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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DXFR

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 **06/04/2018** (L34)

8. ACCREDITATION STATUS: **& 7/3/2018** (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:
Eva Loch, Unit Supervisor 07/11/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/11/2018 (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
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245450
July 11, 2018

Ms. Deanna Pierzina, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

Dear Ms. Pierzina:

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 June 27, 2018 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 Medicaid provider agreement may be subject to non-renewal or termination.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

July 11, 2018

Ms. Deanna Pierzina, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

RE: Project Numbers S5450028, H5250034, H5250029, H5250036

Dear Ms. Pierzina:

On May 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 19, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 23, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 28, 2018. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 19, 2018. (42 CFR 488.417 (b))

Also, we notified you in our letter of May 23, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 19, 2018.

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for the abbreviated standard survey completed on May 9, 2018. The most serious deficiencies were found 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 May 24, 2018, a partial extended survey was completed at your facility to investigate complaint number H5450036. We found that your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

Based on the visit, we determined that your facility had not corrected the deficiencies issued pursuant to the standard survey completed on April 19, 2018 and the abbreviated standard survey completed on May 9, 2018. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

In addition, note the following actions related to the imposed remedies:

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

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 19, 2018. (42 CFR 488.417 (b))

On June 4, 2018, the Minnesota Department of Health and on July 3, 2018 the Minnesota Department of Health, Office of Health Facility Complaints completed Post Certification Revisits to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the surveys completed on April 19, 2018, May 9, 2018 and May 24, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 27, 2018. Based on our visits, we have determined that your facility has corrected the deficiencies issued pursuant to the PCRs, completed on June 4, 2018 and on July 3, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 27, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of May 23, 2018:

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

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 19, 2018 be rescinded effective June 27, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

June 18, 2018

Ms. Deanna Pierzina, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

RE: Project Numbers S5450028, H5250034, H5450029, H5450036

Dear Ms. Pierzina:

On May 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 19, 2018. The standard 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 May 23, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 28, 2018. (42 CFR 488.422)

Also, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 19, 2018. (42 CFR 488.417 (b))

In addition, we notified you in our letter of May 23, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 19, 2018.

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on May 9, 2018. The most serious deficiencies were found 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 May 24, 2018, a partial extended survey was completed to verify that your facility had achieved and maintained compliance with federal certification deficiencies.

We found that your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We verified, on May 24, 2018, that the conditions resulting in our notification of immediate jeopardy

have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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:

Eva Loch, 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: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 from the abbreviated standard survey completed on May 9, 2018 should be directed to:

Matthew Heffron, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: matthew.heffronheffron@state.mn.us
Phone: (651) 201-4221

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective May 28, 2018, will remain in effect. (42 CFR 488.422)

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective July 19, 2018, will remain in effect. (42 CFR 488.417 (b))

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject a denial of payment. Therefore, Three Links Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 19, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

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

The CMS Region V Office will notify you of their determination regarding our recommendation and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.24, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Three Links Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 24, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human
Services Departmental Appeals Board,
MS 6132

Civil Remedies Division
Attention: Karen R. Robinson,
Director 330 Independence
Avenue, SW Cohen Building, Room
G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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.

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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the fourth revisit.

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 19, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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: DXFR

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: **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 **04/19/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
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):

Reduction in the number of certified SNF/NF beds from 101 beds to 92 beds, effective June 30, 2018, in accordance with a change in licensure. Due to nine beds being placed in layaway status (in accordance with Minn. Stat. 144A.071, Subd. 4b., as amended by the Minnesota State Licensure) effective June 30, 2018, all 92 facility beds are certified SNF/NF. After this change they currently have nine (9) beds on layaway.

17. SURVEYOR SIGNATURE — Date:
Laura Glenn, HFE - NE II — 05/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 05/29/2018 (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
(L33)

DETERMINATION APPROVAL

Electronically delivered
May 4, 2018

Ms. Deanna Pierzina, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

RE: Project Numbers S5450028, H5450033, H5450034, H5450035

Dear Ms. Pierzina:

On April 19, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567 whereby corrections are required. In addition, at the time of the April 19, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5450033 and H5450035 that were found to be unsubstantiated and complaint number H5450034 that was found to be substantiated.

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

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Eva Loch, 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: eva.loch@state.mn.us
Phone: (651) 201-3792
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 May 29, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 19, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal

regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 19, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245450	A. BUILDING _____ B. WING _____	C 04/19/2018

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 4/16/18 through 4/19/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 4/16/18 through 4/19/18, and complaint investigation(s) were also completed at the time of the standard survey. Investigation of complaint #H5450033 was completed and the complaint was found to be unsubstantiated. An investigation of complaint #H5450034 was completed and was found to be substantiated at F609 and F610. An investigation of complaint #H5450035 was completed and was found to be unsubstantiated. 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable	F 558		6/1/18

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

Electronically Signed | 05/14/2018

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F 558	Continued From page 1 accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the call light, and drinking water container, were accessible for 1 of 1 resident (R13) who was capable of drinking from a water container independently, and was capable of using the call light to call for assistance. Findings include: On 4/18/18, at 7:20 a.m. R13 was observed sitting in a geriatric chair in her room. When approached R13 stated she wanted help with getting something to drink but could not move her chair without staff assistance and did not know where her call light was. The call light button was observed clipped to R13's blouse on the outside of her right shoulder and the water container was approximately 10 feet away from the resident on an end table. When R13 was informed of where her call light was, she tried to turn her head and still could not see it. R13 then tried to reach it with her left hand but was unable to. R13 stated the call light was not placed where she could see it or reach it probably twice a week, and stated she would have to ask for someone to help her during those times. On 4/18/18, at 7:27 a.m. nursing assistant (NA)-C was notified by the surveyor that R13 needed assistance. NA-C entered R13's room and asked the resident if she could press her call light button. R13 stated she could not see or reach the	F 558	Although Three Links Care Center does not necessarily agree with the findings of non-compliance, however in the spirit of cooperation, Three Links will work with the Department of Health to remedy the deficiencies cited. F558: The resident who was affected by this finding was provided the call light and water pitcher at the time of incident. All Nursing staff will receive mandatory training regarding placement of call-light, water, and other essential items per resident, within reach for resident and where individual residents can reach items. Audits will be conducted by clinical coordinators and nurse supervisors at various times once a week for four weeks, once a month for four months until acceptable practice is observed. Outcomes will be observed at our Quality Improvement meeting. The Director of Nursing or designee will be responsible for compliance by 6/1/18.	

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F 558	Continued From page 2	F 558		

call light button but would try, and attempted but was unable to reach the call light. NA-C confirmed R13 could not see or reach her call light button and stated it should have been placed where R13 could access it. NA-C moved the call light button, clipped it to the front of R13's blouse and had the resident demonstrate she could press it.

On 4/18/18, at 7:39 a.m. NA-D entered R13's room and confirmed there were no beverages within reach of R13. NA-D said R13's lips appeared dry and chapped and stated R13 could drink beverages if they were within reach of her left hand. NA-D moved the bedside tray with a water container and straw to the left side of the resident next to her chair. R13 reached for the beverage, and drank from it independently.

R13's care plan dated 2/8/18, indicated the resident needed support to maintain as much independence and control as possible. The care plain indicated R13 remained able to call for help as needed which was a strength for her.

R13's face sheet dated 4/19/18, indicated R13 had diagnoses including multiple sclerosis and functional quadriplegia.

When interviewed on 4/19/18, at 10:16 a.m. registered nurse (RN)-E stated her expectation would be for all residents to have their call lights and water within reach to promote as much independence as possible.

When interviewed on 4/19/18, at 10:53 a.m. the director of nursing (DON) stated she had been informed regarding the call light and water container not being within reach of R13. The

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F 558	Continued From page 3 DON said her expectation would be for all essential items to be within reach of all residents in the facility. The facility's call light and resident accommodation of needs policies were requested but none were provided.	F 558		
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 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);	F 584		6/1/18

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F 584	Continued From page 4 §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 1 of 1 resident (R46) room was kept clean and free of odors, and failed to ensure 4 of 4 resident (R32, R26, R77, R6) shared resident bathrooms (R32, R26) were maintained in a clean, functional manner, and in good repair. Findings include: Bedroom: On 4/16/18, at 1:23 p.m. during R46's room observation a strong musty odor was noted outside of R46's room. Upon entering, a strong urine smell was notable in R46's room. On 4/17/18 from 9:00 a.m. to 2:30 p.m., the room continued to have a strong urine odor, also evident in the hallway outside of the room. On 4/18/18 from 11:15 a.m. to 11:43 a.m., an environmental tour was completed with the environmental services coordinator (ESC). During the tour, R46's room was noted to have a strong urine odor, obvious even when standing in the hall outside R46's room entrance. ESC verified	F 584	F584: At the time of the incident the chair and room were deep cleaned. The flooring of the room and bathroom are in the process of being replaced. At the time of notification, housekeeping staff did a deep clean on the bathroom including the toilet. Bathroom cleaning was increased to a two cleanings per day schedule. Identified chairs and loveseats were cleaned at the time of survey. All staff will receive training to notify Housekeeping supervisor when there is an unwanted odor and soiled furniture. Housekeeping supervisor will develop an individual program to work to eliminate the odors and prevent future odors. Housekeeping supervisor or designee will perform weekly inspections of common area furniture for cleanliness and odor. Staff will be educated to use the	

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F 584	Continued From page 5 the urine smell, and after walking around by R46's bed and the recliner chair, ESC stated he thought the urine odor was coming from the recliner chair. When asked who was responsible for notifying the environmental services department about the odor, ESC stated housekeeping cleaned the room daily and should have identified the smell. Bathrooms: On 4/16/18, at 2:11 p.m. when R26 was asked if the room and building were clean, R26 stated the inside of the toilet bowl in the bathroom shared with R32 was always splattered with fecal matter. R26 stated the bathroom was always dirty after R32 used it. In addition R26 stated she did not know why the facility staff did not clean it after R32's use. On 4/17/18, at 10:43 a.m. when asked who was responsible for cleaning bathrooms the nursing assistant (NA)-B stated housekeeping cleaned the bathrooms daily and thought R26's bathroom cleanliness concern was being addressed. NA-B further stated housekeeping had not been up on the floor yet and she knew R26 had asked to clean her own bathroom as housekeeping could not keep up with it. NA-B further stated nursing staff wanted access to the housekeeping cleaning cart so they could clean as needed after housekeeping left for the day. On 4/18/18, at 9:52 a.m. the shared bathroom for R26 and R32 was observed. The inside of toilet bowl was stained with blackish colored fecal matter, and had a strong smell of feces. At 9:55 a.m. surveyor went with the maintenance staff to look at a lock on R26's bathroom door which needed to be fixed. At that time, the maintenance	F 584	maintenance work order system and notify housekeeping if they see any soiled furniture. An odor log was created to identify, report, and address. Weekly Audits will be completed various times once a week for four weeks, once a month for four months until acceptable practice is observed. Outcomes will be observed at our Quality Improvement meeting. The Director of Environmental Services or designee will be responsible for compliance by 6/1/18.	

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F 584	Continued From page 6	F 584		

staff never acknowledged the smell or the dirty toilet bowl which were obvious. At 10:01 a.m. the maintenance staff went back to the shared bathroom to fix the lock, the toilet bowl remained dirty and the smell was still obvious in the hallway, outside of R26's room.

On 4/18/18, from 11:15 a.m. to 11:43 a.m, during an environmental tour with ESC, ESC stated toilets were cleaned daily by housekeeping. The ESC also stated if toilets were dirty at other times, residents could let staff know and they would be cleaned.

On 4/19/18, at 3:04 p.m. the life enrichment director reviewed the Resident Council minutes for 12/12/17, and 3/21/18, which indicated R32 had brought up the concern about bathroom cleanliness during the council meetings. When asked who took the notes on behalf of the residents, the life enrichment director stated the activities staff did and when concerns were brought up at the council meetings she would talk to the department head and provide them a copy of the resident council minutes. The life enrichment director verified R32 had brought up a concern about the bathroom not being clean.

On 4/16/18, at 6:05 p.m. multiple straight back chairs and loveseats around the pathway living unit and dining room were observed with large stains on the seat part and on the armrests. In addition the chairs were observed with visible white and yellow dirt along the seams and armrests that were dried into the fabric of the chairs.

On 4/16/18, at 2:22 p.m. during room observation of R77 and R6's shared bathroom, the air vent in

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F 584	Continued From page 7 the ceiling above the toilet was observed to be soiled with grayish colored fuzzy textured debris. In addition the air vent was observed to be partially hanging down with loose screws. On 4/17/18, at 9:00 a.m. to 3:00 p.m. the air vent in the ceiling remained the same. During the environmental tour with ESC on 4/18/18 from 11:15 a.m. to 11:43 a.m., ESC verified the eight loveseats and regular chairs were heavily soiled with dried large stains on the sitting part and armrests. In addition ESC verified all eight chairs had dried on food/liquid stains on the seams and and fabric. When asked who was responsible for ensuring the chairs and other furniture on the unit were maintained in a clean manner, ESC stated the staff were supposed to alert housekeeping when they identified dirty and soiled chairs. When asked if there were any routine audits/checks to identify concerns, ESC stated there weren't. ESC further stated recently a few chairs in the dining room had been cleaned however, the chairs located in the rest of the unit in the common areas had not been cleaned. ESC also verified the air vent in R77 and R6's shared bathroom was dirty and needed to be reattached to the ceiling. ESC stated the facility had done some work in bathrooms in February 2018 however, since there had been no routine preventative rounds completed. ESC indicated the staff was supposed to notify the environmental department about concerns, so they could address them.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		6/1/18

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(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 609	Continued From page 8 neglect, exploitation, or mistreatment, the facility must: §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 observation, interview and document review, the facility failed to ensure an allegation of abuse was immediately reported to the administrator and State Agency (SA) for 1 of 3 residents (R26) reviewed for abuse. Findings include: During interview with R26 on 4/17/18, at 9:55 a.m. R26 reported she had been sexually and	F 609	F609: Upon notification, this event was immediately reported to the Office of Health Facility Complaints. All staff members at Three Links Care Center will be reeducated on reporting abuse of any type to the Administrator or designee immediately. Administration will	

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F 609	Continued From page 9 physically abused in the facility on a different unit approximately six months ago, when a staff member had picked her up, threw her over his shoulder and onto the bed and sexually abused her. R26 stated she had told the supervisor about it but "nothing had been done". R26 did not offer additional information regarding what had happened. R26's face sheet indicated R26 was admitted to the facility on 10/25/17, and had diagnoses of mild cognitive impairment, generalized muscle weakness and schizoaffective disorder. R26's admission Minimum Data Set (MDS) dated 11/1/17, indicated R26's cognition was intact. R26's significant change MDS dated 3/20/18, indicated R26's cognition was moderately impaired. During interview on 4/17/18, at 11:07 a.m. Social Services Director (SSD) stated R26 was admitted to the facility's transitional care unit (TCU) last October, and had moved to the Marigold long term care unit in early November 2017. Review of R26's progress dated 12/7/17, indicated R26 had reported abuse by a staff. "He threw me over his shoulder when I was laying in bed and put me on the floor." Review of the facility's vulnerable adult incidents indicated there was no report made to the SA regarding R26's allegation of physical and sexual abuse. On 4/17/18, at 2:35 p.m. the administrator stated she had looked at R26's progress notes since admission and had found a progress note dated 12/7/17, regarding R26 alleging she'd been	F 609	be reeducated on the protocol of reporting per state regulations/guidelines. A log was created which informs the Administrator of type of incident to ensure the Administrator or designee are informed timely. As information is identified, Administrator or designee will review information to verify the process is effective. Outcomes will be observed at our Quality Improvement meeting. The Administrator or designee will be responsible for compliance by 6/1/18.	

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F 609	Continued From page 10 thrown over a staff worker's shoulder. The administrator stated the progress note had been written by [registered nurse (RN)-D] who was no longer employed at the facility. The administrator verified the allegation of staff picking up the resident and throwing her over his shoulder, would "sure qualify for roughness and was an allegation of abuse either way and should have been reported." The administrator said the issue should have been reported to the administrator and SA immediately and verified no report had been made. The administrator further explained she had also found a progress note dated 10/28/17, indicating R26 requested only female caregivers but the progress note did not indicate why. R26's care plan had had been updated 10/30/17, to ensure care was provided only by female caregivers. The administrator stated additional investigation should have occurred to determine why R26 had decided she only wanted female caregivers. The facility's undated Abuse and Neglect policy indicated, "... allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse" to the administrator of the facility and the SA.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged	F 610		6/1/18

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F 610	Continued From page 11 violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 observation, interview and document review, the facility failed to thoroughly investigate allegations of abuse and misappropriation of resident property for 1 of 3 residents (R26) reviewed. Findings include: During interview with R26 on 4/17/18, at 9:55 a.m. R26 reported she had been sexually and physically abused in the facility on a different unit approximately six months ago, when a staff member had picked her up, threw her over his shoulder and onto the bed and sexually abused her. R26 stated she had told the supervisor about it but "nothing had been done". R26's face sheet indicated R26 was admitted to the facility on 10/25/17, and had diagnoses of mild cognitive impairment, generalized muscle weakness and schizoaffective disorder. R26's admission Minimum Data Set (MDS) dated 11/1/17, indicated R26's cognition was intact. R26's significant change MDS dated 3/20/18,	F 610	F610: Upon notification, this event was immediately reported to the Office of Health Facility Complaints and completed an investigation on alleged sexual and physical encounter. Upon notification, this event was immediately reported to the Office of Health Facility Complaints and completed an investigation on alleged misappropriation of funds. Nursing staff will review the 24hour progress notes to identify any other residents affected by the same deficient practice. The outcome of this communication will now include the Administrator to ensure the deficient practice will not recur. All staff members at Three Links Care	

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F 610	Continued From page 12 indicated R26's cognition was moderately impaired. During interview on 4/17/18, at 11:07 a.m. Social Services Director (SSD) stated R26 was admitted to the facility's transitional care unit (TCU) last October, and had moved to the Marigold long term care unit in early November 2017. Review of R26's progress note dated 12/7/17, indicated R26 had reported abuse by a staff. "He threw me over his shoulder when I was laying in bed and put me on the floor." There was no documentation of an investigation having been thoroughly conducted. On 4/17/18, at 2:35 p.m. the administrator stated she had looked at R26's progress notes since admission and had found a progress note dated 12/7/17, regarding R26 alleging she'd been thrown over a staff worker's shoulder. The administrator stated the progress note had been written by [registered nurse (RN)-D] who was no longer employed at the facility. The administrator verified the allegation of staff picking up the resident and throwing her over his shoulder, would "sure qualify for roughness and was an allegation of abuse either way..." The administrator further explained she had also found a progress note dated 10/28/17, indicating R26 requested only female caregivers but the progress note did not indicate why. R26's care plan had had been updated 10/30/17, to ensure care was provided only by female caregivers. The administrator stated additional investigation should have occurred to determine why R26 had decided she only wanted female caregivers. During interview with R26 4/17/18 at 10:10 a.m.,	F 610	Center will be reeducated on reporting abuse of any type, including but not limited to, financial abuse such as misappropriation of funds. All abuse will be reported the Administrator or designee immediately and reported per state guidelines. Outcomes will be observed at our Quality Improvement meeting. The Administrator or designee will be responsible for compliance by 6/1/18.	

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F 610	Continued From page 13	F 610		

R26 said money had disappeared from her wallet and she thought it had been stolen. R26 stated she'd reported the theft to the facility and the facility was going to check into it. R26 stated her wallet was in her room at the time of the theft, and stated she did not know whether the facility had done anything about the missing money.

An additional Incident Report, which had been submitted to the State Agency (SA) on 11/17/17, indicated R26 had reported to staff missing $179 which R26 thought had been stolen. The incident report indicated R26 had received $150 from her son on 11/13/17, and R26 was not able to say who may have taken the money. There was no evidence the allegation of misappropriation of resident property was thoroughly investigated or whether corrective actions were taken.

During interview on 4/17/18 at 11:07 a.m., the Social Services Director (SSD) stated she had submitted a report for R26's allegation of missing money to the SA. At 12:37 p.m. SSD stated she was notified about R26 missing $179 from activities staff (AS)-C on 11/17/17. AS-C staff had checked the laundry, completed a missing item form and had searched R26's room. SSD stated she had called the son who had verified having given R26 $150. The SSD stated the missing money was never found, but that she'd thought "in time it might show up". SSD acknowledged she had not talked to the beautician, gift shop staff, or staff on the floor about the missing money. SSD stated in hindsight she should have found out how much money was missing, and should have completed a thorough investigation by interviewing those other staff.

On 4/19/18 at 1:23 p.m., the administrator verified

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F 610	Continued From page 14 a full investigation should have been initiated when the misappropriation of funds was reported. The administrator stated she expected a full investigation to include talking to the resident, searching for the missing property, calling the police as needed, speaking to the family, staff, and trying to figure out how much money was missing. The facility's Resident Property Replacement Policy dated September 2017, indicated "A thorough investigation will commence to identify how the item was broken, or to locate the missing item." The facility's undated Abuse and Neglect policy indicated, "... allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse" to the administrator of the facility and the SA. In addition, the policy indicated misappropriation of property would be thoroughly investigated and staff members who had contact with the resident during the time of the alleged incident would be interviewed.	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the admission	F 641	F641:	6/1/18

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F 641	Continued From page 15 Minimum Data Set (MDS) assessment was coded accurately for 1 of 3 (R7) residents reviewed and coded as being being on a ventilator. Findings include: On 4/16/18, at 4:41 p.m. R7 was observed seated in a Broda (specialized wheelchair) which was reclined back. When approached and asked how he was doing R7 stated he was tired as he had just completed a therapy session in his room. R7 did not have a ventilator/respirator in place. During review of the admission MDS dated 3/26/18, it was revealed the MDS had been coded to indicate R7 had was on a ventilator while in the facility. On 4/17/18, at 2:42 p.m. registered nurse (RN)-B, the facility's MDS coordinator, reviewed the admission MDS dated 3/26/18, and verified the MDS had not been coded accurately. RN-B said coding R7 as having a ventilator "was a mistake." On 4/17/18, at 2:44 p.m. when asked how she double checked MDS's for accuracy before being submitted, RN-C stated, "when I was going to sign off on the MDS, I looked at the RUG [Resource Utilization Group] rate which did not make sense, but it didn't click. I will modify it right now." On 4/19/18, at 12:41 p.m. the director of nursing (DON) stated she expected staff to double check the MDS's since in R7's situation, the inaccurate coding changed the RUG rate. The DON further stated she expected all MDS's to be coded accurately to reflect the resident's current status	F 641	At the time of incident, the MDS was corrected. MDS members were educated on charting accurate MDS documentation. Both staff members understood that all RUG levels will be double checked prior to submission. Audits will be conducted by MDS coordinators at various times once a week for four weeks, once a month for four months until acceptable practice is observed. Outcomes will be observed at our Quality Improvement meeting. The Director of Nursing or designee will be responsible for compliance by 6/1/18.	

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F 641	Continued From page 16 and care they are receiving. The Resident Assessment Instrument last updated in October 2017, included: "Code any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensure adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration in this item. Residents receiving closed-system ventilation includes those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) as well as those residents with a tracheostomy."	F 641		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 688	F688:	6/1/18

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F 688	Continued From page 17 review, the facility failed to ensure an orthotic brace was applied for 1 of 1 resident (R6) reviewed for range of motion (ROM). Findings include: R6's Face Sheet dated 4/19/18, included diagnoses of persistent vegetative state and contracture to left hand. R6's Order Summary Report with a start date of 7/26/17, identified an order for a left hand orthotic brace to be placed daily for four hours from 9:00 a.m. to 1:00 p.m. R6's history included an occupational therapy plan of care dated 4/26/16, which indicated R6 was tolerating a left hand orthotic well and directed staff to increase wear time of left hand orthotic from two to four hours daily. R6's Care Plan initiated on 1/10/18, indicated R6 had rigidity and contractures of extremities and neck with an intervention to apply a left hand orthotic for four hours (from 9:00 a.m. to 1:00 p.m.) daily. R6's Care Area Assessment dated 4/8/18, identified R6 was at risk for functional decline due to contractures, was unable to express needs, and that staff had to anticipate all needs, provide all cares, and cue/redirect as needed. On 4/18/18, at 9:07 a.m. R6 was observed in the dining area without an orthotic brace on her left hand. At 10:09 a.m., R6 was observed in her room without an orthotic brace on her left hand. When interviewed on 4/18/18, at 10:09 a.m.	F 688	At the time of the incident, the brace schedule was recorded on the Treatment Administration Record (TAR), Point Click Care (PCC-EMR), and Point of Care (POC-EMR) to remind staff to place brace on resident in a timely manner. Any resident who was identified as having a brace or splint, the device was recorded to the TAR, PCC, and POC. Nursing and Therapy staff will be educated on the protocol for brace or splint use per therapy. Upon need, therapy will recommend use of a brace or splint for a resident. Once decided that it is the best for the resident an education on how to use the device will be given by therapy. Additional information will go into PCC, POC and the TAR and directions for use will be discretely placed in the resident room to help ensure proper usage and timely wear. Audits will be conducted by clinical coordinators and nurse supervisors at various times once a week for four weeks, once a month for four months until acceptable practice is observed. Outcomes will be observed at our Quality Improvement meeting. The Director of Nursing or designee will be responsible for compliance by 6/1/18.	

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F 688	Continued From page 18 nursing assistant (NA)-E confirmed R6 was not wearing her left hand orthotic brace which should have been put on at 9:00 a.m. for four hours. NA-E said she would put it on. When interviewed on 4/19/18, at 8:59 a.m. physical therapist (PT)-E stated R6 was supposed to have her left hand orthotic brace on from 9:00 a.m. to 1:00 p.m. daily as directed because it was working well. PT-E then assessed R6's left hand, stated it looked good, and explained if the splint was not put on the resident as scheduled it could lead to skin breakdown, yeast infections and an increase in pain. When interviewed on 4/19/18, at 10:24 a.m. registered nurse (RN)-E stated her expectation would be for R6's orthotic brace to be applied by staff as ordered. When interviewed on 4/19/18, at 10:57 a.m. the director of nursing stated the staff had informed her about R6's left hand orthotic brace not being applied and the facility would take corrective action by retraining nursing staff and instituting a log sheet with dates and times of brace placement. A facility policy regarding splints and braces was requested but not provided.	F 688		
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	F 880		6/1/18

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F 880	Continued From page 19	F 880		

development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control 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.

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F 880	Continued From page 20 (v) The circumstances under which the facility must prohibit employees with a communicable 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 a urinary catheter drainage tubing was secured off the floor to prevent cross-contamination and infections for 1 of 3 residents (R71) reviewed for a urinary catheter. Findings include: R71's diagnoses included: benign prostatic hyperplasia, hemiplegia and obstructive uropathy, obtained from the annual Minimum Data Set (MDS) dated 2/24/18. In addition, the MDS indicated R71 had an indwelling Foley catheter, required staff assistance to empty the catheter bag and required extensive physical assistance of two staff with toileting.	F 880	F880: At the time of the incident, the catheter was cleaned and placed back into the designated bag to ensure infection control. Also residents with a catheter were identified, observed, audited to ensure propped usage. All staff will be educated about the importance of having catheter tubing off the floor and properly secured and to alert the nursing staff as necessary. Audits will be conducted by clinical	

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 04/19/2018

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F 880	Continued From page 21 R71's care plan dated 2/26/18, identified R71 had an alteration in elimination related to chronic Foley since July 2009, due to hypertrophy of prostate with urinary obstruction and other lower urinary tract symptoms. The care plan directed staff to anchor the catheter tubing. On 4/18/18 at 11:44 a.m., R71 was observed seated in a wheelchair. A dietary staff wheeled R71 out of the dining room to the entrance and R71 then propelled himself down the hallway, using the hand rails. During the observation R71's catheter tubing, which was approximately two feet long was dragging on the floor next to the right front wheel of the wheelchair. In addition, the entire length of the tubing was observed with amber colored urine and the catheter bag was stored in the blue bag underneath the wheelchair. As R71 wheeled down the hallway the health unit coordinator was observed to walk past R71, but did not adjust the tubing or get assistance. From 11:48 a.m. to 12:28 p.m., R71 remained seated in the wheelchair in front of the television area which was located across from the nursing station. Several staff were observed go by, but none made any attempts to adjust the catheter tubing which was still noted to be lying on the floor. At 12:29 p.m. nursing assistant (NA)-B approached R71, spoke to him briefly and boosted him up by puling on R71's pants from the back. NA-B did not adjust the catheter tubing which was still touching the floor. On 4/18/18, at 1:43 p.m. R71 was observed again, waiting at the dining room table to play Bingo. The catheter tubing was observed on the floor. NA-A was interviewed at that time, and verified the tubing was laying on the floor. NA-A	F 880	coordinators and nurse supervisors at various times once a week for four weeks, once a month for four months until acceptable practice is observed. Outcomes will be observed at our Quality Improvement meeting. The Director of Nursing or designee will be responsible for compliance by 6/1/18.	

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F 880	Continued From page 22	F 880		

then approached R71 and requested to bring him to the bathroom to adjust the tubing which R71 agreed to. At 1:48 p.m. registered nurse (RN)-A acknowledged staff should have ensured the catheter tubing was secured and not lying on the floor as there was a risk of the tubing getting caught. RN also stated all staff were supposed to offer to adjust the tubing if they saw it lying on the floor.

On 4/19/18, at 12:08 p.m. RN-A stated the catheter tubing was to be secured as there was a risk of being caught when dragging on the floor and was at risk for infections.

On 4/19/18, at 12:39 p.m. the director of nursing (DON) stated she would expect the tubing and bag to be secured. The DON said catheter bags were supposed to be covered and the tubing should not drag on the floor as this was a dignity issue and an infection control issue.

The facility's Urinary Collection Bag policy revised 3/18, directed staff to ensure the bag was secured properly to maintain clearance from the floor. In addition, the policy directed staff to ensure privacy of the urinary cathter bag by keeping it out of view of others whenever possible.

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	245450	A. BUILDING **01 - THREE LINKS CARE CENTER** B. WING _____	**04/18/2018**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on April 17, 2018. At the time of this survey, Three Links Care Center was found 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. 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 protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 102 beds and had a census of 86 at the time of the survey.	K 000		

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

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.