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: JBNJ

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)

6. DATE OF SURVEY **03/02/2015** (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 **102** (L18)

13.Total Certified Beds **102** (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
	102			
(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 :
Gayle Lantto, Supervisor 03/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/02/2015 (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 **02/25/2015** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5450

Electronically Delivered: March 2, 2015

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 February 23, 2015 the above facility is certified for:

102 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 102 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. Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 2, 2015

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

RE: Project Number S5450025

Dear Ms. Vincent:

On January 27, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 14, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 2, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 14, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 23, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 14, 2015, effective February 23, 2015 and therefore remedies outlined in our letter to you dated January 27, 2015, 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.

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245450	A. Building B. Wing	3/2/2015

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(t LSC	02/23/2015	ID Prefix F0322 Reg. # 483.25(g)(2) LSC	02/23/2015	ID Prefix F0463 Reg. # 483.70(f) LSC	02/23/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/AK	03/02/2015	15507	03/02/2015
CMS RO				

Followup to Survey Completed on: 1/14/2015

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: JBNJ
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 **01/14/2015** (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 **102** (L18)

13.Total Certified Beds **102** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	102			
(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 :
Lisa Hakanson, HPR Dietary Specialist 02/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/19/2015 (L20)

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

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

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 (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: January 27, 2015

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

RE: Project Number S5450025

Dear Ms. Vincent:

On January 14, 2015, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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;

<u>Potential Consequences</u> - 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 a "F" tag), i.e., the plan of correction should be directed to:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

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 February 23, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 23, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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. 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 April 9, 2015 (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 July 9, 2015 (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
Division of Compliance Monitoring
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.

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 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 ______	01/14/2015

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 156 SS=F	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		2/23/15

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

Electronically Signed — 02/10/2015

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 ______	01/14/2015

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 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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 ______	01/14/2015

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 156	Continued From page 2	F 156		

agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review the facility failed to periodically review the Resident Bill of Rights with residents and provide evidence oral and written information was provided as required. This had the potential to affect all residents residing in the facility.

Findings include:

R65 stated in an interview on 1/14/15, at 9:20 a.m. "I don't know what my rights [as a resident] are." R65 also stated no one in the facility had ever reviewed the Resident Bill of Rights with her since her admission to the facility.

Following the interview at 9:30 a.m. a licensed practical nurse (LPN)-B said, "She [R65] is pretty with it. She can remember things."

Facility SS/Household Coordinator will provide a copy of Resident's Bill of Rights to all in-house residents and explain orally and document in their medical records by 2/23/15.

Facility SS/Household Coordinator will review Resident's Bill of Rights at annual care conferences and document. On admission, facility will continue to provide oral and written information of the Resident's Bill of Rights.

SS will audit for compliance quarterly.

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 ______	01/14/2015

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 156	Continued From page 3	F 156		

R65 had resided at the facility since 2/14. A quarterly MDS dated 12/3/14, indicated she had moderately impaired cognition.

R11 stated in an interview on 1/14/15, at 10:07 a.m. she did not know where she could have found the Resident Bill of Rights posted in the facility. She added, "My memory is getting shorter. I have a social at 10:15 a.m."

R11 had resided at the facility for four years. A quarterly Minimum Data Set (MDS) dated 11/26/14, indicated R11's cognition was intact, and the resident had no problems with recall.

On 1/13/15, at 10:47 a.m. a nursing assistant (NA)-F stated, "Pathways [memory care unit] just started a resident council yesterday because of a change in residents. We had a little turnover. Because of cognitive issues, the residents before were not able to vocalize. It [resident council] just started up again." NA-F also stated, "Some residents are able to voice here and there, but it depends on their cognition and the day." Previously residents from the Pathways unit had been invited to attend resident council meetings "upstairs."

On 1/13/15, at 2:15 p.m. a life enrichment coordinator (LEC) stated she was in charge of activities at the facility. The LEC explained that the residents said they did not like the resident council meetings, but it depended on the group. They did receive a lot of resident input from the meetings during the Lane (unit) lunches. The LEC explained meetings were held at least quarterly, and the Pathways residents were invited to attend meetings upstairs. The LEC said both R11 and

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 ______	01/14/2015

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 156	Continued From page 4	F 156		

R65 attended meetings regularly, and were good representatives.

On 1/14/15, at 9:36 a.m. the social services director (SSD) explained there had been changes about a year prior when the residents had met together as one group. At that time, two or three rights from the Bill of Rights were covered at each monthly meeting. However, only three or four residents were showing up each month. It was decided the facility would make a "culture change" and a household model was put in place to solicit more resident feedback. The SSD further stated she was insure if the household coordinators (HCs) had continued reviewing the Bill of Rights at their meetings. At 10:39 a.m. the SSD added that she had not been attending resident council meeting or reviewed the Bill of Rights with residents in over a year when the meeting style changed from formal to informal.

On 1/14/15, at 9:46 a.m. a HC-C, "I run the meetings [resident council]. Residents meet every other month. I do not go over the resident rights with the residents," and said she had never reviewed the Bill of Rights with residents. She added, "I just go over the agenda provided--dietary, housekeeping, activities, maintenance concerns."

On 1/14/15, at 9:58 a.m. HC-D stated, "We used to hold resident council in the chapel" and the SSD and chief executive officer attended monthly. "It was more formal. HC-D explained that over a year ago the facility made the meetings more informal, and it was more of a discussion with the agenda set by the LEC.

On 1/14/15, at 11:05 a.m. the LEC stated, "We

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 ______	01/14/2015

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 156	Continued From page 5 talk to families about residents' rights upon admission and we have a posting of the rights on the wall." The facility provided minutes of the past years resident council minutes. The minutes did not include any information regarding the Resident Bill of Rights being covered with the residents at that time. The facility's undated Policy and Procedure Activities, Resident Council did not include information directing staff to periodically review the Resident Bill of Rights with residents as required.	F 156		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		2/23/15

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 ______	01/14/2015

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 322	Continued From page 6	F 322		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure a gastrostomy tube (G-tube) placement or gastric residual was checked prior to medication administration, for 1 of 1 resident (R20) observed for medication administration through a G-tube.

Findings include:

R20 was observed in her room on 1/12/15, at 4:40 p.m. The resident was seated in an upright position in a wheelchair. R20's medication administration record indicated staff was to check placement each time water or medication was administered via G-tube (placed into the stomach for feeding, fluids an medication administration).

On 1/12/15, at 4:51 p.m. a licensed practical nurse (LPN)-A prepared R20's medications by crushing and placing the medication into 30 millimeters (ml) of water. LPN-A held onto R20's G-tube and attached an empty 60 cc syringe barrel to the G-tube. LPN-A took the crushed the medication and was about to pour the medication into the syringe barrel when the surveyor stopped the LPN. The LPN was informed placement and residual had not been checked, which LPN-A acknowledged.

On 1/13/15, at 12:48 p.m. a registered nurse (RN)-B stated staff should have been checking G-tube placement and residual each time medication was administered. RN-B stated R20's electronic medication administration record had an area for staff to check off showing placement

Facility re-educated (LPN)-A immediately on checking placement of G-tube prior to medication administration.

Policies and procedures related to gastric tube feedings and medication administration have been reviewed and updated by the Director of Nursing to ensure appropriate information is available.

Facility's Staff Development Director will present education to all facility nurses. The training agenda will include G-tube policy and procedure review, regulatory guidelines and assessment of risk factors.

The Quality Coordinator and DON will audit monthly for compliance of procedures as long as there is a resident with a G-tube in place.

This will be completed by 2-23-15.

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 ______	01/14/2015

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 322	Continued From page 7 and residual had been completed. The facility's 8/09 policy and procedure titled G-Tube directed staff to check placement of the feeding tube and measure residual gastric contents. Step-by-step instructions were included in the policy.	F 322		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure call lights were operational for 2 of 40 residents (R36, R69) whose call lights were tested. Findings include: R36's call light cord was observed with a slit approximately two inches in two different places on the cord with exposed wires on 1/11/15, at 1:10 p.m. R36 stated, "The cord has been like that for a while--about two to three weeks. I gets caught in the bed frame." NA-E then verified the slit cord and stated, "I honestly did not know it was like that. I am going to tell my nurse supervisor. Because it is electrical I will be right back." NA-E verified R36 used his call light to ask for staff assistance. At 1:17 p.m. NA-E stated she had notified her supervisor who would also inform a maintenance staff person of the issue.	F 463	Facility replaced malfunctioning call light/cords for R36 and R69 immediately, prior to the surveyors' departure. Facilities maintenance has completed an audit of facility's call lights/cords during the survey and found no other malfunctioning call light/cords. Maintenance will implement annual Arial Nurse Call full system test. On a monthly basis, maintenance will complete a random audit of 10% of the facility's rooms' call system. Arial Nurse Call System policy and procedure has been revised. Staff notified via Point Click Care on 1/30/15 and staff will be educated on this policy at	2/23/15

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 ______	01/14/2015

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 463	Continued From page 8 R36's Minimum Data Set (MDS) dated 12/11/14, indicated R36 was cognitively intact and needed extensive staff assistance with activities of daily living (ADLs). R69 was asked whether she was able to use her call light during a resident interview on 1/11/15, at 1:45 p.m. When R69 pushed the red button on top of her call light it, did not activate. A nursing assistant (NA)-A was then notified of the malfunctioning call light. NA-A verified the call light was not working and replaced R69's call light with a new working call light. R69's MDS dated 12/9/14, indicated R69 had severely impaired cognition. On 1/13/15, at 10:18 a.m. the maintenance director explained that maintenance staff completed random call light checks in one resident room a month on each unit. The maintenance director also stated the facility had an online work order system "TELS" that maintenance checked several times a shift. In addition, staff could call maintenance staff if there were problems after business hours. During the tour on 1/13/15, at 3:30 p.m. the maintenance director verified R69's call light was working and stated residents' call lights should always be functioning. At 3:37 p.m. the maintenance director verified R36's call light cord had been replaced and stated it had posed a safety issue. The facility's 1/2/15, Nurse Call System Test: Nurse Call Systems policy directed staff to "Randomly check in one room, a wall station, call	F 463	upcoming meetings. This will be completed by 2/23/15.	

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 ______	**01/14/2015**

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 463	Continued From page 9 cord function, bath function, and staff emergency functions. Do this in one random room in each of the following wings: The Bridge, Daisy Lane, Iris Lane, Marigold Lane, and Pathways."	F 463		

DEPARTMENT OF HEALTH AND HUMAN SERVICES F5450025
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245450	A. BUILDING **01 - THREE LINKS CARE CENTER** B. WING ______	**01/12/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Three Links Care Center was found 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. 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 96 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	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.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: January 27, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5450025

Dear Ms. Vincent:

The above facility was surveyed on January 11, 2015 through January 14, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00564	A. BUILDING: ____ B. WING ____	01/14/2015

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) COMPLETE DATE
2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at:

http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00564	A. BUILDING: ______ B. WING ______	01/14/2015

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) COMPLETE DATE
2 000	Continued From page 1 The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a gastrostomy tube (G-tube) placement or gastric residual was checked prior to medication administration for 1 of 1 resident (R20) observed for medication administration through a G-tube.	2 930	Reviewed	2/23/15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00564	A. BUILDING: ______ B. WING ______	01/14/2015

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) COMPLETE DATE
2 930	Continued From page 2	2 930		

Findings include:

R20 was observed in her room on 1/12/15, at 4:40 p.m. The resident was seated in an upright position in a wheelchair. R20's medication administration record indicated staff was to check placement each time water or medication was administered via G-tube (placed into the stomach for feeding, fluids an medication administration).

On 1/12/15, at 4:51 p.m. a licensed practical nurse (LPN)-A prepared R20's medications by crushing and placing the medication into 30 millimeters (ml) of water. LPN-A held onto R20's G-tube and attached an empty 60 cc syringe barrel to the G-tube. LPN-A took the crushed the medication and was about to pour the medication into the syringe barrel when the surveyor stopped the LPN. The LPN was informed placement and residual had not been checked, which LPN-A acknowledged.

On 1/13/15, at 12:48 p.m. a registered nurse (RN)-B stated staff should have been checking G-tube placement and residual each time medication was administered. RN-B stated R20's electronic medication administration record had an area for staff to check off showing placement and residual had been completed.

The facility's 8/09 policy and procedure titled G-Tube directed staff to check placement of the feeding tube and measure residual gastric contents. Step-by-step instructions were included in the policy.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could ensure licensed staff receive training in administration of

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00564	A. BUILDING: ______ B. WING ______	01/14/2015

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) COMPLETE DATE
2 930	Continued From page 3 G-tube medications. Return demonstrations could be implemented. Periodic audits could be conducted and the results of the audits borsht to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 930		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to	21800		2/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00564	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 01/14/2015

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) COMPLETE DATE
21800	Continued From page 4 vulnerable adults. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to periodically review the Resident Bill of Rights with residents and provide evidence oral and written information was provided as required. This had the potential to affect all residents residing in the facility. Findings include: R65 stated in an interview on 1/14/15, at 9:20 a.m. "I don't know what my rights [as a resident] are." R65 also stated no one in the facility had ever reviewed the Resident Bill of Rights with her since her admission to the facility. Following the interview at 9:30 a.m. a licensed practical nurse (LPN)-B said, "She [R65] is pretty with it. She can remember things." R65 had resided at the facility since 2/14. A quarterly MDS dated 12/3/14, indicated she had moderately impaired cognition. R11 stated in an interview on 1/14/15, at 10:07 a.m. she did not know where she could have found the Resident Bill of Rights posted in the facility. She added, "My memory is getting shorter. I have a social at 10:15 a.m." R11 had resided at the facility for four years. A quarterly Minimum Data Set (MDS) dated 11/26/14, indicated R11's cognition was intact, and the resident had no problems with recall.	21800	Acknowledged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00564	A. BUILDING: ______ B. WING ______	01/14/2015

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) COMPLETE DATE
21800	Continued From page 5	21800		

On 1/13/15, at 10:47 a.m. a nursing assistant (NA)-F stated, "Pathways [memory care unit] just started a resident council yesterday because of a change in residents. We had a little turnover. Because of cognitive issues, the residents before were not able to vocalize. It [resident council] just started up again." NA-F also stated, "Some residents are able to voice here and there, but it depends on their cognition and the day." Previously residents from the Pathways unit had been invited to attend resident council meetings "upstairs."

On 1/13/15, at 2:15 p.m. a life enrichment coordinator (LEC) stated she was in charge of activities at the facility. The LEC explained that the residents said they did not like the resident council meetings, but it depended on the group. They did receive a lot of resident input from the meetings during the Lane (unit) lunches. The LEC explained meetings were held at least quarterly, and the Pathways residents were invited to attend meetings upstairs. The LEC said both R11 and R65 attended meetings regularly, and were good representatives.

On 1/14/15, at 9:36 a.m. the social services director (SSD) explained there had been changes about a year prior when the residents had met together as one group. At that time, two or three rights from the Bill of Rights were covered at each monthly meeting. However, only three or four residents were showing up each month. It was decided the facility would make a "culture change" and a household model was put in place to solicit more resident feedback. The SSD further stated she was insure if the household coordinators (HCs) had continued reviewing the Bill of Rights at their meetings. At 10:39 a.m. the SSD added that she had not been attending

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00564	A. BUILDING: ______ B. WING ______	01/14/2015

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) COMPLETE DATE
21800	Continued From page 6	21800		

resident council meeting or reviewed the Bill of Rights with residents in over a year when the meeting style changed from formal to informal.

On 1/14/15, at 9:46 a.m. a HC-C, "I run the meetings [resident council]. Residents meet every other month. I do not go over the resident rights with the residents," and said she had never reviewed the Bill of Rights with residents. She added, "I just go over the agenda provided--dietary, housekeeping, activities, maintenance concerns."

On 1/14/15, at 9:58 a.m. HC-D stated, "We used to hold resident council in the chapel" and the SSD and chief executive officer attended monthly. "It was more formal. HC-D explained that over a year ago the facility made the meetings more informal, and it was more of a discussion with the agenda set by the LEC.

On 1/14/15, at 11:05 a.m. the LEC stated, "We talk to families about residents' rights upon admission and we have a posting of the rights on the wall."

The facility provided minutes of the past years resident council minutes. The minutes did not include any information regarding the Resident Bill of Rights being covered with the residents at that time.

The facility's undated Policy and Procedure Activities, Resident Council did not include information directing staff to periodically review the Resident Bill of Rights with residents as required.

SUGGESTED METHOD OF CORRECTION:
The administrator and SSD could ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00564	A. BUILDING: ____ B. WING ____	01/14/2015

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) COMPLETE DATE
21800	Continued From page 7 residents are informed both in writing and orally of their rights upon admission. A system to also ensure residents are reminded of those rights periodically throughout their stay could be implemented. Residents could be randomly interviewed to ensure they have been informed of their rights. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21800		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure call lights were operational for 2 of 40 residents (R36, R69) whose call lights were tested. Findings include: R36's call light cord was observed with a slit approximately two inches in two different places on the cord with exposed wires on 1/11/15, at 1:10 p.m. R36 stated, "The cord has been like that for a while--about two to three weeks. I gets	21810	Acknowledged	2/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00564	A. BUILDING: ______ B. WING ______	01/14/2015

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) COMPLETE DATE
21810	Continued From page 8	21810		

caught in the bed frame." NA-E then verified the slit cord and stated, "I honestly did not know it was like that. I am going to tell my nurse supervisor. Because it is electrical I will be right back." NA-E verified R36 used his call light to ask for staff assistance. At 1:17 p.m. NA-E stated she had notified her supervisor who would also inform a maintenance staff person of the issue.

R36's Minimum Data Set (MDS) dated 12/11/14, indicated R36 was cognitively intact and needed extensive staff assistance with activities of daily living (ADLs).

R69 was asked whether she was able to use her call light during a resident interview on 1/11/15, at 1:45 p.m. When R69 pushed the red button on top of her call light it, did not activate. A nursing assistant (NA)-A was then notified of the malfunctioning call light. NA-A verified the call light was not working and replaced R69's call light with a new working call light.

R69's MDS dated 12/9/14, indicated R69 had severely impaired cognition.

On 1/13/15, at 10:18 a.m. the maintenance director explained that maintenance staff completed random call light checks in one resident room a month on each unit. The maintenance director also stated the facility had an online work order system "TELS" that maintenance checked several times a shift. In addition, staff could call maintenance staff if there were problems after business hours.

During the tour on 1/13/15, at 3:30 p.m. the maintenance director verified R69's call light was working and stated residents' call lights should always be functioning. At 3:37 p.m. the

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00564	A. BUILDING: ______ B. WING ______	01/14/2015

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) COMPLETE DATE
21810	Continued From page 9 maintenance director verified R36's call light cord had been replaced and stated it had posed a safety issue. The facility's 1/2/15, Nurse Call System Test: Nurse Call Systems policy directed staff to "Randomly check in one room, a wall station, call cord function, bath function, and staff emergency functions. Do this in one random room in each of the following wings: The Bridge, Daisy Lane, Iris Lane, Marigold Lane, and Pathways." SUGGESTED METHOD OF CORRECTION: The director of maintenance or designee could ensure call lights continue to be routinely tested. The administrator could ensure all staff are trained to immediately report non-functioning call lights. Audits could be conducted and the results brought to the quality committee for their review. TIME PERIOD FOR CORRECTION: Seven (7) days.	21810		