calm and quiet approach, medications as ordered and observe for changes. R73's Vulnerable Adult Care Plan created 6/18/19, identified R73 was combative with staff which included striking and kicking out with toileting, perineal and other hygiene tasks and directed staff to see activity of daily living (ADL) and fall risk, cognition and communication and elopement/wandering and elimination and skin focuses for additional interventions. R73's Elimination Care Plan revised 9/25/19, identified R73 was always incontinent and directed staff to inform nurse when R73 was combative striking or	F 689	expectations for falls follow-up and intervention will be reviewed and implemented accordingly. Falls will be reported daily at the morning IDT and at the weekly IDT quality meeting for follow-up on interventions for prevention and at the facility stand-up meeting with all departments in attendance, so that all are aware of current trends in falls and awareness for prevention purposes. Fall risk assessment audits will be completed to ensure compliance with current policy by the Director of Nursing once weekly for all falls for four weeks. Until acceptable practice is attained. Education of policies, forms, and expectations will be completed for all staff. The administrator or designee will be responsible for compliance on this tag by March 8, 2020.	

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kicking out during toileting cares. R73's Cognition and Communication Care Plan created 1/8/20, identified R73 had severe cognitive impairment and was able to understand verbal language only occasionally and directed staff to identify yourself with each interaction, face R73 when speaking, make eye contact, reduce distractions, understands consistent, simple, directive sentences, provide with necessary cues stop and return when agitated, use pictures or real items, gestures and facial expressions, lavender essential oil at 2:30 a.m. to reduce agitation with overnight cares in the early morning, assist with all decision making, limit choices, use cueing, task segmentation and one-step instructions. R73's ADL/mobility Care Plan revised 1/10/20, identified R73 had cognitive impairment and history of being resistive to cares and directed staff to hand-hold guidance of one staff and two when resistive or wandering into others rooms, cues for bed mobility, cue and prompt with one to two staff to dress and with hygiene, assist with eating, offer stuffed dog to hold before starting cares at night, assist of two staff with hand-hold guidance for transfers and wheelchair with anti-rollback. R73's Elopement/wandering Care Plan revised 1/13/20, identified R73 had agitation with hygiene/toileting due to dementia with behavioral disturbance and directed staff to observe whereabouts on unit frequently, ensure family sign R73 out at desk, redirect, resided on secured dementia care unit, picture and word toilet on R73's bathroom door, name on room door, guide to bed and validate feelings. R73's Fall Risk Care Plan revised 1/15/20, after survey began, identified R73 was at risk for falls and directed staff to lead R73 to a chair and encourage to "sit as he allows to avoid more than

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F 689	Continued From page 24 one person attempting to sit in a chair," non-skid socks, manual wheelchair with anti-rollback, hip pads, bed at appropriate height and see ADL/mobility bowel and bladder and mood/behavior interventions as appropriate. R73's care plan lacked evidence of incident with R29 on 1/8/20, when R73 was noted to have pushed R29 due to both R73 and R29 attempting to sit in the same chair. Furthermore, R73's care plan lacked evidence regarding R73 not wanting others close to him. R29's Vulnerable Adult Assessment Care Plan revised 9/20/19, identified R29 was at risk for injury to self or others due to dementia diagnosis and directed staff to monitor whereabouts and redirection. R29's Vision Care Plan revised 1/10/20, identified R29 cannot see right field of vision and directed staff to assist R29 in crowded areas such as dining room. R29's Care Plan revised 1/15/20, after survey began, identified R29 was at risk for falls due to loss of balance when turning head to the left and directed staff to place silent bed alarm, anti-roll back wheelchair, bed at appropriate height, call light within reach, proper footwear, therapy as ordered and ambulate as tolerated. R29's care plan lacked evidence of R29 having been pushed by R73 on 1/8/20, which resulted in a fall and pelvic fracture. R29's quarterly Minimum Data Set (MDS) dated 12/23/19, identified R29 had moderately impaired cognition and diagnoses which included dementia and anxiety. The quarterly MDS indicated R29 had no behaviors during the reference period and required extensive assistance from one staff for ADLs (activities of daily living).	F 689		

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F 689	Continued From page 25 R73's quarterly MDS dated 12/26/19, identified R73 had severe cognitive impairment and diagnoses which included dementia and anxiety. The quarterly MDS indicated R73 had physical behavioral symptoms one to three days during the reference period. The quarterly MDS further indicated R73 required extensive assist of two staff with ADLs. R73's Progress Notes (PN) dated 1/8/20, indicated R73 and another resident were attempting to sit in the same chair and R73 "pushed" the other resident on the chest, "causing her to stumble. Other resident unable to regain her balance and fell to the floor." R73 and R29 separated immediately and R73 was under constant supervision throughout the evening. R29's PN were reviewed 1/8/20 through 1/16/20, and revealed the following: -The PN dated 1/9/20, R29 had x-ray related to right hip pain. A subsequent PN dated 1/9/20, indicated R29's x-ray showed no acute fracture, however identified a subacute right superior and inferior pubic rami (pelvic area) fracture; -The PN dated 1/10/20, indicated staff were educated to assist R29 when in crowded areas such as dining room; -The PN dated 1/13/20, indicated R29 had subacute pelvic fracture "happened at least 5 weeks ago" per NP following x-ray results review; -The PN dated 1/14/20, indicated R29 had an orthopedic appointment scheduled for 1/21/20. A subsequent PN dated 1/14/20, indicated updated care plan to include recent fall intervention anti-roll back wheelchair to reduce risk of falls; -The PN dated 1/15/20, after survey began,	F 689		

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indicated care plan updated following fall on 1/8/20, and directed staff to observe R29 when coming into the dining room to ensure everyone had their own chair. A subsequent PN dated 1/15/20, indicated R29 had severe pain all the time due to hip fracture. Additionally, the PN dated 1/15/20, indicated NP updated regarding R29's pain; NP spoke to family and family decided to take R29 to the emergency department to "have her hip checked out again and get more x-rays to see if there is more wrong ...;"
-The PN dated 1/16//20, indicated R29 was admitted to the hospital for pain control due to R29 having had two complete displaced fractures of the Rami on the right side. A subsequent PN dated 1/16/20, indicated R29 returned from the hospital reviewed CT of right hip noted acute fractures of the right superior and inferior pubic rami mild right hematoma noted.

R29's Emergency Department Note dated 1/15/19, indicated R29 had a CT of right hip and there was an acute oblique comminuted mildly displaced fractures of the medial aspects of the right superior pubic rami and the midportion of the right inferior pubic rami and mild right pelvic hematoma. The note further indicated R29 had conditions which included, not limited to fracture, sprain, contusion, dislocation, vascular damage, nerve damage, ligament damage, tendon damage, and other etiologies. Based on history, physical exam and imaging impression was fractures of multiple pubic rami.

The administrator, the director of nursing (DON) and registered nurse (RN)-A were interviewed on 1/17/20, at 11:18 a.m. RN-A stated R73 was not

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upset when he pushed R29. DON stated R73 did not have intent when he pushed R29. DON stated R73 had not shown agitation toward other residents since 1/8/20. DON stated R73 and R29 were two people who have dementia perception issues and there was nothing that indicated agitation with the other resident. DON further stated R73 only had a history of striking out with cares towards staff. DON explained R73 could have been reaching out for the chair with his arm and ended up pushing R29. DON stated R73 did not mean for it to happen and indicated RN-B was present at the time of the incident on 1/8/20, and said R73 "appeared apologetic."

RN-B was interviewed on 1/17/20, at 12:27 p.m. and stated "No I was not present when the altercation" between R73 and R29 happened. RN-B explained she was in the dining room five minutes earlier and R73 and R29 were at two different tables then I left and when I returned NA-A notified RN-B that R29 had fallen. RN-B stated R73 extended his arm to "say this is my chair" and when R73 made contact with R29; R29 lost her balance and fell. RN-B stated R73 did not appear to be upset, however seemed "surprised." RN-B stated R73 intended to sit in the chair and "was like with his arm no I am sitting here." RN-B confirmed she completed R29's fall incident reported and acknowledged "He [R73] did push her, it was a not this is my chair, it was enough with his hand to make" R29 off balance and fall.

NA-A was interviewed via telephone on 1/17/20, at 1:15 p.m. and recalled on 1/8/20, in the dining room R73 and R29 were observed attempting to sit in the same chair and R73 "pushed her away

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then she fell." NA-A explained R29 usually sat in the chair, and NA-A went behind R73 stating if "you" approach R73 "he will hit you." NA-A stated, "I think that was why he pushed her away, she was too close when she approached him." NA-A stated it was too late, and NA-A was unable to intervene due to being too far away. NA-A stated, "You need to be careful when approaching [R73] otherwise he gets very aggressive and agitated." NA-A stated R73 had not been aggressive toward other residents prior to this incident, but had only previously been aggressive towards staff. NA-A stated R73 did not look angry or upset "that is just the way he is he doesn't like people close too him."

The facility's medical director was interviewed via telephone on 1/17/20, at 1:24 p.m. and stated it was his expectation for the facility to follow their policies and procedure for resident to resident altercations.

The Resident Protection Program Policy approved 3/2019, indicated abuse was the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. The policy indicated resident to resident abuse may not cause serious harm. If it was willful (meaning the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish) or causes serious harm it should be reported. Even though a resident may have cognitive impairment, he/she could still commit a willful act. The population of the facility included individuals whom met criteria for skilled care as well as specialty programs including dementia care. Every resident was

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unique and subject to abuse based on a variety of circumstances which included physical plant, environment, health status, behavior and cognitive level. The interdisciplinary team would identify the vulnerabilities on the resident care plan. The facility's population presents the following factors, which could result in maltreatment of residents and indicated the assessment, planning of care and services, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents whom have had behaviors such as entering other residents' rooms, wandering and socially inappropriate behaviors.
R10's admission MDS dated 11/27/19, identified moderately impaired cognition based on a Brief Inventory of Mental Status score of 9. R10 required extensive assist from staff with activities of daily living. R10 was frequently incontinent of urine and continent of bowel. R10 had history of falls and had falls since admission.

R10's Care Are Assessment worksheet dated 12/3/19, identified staff were to anticipate all needs, provide for all cares, cue and redirect R10 as needed. Staff were to provide incontinent cares and assist with toileting. R10 had one fall since admit on 11/27, with no injury.

R10's admission Fall Risk Data Collection assessment dated 11/21/19, placed R10 in the high risk fall risk score category. Furthermore, "Resident is a fall risk d/t [due to] medications, need for hands on assistance, variability in the level of assistance needed."

R10's care plan dated 11/21/19, indicated R10

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was at risk for falls or injury related to history of one to two falls prior to admission and diagnosis of history of cerebral vascular accident (stroke) with left sided weakness and impaired cognition. Required assist of one with transfers and ambulation with four wheeled walker. R10 has a history of self-transfers. Interventions as of 11/21/19, included bed at appropriate transfer height, call light within reach at all times, education regarding fall prevention, proper footwear on when up.

The facility Fall Scene Investigation Report dated 11/27/19, at 4:15 p.m. indicated R10 fell because shoes were slippery and R10 was left alone in the bathroom. R10 had no pain and no injuries were indicated.

The care plan was updated on 11/27/19, to indicate "Fell in bathroom on 11/27/19. Stay with her while she is on the toilet to prevent self transfer." R10's Kardex report indicated "Fell in bathroom on 11/27/19. Stay with her while she is on the toilet to prevent self-transfer."

Progress note dated 12/9/19, at 6:45 p.m. indicated R10 "fell while self transferring from the toilet, with NAR [nursing assistant, registered] briefly out of room to get pad."

The facility Fall Scene Investigation Report dated 12/9/19, at 6:40 (a.m. or p.m. not indicated) indicated staff went to closet to grab pad. Pads not in closet. The fall happened because R10 was left on toilet and self transferred. There was no mention if education was provided to the staff due to care plan not followed.

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When interviewed on 1/16/20, at 10:39 a.m. clinical coordinator RN-A verified the fall on 11/27/19, had an intervention placed that required staff to stay with R10 on the toilet. RN-A verified the care plan was updated. The shoes with slippery soles were sent home with the daughter. When asked if the care plan was followed for the fall dated 12/9/19, RN-A stated, "I wasn't here at the time. I would assume pads are kept in the closet, I'd have to follow up on it further. I'd assume there was an investigation, after 12/9, it was put in the care plan to gather the needed supplies."

When interviewed on 1/16/20, at 11:28 a.m. NA-C stated she is familiar with R10's care. NA-C knew R10 was a fall risk and the instructions were on the kardex so staff know what interventions are in place.

When interviewed on 1/16/20, at 12:01 p.m. DON stated the clinical coordinator is responsible to re-evaluate fall interventions. Fall interventions are re-evaluated after the IDT (interdisciplinary team) meeting that takes place at quality meetings on Wednesdays. When asked to review the falls from 11/27/19, and 12/9/19, DON stated, "it looks like they didn't follow what the plan was." DON stated it would be the expectation that the care plan should be followed and interviews and interventions should be included in the initial fall note.

On 1/16/20, at 3:59 p.m. information was requested from RN-A for any training that was provided after the fall events for R10, especially for following the care plan. There was no education provided to NA involved in the incident

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nor other facility staff about following the care plan after the fall on 12/9/19.

On 1/16/20, at 4:45 p.m. DON stated there was no further education provided to staff after the fall on 12/9/19, regarding the importance of following care plan.

On 1/16/20, at 4:51 p.m. a voicemail and request for return call was left for NA-J, whom was working with R10 during the fall on 12/9/19. No return call was received.

When interviewed by phone on 1/16/20, at 4:51 p.m. RN-C recalled working for a couple hours during R10's fall on 12/9/19. RN-C stated, "Well I remember my CNA [certified nursing assistant] came to tell me that she [R10] fell. I came in and she [R10] was on the bathroom floor. The CNA said she turned her back to get something out of the closet. I think she was following care plan. I didn't suspect any wrong doing she just turned her back for a second."

The facility policy Falls/Prevention/Intervention dated 3/19 identified Risk Assessment to be completed in Point Click Care (computerized charting system) after a fall occurs. Risk management follow up to be completed by the clinical coordinator within 48 hours of incident occurring. Interdisciplinary quality meeting will meet weekly to review falls and make suggestions for changes to plan of care.

The facility policy Care Planning and the MDS 3.0, dated 5/11, indicated care plans are individualized for each resident to identify their needs and preferences, including measurable

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goals and interventions. Additionally, care plans are updated as appropriate to reflect resident's current status.

On 1/13/20, at 2:30 p.m. R29's bed alarm cord was observed lying on floor and outward from under the bed. A portion of the cord was wrapped into a bundle but lying on the floor. The cord was at least a foot from under the bed.

During observation on 1/14/20, at 9:34 a.m. the bed alarm cord was lying on floor near foot of bed and outward from under the bed. A portion of the cord was wrapped into a bundle but lying on the floor. The cord was about two to three feet long from the lower midpoint of the bed to the sensor control panel at the base of the bed board. The cord was outward at least a foot from under the bed.

On 1/14/19, at 1:10 p.m. R29 was observed in her room standing up near foot of bed in front of wheelchair and attempted to walk around the foot of the bed while holding on to the foot board. NA-E was in room near resident attempting to redirect resident.

Review of Admission MDS dated 9/22/19, indicated R29 diagnoses included dementia and Tourette's Syndrome (a neurological condition that causes unwanted, involuntary muscle movements and sounds known as tics). R29 was frequently incontinent of bladder, had no functional limitation to lower extremity, severe cognitive impairment; required extensive assist of 1 staff for bed mobility, dressing, toileting, personal hygiene and limited assist with transfers, walking in room and unit, and

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locomotion on and off unit. Balance was not steady from seated to standing, walking with assist, turning around and facing opposite direction and not steady during transfers between bed, chair, and wheelchair.

Review of updated care plan dated 1/13/20, indicated R29 had a risk for falls or injury. Risk for fall included history of Cerebral Vascular Accident (stroke), hypertension, cognitive impairment, impaired gait with instability/balance, loss of balance when turning head to the left. Interventions included the placement of a temporary silent bed alarm placed on 1/9/20, to alert staff if R29 was attempting to get out of bed.

When interviewed on 1/14/20, at 3:25 p.m. NA-E explained the bed sensor alarm was a quiet alarm placed to notify staff when R29 attempted to get out of bed since R29 was a fall risk and had been injured after a fall about a week earlier. R29 did stand up on her own and was observed walking self into the bathroom by NA-E about a day or two prior and redirected. Staff tried to keep the bed sensor alarm cord under the bed but verified cord was outward and not under the bed and further indicated it was possible for R29 to trip on the bed alarm cord and fall. NA-E explained he would immediately go and find something to tie the bed alarm cord under the bed so that it was not outwards from under the bed.

On 1/17/20, at 11:47 a.m. DON indicated maintenance was responsible to check and audit bed alarms and bed alarms were assessed during quarterly meetings. DON stated the facility was trying to decrease the use of bed alarms and

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F 689	Continued From page 35 further explained it was the expectation for staff to notify the nurse managers immediately as soon as staff was aware of a safety risk/hazard to any resident. Staff were expected to notify the nurse manager who was unaware of the bed alarm cord as a tripping hazard in R29's room. Review of undated facility policy titled Falls/Prevention/Intervention, included bed, floor or chair alarm to alert staff, only if other interventions ineffective, reevaluate at weekly Quality meeting.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		3/8/20

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F 690	Continued From page 36 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide necessary catheter services for 1 of 1 resident (R58) reviewed. Findings include: R58's quarterly Minimum Data Set (MDS) dated 10/12/19, indicated R58 had moderate cognitive impairment, and required extensive two person assist for transfer and bed mobility, and was totally dependant with toileting. R58's face sheet printed on 1/17/20, indicated diagnoses that included dementia and stage three chronic kidney disease. On 1/13/20, at 2:07 p.m. R58 was observed sleeping. The bed was in the low position, a Foley bag was visible and contained a minimal amount of urine. The drain tube not tucked into the holder and laid on floor. On 1/14/20, at 9:37 a.m. R58 was observed sleeping with the bed in the low position. The Foley bag was on the floor slightly tucked under	F 690	F690 Upon notification of catheter concern for R58 staff was educated regarding the concern and risks for infection when catheter opening touches the floor. Further corrective action is not being implemented at this time for this particular resident as R58 no longer resides at the facility. Residents who utilize a catheter are reported on at the weekly quality IDT meeting. The catheter care policy will be reviewed, updated, and implemented. Education of policies, forms, and expectations will be completed for all staff. All NARs will complete a competency for catheter cares including infection prevention practices. A PCC task for each resident with a catheter will added to be documented on each shift by	

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F 690	Continued From page 37 the bed and was half covered with a blanket. The drain tube laid on the floor, and was not tucked into the holder. Nursing assistant (NA)-I was interviewed on 1/14/20, at 9:39 a.m. and confirmed the Foley bag was on the floor and the drain spout was not in the holder. NA-I put the tube into the holder and raised the bed until the Foley bag cleared the floor. NA-I stated the Foley bag should not have been in that position. NA-I stated she had not emptied Foley and had just started her shift. NA-I described the procedure for the Foley care which NAs are accountable for. The Foley are emptied once a shift, covered when in a public area, made sure it drained properly via gravity, and peri cares were done at least once a day. The Certified Nurse Practitioner (CNP) was interviewed on 1/15/20, at 12:43 p.m. stated that R58 had history of chronic urinary tract infections (UTIs) and a condition similar to neurogenic bladder with constant urine leakage, which was the indication for the Foley catheter. CNP stated she expected appropriate Foley care would be in place and that a drain spout touching the floor would pose a significant risk for causing a UTI. Licensed practical nurse (LPN)-D was interviewed on 1/16/20, at 8:04 a.m. and stated NAs were responsible for emptying the catheter bag at least once per shift and to perform catheter and peri cares once a shift as well. LPN-D indicated that she did catheter checks during cares. LPN-D verified the Foley bag was on the floor and the drain spout was not in the holder and was touching the floor.	F 690	all NARs indicating proper catheter care was completed. The administrator or designee will be responsible for compliance on this tag by March 8, 2020.	

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F 690	Continued From page 38 A facility policy for catheter care was requested, but not provided.	F 690		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dementia services were provided including implementation of personalized behavioral interventions and failed to reassess the effectiveness of interventions for 1 of 3 residents (R73) reviewed for dementia care. Findings include: R73's Behavioral Symptoms Care Area Assessment (CAA) dated 3/28/19, identified R73 wandered on the unit, into other resident rooms, yelled and threatened staff, and raised his hand towards staff. The CAA directed staff to reapproach, use calm and quiet approach, medications as ordered and observe for changes. R73's Vulnerable Adult Care Plan created 6/18/19, identified R73 was combative with staff which included striking and kicking out with toileting, perineal and other hygiene tasks and directed staff to see activity of daily living (ADL) and fall risk, cognition and communication and elopement/ wandering and elimination and skin	F 744	F744 Preparation, submission and implementation of this plan of correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed this alleged deficiencies and licensing violations. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and compliance with all applicable state and federal regulatory requirements and it constitutes the facility□s compliance. Upon notification of R73, no further corrections were made as documentation states that there have been decreased incidence in resident agitation during personal cares. The increase in medications along with non-pharmacological interventions made on and before 1/13/2020 can be concluded to be effective at this time.	3/8/20

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F 744	Continued From page 39 focuses for additional interventions. R73's Elimination Care Plan revised 9/25/19, identified R73 was always incontinent and directed staff to inform nurse when R73 was combative striking or kicking out during toileting cares. R73's Cognition and Communication Care Plan created 1/8/20, identified R73 had severe cognitive impairment and was able to understand verbal language only occasionally and directed staff to identify yourself with each interaction, face R73 when speaking, make eye contact, reduce distractions, understands consistent, simple, directive sentences, provide with necessary cues stop and return when agitated, use pictures or real items, gestures and facial expressions, lavender essential oil at 2:30 a.m. to reduce agitation with overnight cares in the early morning, assist with all decision making, limit choices, use cueing, task segmentation and one-step instructions. R73's ADL/mobility Care Plan revised 1/10/20, identified R73 had cognitive impairment and history of being resistive to cares and directed staff to hand-hold guidance of one staff and two when resistive or wandering into others rooms, cues for bed mobility, cue and prompt with one to two staff to dress and with hygiene, assist with eating, offer stuffed dog to hold before starting cares at night, assist of two staff with hand-hold guidance for transfers and wheelchair with anti-rollback. R73's Elopement/wandering Care Plan revised 1/13/20, identified R73 had agitation with hygiene/toileting due to dementia with behavioral disturbance and directed staff to observe whereabouts on unit frequently, ensure family sign R73 out at desk, redirect, resided on secured dementia care unit, picture and word toilet on R73's bathroom door, name on room door, guide to bed and validate feelings. R73's	F 744	R73 is on frequent checks as able to observe any behavior risk to others. Review of R73□s progress notes indicates no indicative behavioral expression creating risk towards other residents and incidence of agitation towards staff during personal cares has decreased since 1/8/2020. Resident□s behavioral expressions of combativeness with cares has improved in number of episodes in the last 30 days. This follows the implementation of non-pharmacological interventions and an increase in R73□s antidepressant. Facility will continue behavior tracking record of R73 to assess if non-pharmacological and pharmacological interventions are meeting care plan goals. Residents who display combative behaviors during personal cares or is at risk for resident to resident altercation risk will be reported on at the BHT (behavioral health team) weekly meeting to review needs and behavioral plan. ACP (Associated Clinic of Psychology) consult referrals are made based on need at this meeting. The BHT will complete audits of behavior documentation and ensure an IDT behavior plan for behavioral expressions that have the potential to have a negative result to the resident themselves or others is implemented. Audits will be done once weekly for two weeks. Then once monthly for two months until an	

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F 744	Continued From page 40 Fall Risk Care Plan revised 1/15/20, after survey began, identified R73 was at risk for falls and directed staff to lead R73 to a chair and encourage to "sit as he allows to avoid more than one person attempting to sit in a chair," non-skid socks, manual wheelchair with anti-rollback, hip pads, bed at appropriate height and see ADL/mobility bowel and bladder and mood/ behavior interventions as appropriate. R73's quarterly Minimum Data Set (MDS) dated 12/26/19, identified R73 had severe cognitive impairment and diagnoses which included dementia and anxiety. The quarterly MDS indicated R73 had physical behavioral symptoms one to three days during the reference period. The MDS further indicated R73 required extensive assist of two staff with ADLs. R73's Progress Notes (PN) and Behavior Administration Record (BAR) were reviewed 12/1/19, through 1/16/20, and revealed the following: -The PN dated 12/2/19, indicated R73 was resistive to have vital signs taken; -The PN dated 12/20/19, indicated R73 was walking with nursing assistant (NA) after lunch and R73 stopped at door to room and when NA prompted R73 to enter the room R73 "suddenly with out warning punched NAR [NA] in the (R) [right] breast ...staff walked away from resident and let him be;" -The PN dated 1/1/20, indicated preventing falls would have been "difficult with this resident d/t [due to] behaviors and cognition;" -The PN dated 1/7/20, indicated R73 refused a laboratory draw for a basal metabolic panel; --The BAR dated 1/7/20, night indicated R73 had	F 744	acceptable practice is attained. A Dementia Standards of Care Policy will be written and implemented. This policy with outline interventions and procedures that are standard at our facility for each resident who has dementia. Education of policies, forms, and expectations will be completed for all staff. The administrator or designee will be responsible for compliance on this tag by March 8, 2020.	

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F 744	Continued From page 41	F 744		

an episode of combativeness/ resisting cares; staff attempted redirection, one to one and refer to nurse notes, however the outcome was noted as ineffective;
-The PN dated 1/8/20, indicated R73 attempted to hit staff during cares, however did not make contact one to one and redirection used. A subsequent PN dated 1/8/20, indicated R73 and another resident were attempting to sit in the same chair and R73 "pushed" the other resident on the chest, "causing her to stumble. Other resident unable to regain her balance and fell to the floor." R73 separated immediately and R73 was under constant supervision throughout the evening;
-The BAR dated 1/8/20, evening indicated R73 had one episode of combativeness/ resisting cares; staff attempted toileting and food, however the outcome was noted as ineffective. A subsequent BAR dated 1/8/20, night indicated R73 was combative/ resistive to cares, however lacked interventions that tried;
-The BAR dated 1/9/20, evening indicated R73 was combative/ resistive to cares, however lacked trailed interventions. A subsequent BAR dated 1/9/20, night indicated R73 had an episode of combative/ resistive to cares staff attempted one to one, however the outcome was noted as ineffective;
-The PN dated 1/10/20, indicated R73 was holding stuffed animal dog during cares and tried hitting staff with dog staff finished doing cares and lying quietly when cares were done;
-The BAR dated 1/10/20, night indicated R73 was combative/ resistive to cares, staff attempted redirections, however the outcome was noted as ineffective;
-The BAR dated 1/11/20, days indicated R73 had

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F 744	Continued From page 42 two episodes of combative/ resistive to cares staff attempted redirection, toileting and food, however the outcome was noted as ineffective; -The PN dated 1/12/20, indicated R73 found lying sideways at the bottom of roommates bed staff assisted R73 off of the bed and assisted to the bathroom. R73 became resistive with cares and attempted to hit staff, lavender was ineffective; -The PN dated 1/13/20, indicated R73's Zoloft (anti-depressant) was increased due to R73 having been resistive with cares and hitting staff; -The BAR dated 1/13/20, night indicated R73 was combative/ resistive to cares, staff attempted redirection and one to one, however the outcome was noted as ineffective; -The PN dated 1/14/20, indicated R73 trying to hit staff during cares R73 was holding stuffed animal dog. Staff attempted to redirect and one to one; -The BAR dated 1/14/20, evening indicated R73 was combative/ resistive to cares, however lacked interventions that were tried; -The BAR dated 1/15/20, evening indicated R73 was combative/ resistive to cares, staff attempted redirection and one to one, however the outcome was noted as unknown. A subsequent BAR dated 1/15/20, night indicated R73 was combative/ resistive to cares, staff attempted one to one which was noted as ineffective; -The PN dated 1/16/20, indicated R73 was kicking and trying to hit staff during cares staff finished cares for R73. R73's medical record lacked evidence of comprehensive reassessment of R73's behaviors and current effectiveness of current personalized behavioral interventions.	F 744		

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F 744	Continued From page 43	F 744		

Family member (FM)-A was interviewed via telephone on 1/17/20, at 8:59 a.m. and explained when R73 was asked to do something from staff R73 would get agitated which was why it was important staff would go slow to ensure R73 would not feel he's being forced by staff.

Nursing Assistant (NA)-B was interviewed on 1/17/20, at 9:17 a.m. and stated R73 had behaviors and would push, punch and kick during cares. NA-B indicated the staff would reapproach R73 and keep reapproaching, however, stated reapproaching was not always successful.

NA-C was interviewed on 1/17/20, at 9:21 a.m. and stated R73 would hit, swing and push staff when provided personal cares. NA-C indicated R73 could "switch moods quickly" and explained they would have two staff present during cares one to "hold his hands" as the other staff completed the "cares as quick as we can." NA-C stated R73 "still pushes and shoves and wants you to get out even though holding his hands" during cares. NA-C indicated R73 preferred female over male staff and liked his wash clothes warm.

R73 was interviewed on 1/17/20, at 9:27 a.m. and unable to answer questions.

R73 was observed on 1/17/20, at 10:07 a.m. walk to his room with NA-C and NA-D. R73 entered the bathroom as NA-D guided R73 in while holding his hands. NA-D held R73's hands as NA-C stood behind. NA-C removed R73 pants and R73 while NA-D held his hands pushed NA-D backwards and began to squeeze NA-D's arms. NA-D told R73 they were almost done,

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F 744	Continued From page 44 however R73 again grabbed and squeezed NA-D's arms as NA-C completed peri cares from behind R73. NA-D was interviewed on 1/17/20, at 10:13 a.m. and stated R73 was incontinent of urine and the staff could not leave him without toileting. NA-D indicated one minute R73 would have been upset and the next minute R73 was calm. NA-D stated R73 was combative with cares which was why two staff were used, one to hold R73's hands and one to complete the cares. The administrator, the director of nursing (DON) and registered nurse (RN)-A were interviewed on 1/17/20, at 11:18 a.m. RN-A stated R73 was supposed to hold a stuffed animal dog during cares, however verified this was not effective and R73 was still hitting out. RN-A verified she was aware R73 was continuing to have behaviors. DON stated it was her expectation for staff to notify management when behaviors were not well controlled. The facility policy regarding Dementia Care was requested, but not provided.	F 744		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		3/8/20

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F 880	Continued From page 45 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 46 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that its staff demonstrated proper sanitary glove usage for 1 of 1 resident (R48) reviewed for medication administration. Findings include: During medication administration observation on 1/15/20, at 9:25 a.m. licensed practical nurse (LPN)-B washed hands, donned gloves and applied Nystatin topical powder to R48's left groin area. Without changing gloves, LPN-B proceeded to apply Nystatin topical powder to R48's bilateral breast folds. LPN-B then removed gloves and washed hands. Review of Order Summary Report dated 1/17/20,	F 880	F880 Upon notification of deficient infection control practice in applying topical powder to R48 without change of sanitary gloves, nurse educated and corrective action completed for the nurse observed to have applied powder to the groin and then underneath the breasts without donning new gloves. The infection prevention policy will be reviewed, updated, and implemented. Education of policies, forms, and expectations will be completed for all staff who apply medications and/or products topically. Observation audits of topical	

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F 880	Continued From page 47 indicated R48 had orders for Nystatin Powder 100000 unit/GM (gram), ordered 9/3/19, apply to groin topically one time a day for Intertrego (a rash that shows up between the folds of skin). Nystatin Powder 100000 unit/GM, apply to rash areas topically as needed for fungal skin irritation twice daily. When interviewed on 1/15/20, at 2:02 p.m. LPN-B verified gloves were not changed after applying Nystatin powder to groin and then proceeded to apply Nystatin powder to breast folds. LPN-B further explained usually she would apply the Nystatin powder to the breast folds first, change gloves and then apply the powder to the groin area. LPN-B further stated, she got a bit nervous during the observation and would typically apply powder to clean areas first before dirty areas. On 01/17/20, at 8:01 a.m. Registered Nurse (RN)-B, indicated it was her expectation the nurses applied Nystatin powder to breast folds first and then to the groin. RN-B also explained that the facility process was that Nursing Assistants (NA) would go in and wash the skin areas before the nurses came in to apply topical powders. During interview on 1/17/20, at 11:47 a.m. the director of nursing indicated it was the expectation that staff would apply Nystatin Powder to clean areas first, wash hands, change gloves in between and then proceed to apply the powder to private areas. Review of 1/19, facility policy titled, Infection Control Program Components, indicated,	F 880	medication application will be done at random once weekly for four weeks, then monthly for two months until acceptable practice is observed. The administrator or designee will be responsible for compliance on this tag by March 8, 2020.	

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F 880	Continued From page 48 Process Audit: Will review practices related to resident care which prevent and control infections, i.e. hand washing, use of PPE (personal protective equipment), equipment disinfection. The purpose of the infection control program will be guided by infection control policies, procedures and practices which are build on evidence based infection control principles and outcomes. The program will provide oversight and necessary infection control education.	F 880		

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: 1/17/2020

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 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245450	A. BUILDING: _____ B. WING _____	1/17/2020

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 623	Continued From Page 1

address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide written Notice of Transfer/Discharge to the resident, resident's representative and to the Office of the State Long-Term Care Ombudsman for 1 of 1 residents (R5) reviewed for hospitalization.

Findings include:

R5 was hospitalized from 6/11/19 to 6/12/19. Review of R5's medical record lacked evidence of a signed Notice of Transfer/Discharge and/or acknowledgement of a Notice provided to R5, R5's representative and/or ombudsman for R5's hospitalization on 6/11/19.

Licensed practical nurse (LPN)-B stated on 1/17/20, at 10:10 a.m. a packet of paperwork is sent with the resident when they transfer to the hospital but did not know if it included a Notice of Transfer/Discharge. LPN-B stated the nurses did not talk to the resident or representative about a notice of transfer when a resident was sent to the hospital.

Registered Nurse (RN)-B stated on 1/17/20, at 10:11 a.m. she did not talk to the resident or representative about a Notice of Transfer/Discharge when a resident is sent to the hospital.

Licensed social worker (LSW) stated on 1/17/20, at 11:22 a.m. she would send a notice to the ombudsman regarding the resident hospital transfer.

The Director of Nursing stated on 1/17/20, at 10:40 a.m. LSW should try as soon as they could to call the resident and/or representative and document in the progress notes about notices of transfer.

A Notice of Transfer/Discharge policy was requested and not made available.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245450	A. BUILDING: _____ B. WING _____	1/17/2020

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 625	Continued From Page 2
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide written notice of the facility's bed hold policy to resident and/or resident's representative for 1 of 1 residents (R5) reviewed for hospitalization. Findings include: R5 was hospitalized from 6/11/19 to 6/12/19. Review of R5's medical record lacked evidence of a signed bed hold form and/or acknowledgement of policy provided to R5, R5's representative and/or ombudsman for the 6/11/19, hospitalization. Licensed practical nurse (LPN)-B stated on 1/17/20, at 10:10 a.m. the bed hold policy was sent with the resident when they were sent to the hospital. LPN-B stated the nurses did not ask the resident at the time of transfer if they wanted their bed held and the nurse supervisor would ask in a couple days if the resident wanted their bed held or not. Registered Nurse (RN)-B stated on 1/17/20, at 10:11 a.m. after the resident was admitted to the hospital she would ask whether the resident wanted their bed held or not and would document in the resident progress notes and notify the social worker. Licensed social worker (LSW) stated on 1/17/20, at 11:22 a.m. a policy regarding bed hold was sent with the resident when resident was sent to the hospital. LSW stated she would get a hold of the family and document it in the resident progress notes.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245450	A. BUILDING: _____ B. WING _____	1/17/2020

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 625	Continued From Page 3 The Director of Nursing stated on 1/17/20, at 10:40 a.m. LSW should try as soon as can and call resident and/or representative to get signed Bed hold. A Bed hold policy was requested and not made available.

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 _____	**01/21/2020**

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 000	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. 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) 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: Health Care 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	K 000	EPOC	

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

Electronically Signed | 02/17/2020

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.

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 _____	**01/21/2020**

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 000	Continued From page 1 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. 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. 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. The facility has a capacity of 92 beds and had a census of 86 at the time of the survey.	K 000		
K 355 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Portable Fire Extinguishers CFR(s): NFPA 101	K 355		2/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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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K 355	Continued From page 2 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 and staff interview, the facility failed to maintain clear and ready access to fire extinguisher in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.3.5.12, NFPA 10) This deficient practice could affect 86 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 01/21/2020, observations and staff interview revealed the following: During facility walk-through observed in the Activities Director Office - obstructed access to the fire extinguisher This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 355	K355 Activities director office □ obstructed access to the fire extinguisher. - Activity director□s office □ Table causing obstruction moved away from extinguisher providing proper clearance. 1/21/2020 - All Fire extinguishers were checked for proper clearance and height by 1/27/2020. Corrections made if necessary. - All fire extinguishers will be checked monthly. Records will be kept in Life Safety documentation book. Environmental Services director will verify this. - All staff education will be completed by 3/17/2020. All new staff will receive this information in New Employee Orientation. - Reports of checks will be submitted to Safety committee for three months.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only	K 920		2/17/20

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 _____	**01/21/2020**

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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K 920	Continued From page 3 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 maintain proper management of electrical devices in accordance with the Life Safety Code NFPA 101 - 2012 edition (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 deficient practice could affect 86 residents. Findings Include: On facility tour between 08:00 AM and 12:00 PM on 01/21/2020, observations and staff interview revealed, or observation and documentation reviewed revealed the following:	K 920	K920 Activity director office- daisy chained power strips, Med room 291 appliance connected to power strip. - One power strip removed from daisy chain. Cords reorganized. Power strip removed from med room 291.cords reorganized on 1/21/2020. - All offices, work stations and med rooms were inspected for correct power strip usage by 1/27/2020 by maintenance department. - A preventive maintenance will be performed biannually inspecting offices, work stations and med rooms. It will be recorded in the computer based	

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K 920	Continued From page 4 During facility walk-through observed: (1) Activity Director Office - power strips daisy-chained together (2) Med Rm (291) Appliance connected to power strip (FRIDGE) This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	preventive maintenance program. - All staff will be educated by 3/17/2020. All new staff will receive this information in New Employee Orientation. - Biannual Inspection results will be given to Safety Committee for 2020.	