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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 9WPK

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

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
8. Full Survey After Complaint
9. Other

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/22/2016** (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 **101** (L18)

13. Total Certified Beds **101** (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
	101			
(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
Gayle Lantto, Unit Supervisor
Date : 03/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 05/03/2016 (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. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **03/22/2016** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245450

May 3, 2016

Ms. Patricia Vincent, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, Minnesota 55057

Dear Ms. Vincent:

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 15, 2016 the above facility is certified for or recommended for:

101 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 101 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 24, 2016

Ms. Patricia Vincent, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, Minnesota 55057

RE: Project Number S5450026

Dear Ms. Vincent:

On February 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 4, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On March 22, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 3, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 4, 2016, effective March 15, 2016 and therefore remedies outlined in our letter to you dated February 22, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245450		3/22/2016

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 03/15/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 03/15/2016	ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 03/15/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	03/24/2016	15507	03/22/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/4/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245450	A. Building 01 - THREE LINKS CARE CENTER B. Wing	3/3/2016

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 02/24/2016	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 02/24/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) TL/mm	DATE 03/24/2016	SIGNATURE OF SURVEYOR 37008	DATE 03/03/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/2/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 9WPK
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: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **02/04/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **101** (L18)
13.Total Certified Beds **101** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	101			
(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 :
Conrad Simba, HFE NEII 03/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 03/22/2016 (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)
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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. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
February 22, 2016

Ms. Patricia Vincent, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, Minnesota 55057

RE: Project Number S5450026

Dear Ms. Vincent:

On February 4, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - **your right to request an informal reconsideration to dispute the attached deficiencies.**

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 15, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by May 4, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 4, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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 ______	02/04/2016

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	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow the care plan to ensure a dialysis access was managed to minimize the risk of bleeding, clotting or infection in 1 of 1 resident (R90) reviewed for dialysis. Findings include: R90's care plan dated 12/10/15, indicated the resident was at risk for complications related to end-stage renal disease and dialysis, and had dialysis Monday, Wednesday and Friday. Various approaches were noted and included direction for	F 282	Facility issued treatment errors to nurses who omitted documentation on R90. Facility RN reviewed and updated R90's care plan. RN also received an order from dialysis to remove dressing from access site by 2 PM on dialysis days and to check bruits daily. Facility will offer dialysis training to all nurses. New dialysis policy implemented. Facility has initiated an auditing system daily to ensure completion of treatments.	3/15/16

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

Electronically Signed | 02/29/2016

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 ______	02/04/2016

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 282	Continued From page 1 nurses consistent with the physician orders related to dressing changes and checking for bruit and thrill. R90's 11/13/15, physician orders directed procedures to check for proper function of the access site by nursing: "palpate for thrill or auscultate for bruit on R [right] arm fistula [access site] every shift," including to notify the physician if neither could be obtained. The medication and treatment administration records (MAR/TAR) did not indicate the procedures were performed on 12/17/15, 1/7/16, 1/12/16, 1/14/16, 1/22/16, 1/24/16, 2/1/16, or 2/2/16, as indicated by boxes noted as blank rather than check-marked, without explanation by the nurse. Physician orders also included very slowly removing the dialysis dressing the evening after dialysis. If bleeding occurred, staff were to hold a gauze dressing to the site for 10-15 minutes. If bleeding continued, staff was directed to call the dialysis center staff or GSM (unknown staff designation) on call. A Band-Aid could be applied if needed. Although R90 received dialysis on Mondays, Wednesdays, and Fridays during the latter part of 12/15 through the time of the survey, there was no record the dressing was removed or the site checked for bleeding/potential infection on 1/22/16, 1/25/16 or 2/1/16 without explanation by the nurse. A physician note for R90 dated 1/22/16, revealed, "Received a call from nurse at Dialysis stating resident's right arm site infiltrated [dialysis needle tip penetrated the arm tissue by passing through the far wall of the fistula, which can occur before, during or after dialysis]. Advised to apply ice twice after resident returned to [facility]. Ice applied at 1245 [12:45 p.m.] to right upper arm" (to decrease pain and swelling of	F 282	Health Unit Coordinators are responsible and this will be reviewed by DON. This will be completed by 3-15-16.	

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F 282	Continued From page 2	F 282		

Continued From page 2

infiltration, and potentially minimize bleeding time).

RN-C was interviewed on 2/4/16, at 7:51 a.m. and reported R90 had experienced some difficulties with his access site. RN-C explained, "The area bulges--it's a pseudoaneurysm" (blood pools due to a leaking hole). She added the resident had a related procedure a month prior where "They ballooned it to dilate vessels to lower the local pressure...We observe the site on evening shifts and listen for the bruit and palpate for the thrill." When it was pointed out in an interview at 8:51 a.m. that charting for those procedures was intermittently missing she stated, "I guess someone forgot to do that." She added there were also days where R90 had gone out with family for the day, returning in the evening. "The checks should get done when he gets back. They should still be taken care of by the nurse, checking the site and the removal of the dressing."

A DaVita dialysis RN (RN-D) was interviewed on 2/4/16, at 12:35 p.m. RN-D stated she saw the resident approximately half of the days he had dialysis. Her expectation was that the facility would remove the dialysis dressing a maximum of 24 hours following dialysis, with the consequences of not doing so including the possibility of infection at the site. She also expected facility staff to check daily for thrill and bruit, with the consequences of not doing so including clotting off or stenosis (narrowing) of the access site, resulting in poor function of the site.

The director of nursing (DON) was interviewed on 2/4/16, at 1:07 p.m. and verified there was no indication in the documentation R90's dressing

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F 282	Continued From page 3 had been removed or bruit and thrill had been checked. The DON stated, "I would expect they would do this and sign off," or at least provide an explanation in a nursing note or on the MAR.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to coordinate services to ensure a dialysis access site was managed to minimize the risk of bleeding, clotting or infection for 1 of 1 resident (R90) reviewed for dialysis. Findings include: R90 was interviewed on 2/3/16, at 7:18 a.m. and stated, "I don't like dialysis--it affects my quality of life. But I have to have it or I'll die." R90 reported he had returned from dialysis at 10:00 a.m. the previous day, and said a nurse had checked his dialysis access site (fistula). The resident explained that, "After a while they remove the dressing. I'm a leaker so they put on a Band-Aid" which was observed covering the resident's access site. R90 said although they had changed it at about 4:00 a.m. it was "still leaking." When asked if staff checked the access site for proper	F 309	Facility issued treatment errors to nurses who omitted documentation on R90. Facility RN reviewed and updated R90's care plan. Facility will offer dialysis training to all nurses. New dialysis policy implemented. Facility has initiated an auditing system daily to ensure completion of treatments. Health Unit Coordinators responsible and will be reviewed by DON. Facility RN will communicate via phone with dialysis weekly to collaborate care and discuss concerns. This will be completed by 3-15-16.	3/15/16

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F 309	Continued From page 4	F 309		

function (bruit and thrill) he responded, "once in a while."

R90's 11/13/15, physician orders directed procedures to check for proper function of the access site by nursing: "palpate for thrill or auscultate for bruit on R [right] arm fistula [access site] every shift," including to notify the physician if neither could be obtained. The medication and treatment administration records (MAR/TAR) did not indicate the procedures were performed on 12/17/15, 1/7/16, 1/12/16, 1/14/16, 1/22/16, 1/24/16, 2/1/16, or 2/2/16, as indicated by boxes noted as blank rather than check-marked, without explanation by the nurse. Physician orders also included very slowly removing the dialysis dressing the evening after dialysis. If bleeding occurred, staff were to hold a gauze dressing to the site for 10-15 minutes. If bleeding continued, staff was directed to call the dialysis center staff or GSM (unknown staff designation) on call. A Band-Aid could be applied if needed.

R90's care plan dated 12/10/15, indicated the resident was at risk for complications related to end-stage renal disease and dialysis, and had dialysis Monday, Wednesday and Friday. Various approaches were noted and included direction for nurses consistent with the physician orders related to dressing changes and checking for bruit and thrill.

Although R90 received dialysis on Mondays, Wednesdays, and Fridays during the latter part of 12/15 through the time of the survey, there was no record the dressing was removed or the site checked for bleeding/potential infection on 1/22/16, 1/25/16 or 2/1/16 without explanation by the nurse. A physician note for R90 dated

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F 309	Continued From page 5	F 309		

1/22/16, revealed, "Received a call from nurse at Dialysis stating resident's right arm site infiltrated [dialysis needle tip penetrated the arm tissue by passing through the far wall of the fistula, which can occur before, during or after dialysis]. Advised to apply ice twice after resident returned to [facility]. Ice applied at 1245 [12:45 p.m.] to right upper arm" (to decrease pain and swelling of infiltration, and potentially minimize bleeding time).

RN-C was interviewed on 2/4/16, at 7:51 a.m. and reported R90 had experienced some difficulties with his access site. RN-C explained, "The area bulges--it's a pseudoaneurysm" (blood pools due to a leaking hole). She added the resident had a related procedure a month prior where "They ballooned it to dilate vessels to lower the local pressure...We observe the site on evening shifts and listen for the bruit and palpate for the thrill." When it was pointed out in an interview at 8:51 a.m. that charting for those procedures was intermittently missing she stated, "I guess someone forgot to do that." She added there were also days where R90 had gone out with family for the day, returning in the evening. "The checks should get done when he gets back. They should still be taken care of by the nurse, checking the site and the removal of the dressing."

A DaVita dialysis RN (RN-D) was interviewed on 2/4/16, at 12:35 p.m. RN-D stated she saw the resident approximately half of the days he had dialysis. Her expectation was that the facility would remove the dialysis dressing a maximum of 24 hours following dialysis, with the consequences of not doing so including the possibility of infection at the site. She also

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F 309	Continued From page 6	F 309		

expected facility staff to check daily for thrill and bruit, with the consequences of not doing so including clotting off or stenosis (narrowing) of the access site, resulting in poor function of the site.

The director of nursing (DON) was interviewed on 2/4/16, at 1:07 p.m. and verified there was no indication in the documentation R90's dressing had been removed or bruit and thrill had been checked. The DON stated, "I would expect they would do this and sign off," or at least provide an explanation in a nursing note or on the MAR. The DON then stated she was unsure about potential consequences of leaving the bandage in place or not checking the access site for function and stated, "He's been stable. I think he'd be fine."

A dialysis service agreement/policies were requested but were not provided.

F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		3/15/16

The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning

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F 356	Continued From page 7 of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure actual hours and hours of shifts worked for nursing personnel were accurately posted as required. This practice had the potential to affect all 94 residents residing in the facility as well as visitors. Findings include: The Nursing Staffing--Daily Posting of Hours sheet was observed posted in the main hallway at the front of the building during an initial tour on 2/1/16, at approximately 1:15 p.m. However, the number of the shifts did not match the actual hours nursing personnel worked. A copy of the posted hours for 2/1/16, was then obtained. A review of the posted schedules dated 1/25/16 through 1/31/16, also showed consistent documentation where shift hours did not match the actual hours staff worked. At 2:20 p.m. the staffing coordinator (SC)	F 356	Facility will re-educate Staffing Coordinator and Supervisors on correct completion of Daily Posting of Hours Form. Policy and Procedure related to posting of hours have been reviewed and updated by the Director of Nursing. DON will audit weekly for compliance. This will be completed by 3/15/16.	

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F 356	Continued From page 8 explained that for postings on weekends, she was responsible for placing "projected hours" in a folder for either the supervisor or more likely the light duty employee to post. The SC stated, "To be honest, neither the supervisor or anyone else looks at it until I come in on Monday. We do not have a system in place." She further explained that it was also her responsibility to post staffing hours during the week. If a staff member called in for the evening or night shift, the posting was not changed until the following day. The SC further stated the posting did not reflect actual or shortened shifts rather, "We just mark less hours." An additional copy of the posting for 2/1/16, however, the hours had been significantly revised/corrected. Postings for dated 2/2/16 through 2/4/16 reflected corrected shift hours and actual hours worked for nursing personnel. During an interview on 2/4/16, at 1:00 p.m. the director of nursing revealed she expected the staff posting to be updated as changes occurred, and stated, "I consider it a living document." The facility's 9/13, Posting of Nursing Hours Policy and Procedure directed the SC or supervisor to post the daily Posting Hours form for each shift. The number for nursing staff was to be posted close to the beginning of each shift and reviewed as changes occurred.	F 356		

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

F5450026

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	245450	A. BUILDING 01 - THREE LINKS CARE CENTER B. WING	02/03/2016

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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 on February 2, 2016. At the time of this survey, Three Links Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/29/2016

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 facility is fully sprinkled throughout. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 102 beds and had a census of 94 at time of the survey. The faclity is not in substantial compliance as evidenced by NOT MET as evidenced by:	K 000		
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		2/29/16

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K 025 SS=E	Continued From page 2 Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.3, 8.3, 8.3.2 and 8.3.6. This deficient practice could affect all 94 residents within the smoke compartments. Findings include: On facility tour between 09:00 AM and 2:30 PM on 02/02/2016, it was observed in the Memory care unit above the smoke barrier doors that there were penetrations around wires that were not sealed with fire rated caulk. This deficiency was verified by Maintenance Supervisor at the time of discovery.	K 025	A policy has been developed stating outside contractors will be informed by Environmental Services Department that any fire or smoke wall penetration following any work must be sealed per wall rating requirements by contractor. When finished, Environmental Services Director will inspect wall area and document satisfactory completion. An annual Fire/Smoke barrier inspection preventive maintenance has been created. All Fire/Smoke barrier walls will be inspected annually by in-house maintenance staff and documented. The Environmental Services Director is responsible for random checks on an annual basis to make sure PMs are completed. Opening by Room 103 was sealed up with sheetrock and 1-hour EM fire caulk on 2/2/2016 by the Maintenance Department.	2/24/16
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper	K 056		

PRINTED: 03/02/2016
FORM APPROVED
OMB NO. 0938-0391

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K 056	Continued From page 3 switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 Findings include: On facility tour between 09:00 AM and 02:00 PM on 02/02/2016, the following deficiencies were found with the fire sprinkler system. 1. There was a fire sprinkler head missing in the lift-out ceiling area located in the housekeeping office. 2. The storage room #130 had supplies stored within 18" from a fire sprinkler head. This deficiency was verified by Maintenance Supervisor at the time of discovery.	K 056	Olympic Fire Protection has installed a sprinkler head in the lift-out ceiling area on 2-24-16. Supplies on top shelf in Room #130 were removed on 2-2-16. Top shelves have been labeled "Keep top shelf clear for proper sprinkler head coverage." This closet is now a Housekeeping Storage Room and the need to maintain supplies 18" from a fire sprinkler head was reviewed with Housekeeping Supervisor by the Environmental Services Director.	