Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 3, 2025

Administrator

Three Links Care Center

815 Forest Avenue

Northfield, MN 55057

RE: CCN: 245450

Cycle Start Date: July 31, 2025

Dear Administrator:

On September 11, 2025, we notified you a remedy was imposed.

On September 15, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 11, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 31, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of September 11, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 31, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 11, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 13, 2025

Administrator
Three Links Care Center

815 FOREST AVENUE
NORTHFIELD, MN 55057

RE: CCN:245450
Cycle Start Date: July 31, 2025

Dear Administrator:

On July 31, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

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

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 31, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 31, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245450	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Links Care Center	815 FOREST AVENUE , NORTHFIELD, Minnesota, 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
E0000	Initial Comments No deficiencies were issued at Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities, CFR 483.73, at time of the standard recertification survey, exited on 7/31/25.	E0000		08/22/2025
F0000	INITIAL COMMENTS On 7/28/25 through 7/31/25, a standard recertification survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		08/29/2025
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F0561	Resident was interviewed by nurse and determined preference for shower was on the evening. Nurse updated care plan and bathing schedule on 7/31/25 to accommodate the resident's preference going forward. Resident has been showering in the evening since 7/31/25. All residents will be reassessed on their bathing time preference to identify if current schedule is adequate or if changes are required. By 8/22/25 all residents will be asked their preference on their bathing time. Bath aide was educated to ask residents with weekly bath if bath schedule time is still satisfactory. In addition, bathing preference will be asked upon admission, during quarterly care conference, or upon request or change in condition. Bath aide, and all Staff will be educated to ensure communication is given to nurse coordinator if resident voices a different	08/29/2025

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 reverse for further 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.

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

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F0561 SS = D	Continued from page 1 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident choices for bathing preferences were assessed and honored for 1 of 1 residents (R1) reviewed for choices. Findings Include: R1's admission Minimum Data Set (MDS), dated 5/29/25, indicated R1 had intact cognition with no hallucinations or delusions. The assessment indicated R1 needed moderate staff assistance with dressing, toileting hygiene, personal hygiene and footwear. On 7/28/25 at 6:33 p.m., R1 stated that she preferred to have a shower in the evening. R1 stated the facility had always given her showers during the day except for one time when they did not have time to complete it during the day and gave her a shower in the evening. R1 stated how much she enjoyed the shower in the evening and "I have told everybody how much I liked the shower in the evening." R1's care plan, printed 7/29/25, identified the following: -Resident preferences will be considered when providing care with the following preferences: bedtime preference of 10 p.m., music preference of inspirational/religious the importance of being around animal such a s pets was very important. -"BATHING/SHOWERING: I am able to: Limited A-1 with 2WW and gait belt" - HS ROUTINE: I am a night owl. I prefer to call for assistance when I am ready for bed."	F0561	Continued from page 1 bathing preference than what is desired. Facility will conduct random audits of residents to determine their happiness with the current bathing schedule, compliance with preference, and that the medication and treatment administration record (MAR) matches preference. 3 audits for one week, 2 audits for one week, then one audit for two weeks. These audits will be reviewed at QAPI to determine compliance and continued need.	

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F0561 SS = D	Continued from page 2 On 7/29/25 at 11:34 a.m., licensed practical nurse (LPN)-C provided a copy of the shower/bath schedule and stated this was the schedule the facility used for resident showers/baths. Facility shower schedule, printed 7/29/25, identified R1 “prefers shower only” and R1’s showers were offered weekly on Mondays. The facility shower schedule lacked identification of R1's preference for an evening shower. Furthermore, the shower schedule indicated, “Day bath aide 6-2pm” and any leftover baths would be coordinated with evening staff to complete, and the nurse would continue to do weekly bath audits day/eves. R1’s July 2025 medication and treatment administration record (MAR), printed 7/29/25, identified the following order: -Total body skin assessment every Monday AM (day) shift starting 5/26/25. Per record, was completed 7/7/25, 7/21/25, and 7/28/25. On 7/14/25, it was documented with a “9” which indicated “other/see progress notes.” R1’s Resident Preferences Evaluation, dated 5/29/25, identified R1 had a sponge bath bathing preference. Furthermore, the assessment indicated R1 preferred an afternoon or evening time of day for bathing. R1's progress notes, dated 5/22/25 to 7/29/25, were reviewed. R1's progress notes, dated 5/29/25, indicated a resident preference evaluation had been completed which identified R1 preferred to bathe in the afternoon or evening and preferred a sponge bath. The progress notes lacked evidence of any additional conversations of R1’s preferences or how the facility was going to help meet resident’s preferences. During an interview on 7/30/25 at 8:55 a.m., nursing assistant (NA)-D stated that she did majority of the showers for residents in the facility. NA-D stated the shower schedule was determined by the care coordinators and the days were set, typically, by room numbers. NA-D stated when residents moved into the facility they were assessed to determine if they preferred day or evening showers or if they preferred baths or showers. NA-D stated there were no residents who had a preference for evening showers. NA-D stated she did as many showers as she could during the day but occasionally, she was unable to complete a shower and then it got done in the evening, but the showers were not scheduled in the evenings. NA-D reviewed the shower schedule and verified there was not an identified preference for R1 to have an evening or afternoon shower. NA-D stated R1	F0561		

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F0561 SS = D	Continued from page 3 got one shower a week on Mondays and preferred to have a shower, not a bath. NA-D stated she had always given R1 her showers in the mornings and verified she has given R1 almost 75% of her showers. During an interview on 7/30/25 at 11:45 a.m., registered nurse coordinator (RN)-B stated an assessment was completed on admission to identify resident preferences. RN-B stated if a preference for bathing times was identified, the information would be passed along to the rest of the team and the bath schedule would be updated. RN-B stated she was aware of one resident that preferred an evening bath and verified it was not R1. RN-B reviewed Resident Preferences Evaluation, dated 5/29/25 and verified R1 had identified a preference for an afternoon/evening sponge bath. RN-B stated some of the assessment forms had changed since May, the life enrichment department had completed this assessment, and she was not aware of this. RN-B stated since the preference had been identified during an assessment, the expectation would be R1 would be offered her bathing preference in the afternoon or evening. During an interview on 7/31/25 at 8:59 a.m., life enrichment director (LED) verified she completed the Resident Preference Evaluation for R1 on 5/29/25. LED stated this was a newer form for the facility. LED reviewed the form and verified R1 had identified a bathing preference. LED stated she had not passed this information along as this was information nursing had always evaluated, and she thought nursing had this information. LED stated the facility had newer forms and it has been a learning process, and the facility was working on new processes to increase communication with the team to ensure preferences were met. During an interview on 7/31/25 at 10:35 a.m., director of nursing (DON) stated the expectation would be for the facility to do everything they could to honor a resident's identified preference. DON stated they had recently switched some assessments, and some of the preferences (bathing preferences) were previously assessed by nursing and were switched to the activity assessment and they were working through this. A facility policy titled Dignity, revised 4/17/23, was provided. Policy indicated "reasonable accommodation of the resident's needs, preferences (including sexual), and physical limitations will be directed towards assisting the resident in maintaining independent function, dignity and well-being." A policy on resident preferences/choices was requested	F0561		

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F0561 SS = D	Continued from page 4 and not received.	F0561		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded, with the potential for inaccurate federal reimbursement and resident care planning for 1 of 5 residents (R48) reviewed for MDS accuracy. Findings include:	F0641	Residents MDS was corrected to reflect the healed pressure ulcer at its highest numerical stage. This was completed on 8/22/25. All current residents with pressure ulcers will have their MDS reviewed to ensure pressure ulcers did not reflect an improvement in staging. New pressure ulcers will be reviewed to ensure we remain compliant in documenting ulcers at their highest numerical stage. MDS Directors, along with clinical team (DON, ADON, Nurse Coordinator, primary Physician & Nurse Practitioner) reviewed the CMS LTC facility resident assessment instrument Manual and were educated on the numerical staging documentation of pressure ulcers. Pressure ulcers will be audited monthly to ensure accuracy of coding. Each month, the MDS from residents in house who have pressure ulcers will be reviewed to ensure compliance. These audits will be reviewed at QAPI to determine compliance and ongoing need.	08/23/2025

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F0641 SS = D	Continued from page 5 The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2024, indicates clinical standards do not support reverse staging or back-staging as a way to document healing as it does not accurately characterize what is occurring physiologically as the ulcer heals, as the tissues lost will never be replaced with the same type of tissue (page M-7). The manual instructs that once a pressure ulcer is healed, it should be documented as a healed pressure ulcer at its highest numerical stage, as it would remain at an increased risk for future breakdown and require continued monitoring and preventative care (page M-8). The manual indicates that a previously closed pressure ulcer that reopens should be reported at its worst stage, unless currently presenting at a higher stage or unstageable (page M-7). The manual indicates that “healed” versus “unhealed” ulcers in the section refer to whether or not an ulcer is “closed” versus “open” (page M-2). The manual further defined a “healed” pressure ulcer as “completely closed, fully epithelialized [to be covered by the tissue type typically making up the outer layer of healthy skin], covered completely with epithelial tissue or resurfaced new skin” (page M-2). R48’s quarterly Minimum Data Set (MDS) dated 7/3/25, indicated R48 had one stage two pressure ulcer that was not present on admission and no stage three pressure ulcers. R48’s provider note dated 3/11/25, indicated the provider was able to visualize the depth of the wound, and R48 had a “stage 3 pressure ulcer” on her right foot between her toes. R48’s wound note dated 6/19/25, indicated R48 had a “recurrent” stage two pressure ulcer on her right foot between her great and second toe that was currently unhealed with the presence of slough and increased drainage. R48’s progress note dated 6/24/25, indicated the wound “between the toes” on the right foot remained open. R24’s Comprehensive Skin Risk Assessment dated 7/3/25, indicated R48 had a “healed” stage two pressure ulcer on her right foot between her right and second toe as the area was “scabbed”. During an interview on 7/29/25 at 1:27 p.m., registered nurse (RN)-C stated R48 had a recurrent skin injury that was between the great and next toe on her right foot. RN-C reviewed his notes and stated that the last	F0641		

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F0641 SS = D	Continued from page 6 time he saw that the wound was “open” was on 7/11/25. During an interview on 7/30/25 at 8:12 a.m., RN-D, an MDS coordinator, confirmed she had completed R48’s latest quarterly MDS. RN-D confirmed R48’s wound had not been healed at the time of assessment. RN-D stated she had coded the wound as a stage two but had not realized at the time that R48 previously had a stage three pressure ulcer in that spot. RN-D stated that usually, when someone has a pressure ulcer, they will add a diagnosis indicating this to the diagnosis list. RN-D stated that this was not completed, so she had not realized R48 previously had a stage three pressure ulcer in that same spot. RN-D stated that if she had known, she would have coded the wound as a stage three. During an interview on 7/30/25 at 12:46 p.m., nurse practitioner (NP)-A stated she had assessed R48’s right foot pressure ulcer when it had first been found multiple months ago and had staged it as a stage three related to the wound’s depth. NP-A stated the wound was between R48’s in the crease between her first and second toe, was caused by pressure from her contracture, and had since recurred in the same spot. During an interview on 7/31/25 at 10:29 a.m., the director of nursing (DON) stated she would defer questions regarding the MDS to the MDS coordinator. The Facility’s MDS 3.0 Assessment policy dated 8/20/24, indicated all interdisciplinary team members involved in completing portions of the MDS record must review and under the current version of the RAI user’s manual. The policy indicated the MDS coordinator was responsible for conducting audits to identify errors and make appropriate corrections during the encoding period to ensure accurate information was submitted.	F0641		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the dignity of 1 of 2 residents (R31) reviewed who were cognitively impaired and had facial hair.	F0677	R31 was offered shaving on 7/31/2025 and declined. All female residents with facial hair will be offered shaving during bathing. If resident preference is to not shave facial hair, such preference will be documented in care plan and on bathing schedule. All residents will have care plans reviewed to ensure shaving and grooming facial hair are addressed, this will be completed on 8/22/25. Education was provided to nurse coordinators, DON, & ADON to ensure shaving & grooming of facial hair is incorporated into careplans. Clinical staff were educated on the importance of following revised care	08/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245450	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Links Care Center	815 FOREST AVENUE , NORTHFIELD, Minnesota, 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
F0677 SS = D	Continued from page 7 Findings include: R31's admission Minimum Data Set (MDS) assessment dated 7/29/25, identified admission to the facility on 7/10/25, with diagnoses of non-Alzheimer's dementia, arthritis, depression, and cataracts. R31 had moderate cognitive impairment, used a wheelchair for mobility, required substantial assistance from staff for hygiene to include combing hair, shaving, washing/drying face and hands, baths, showers, and oral hygiene. R31's care plan dated 7/10/25, identified activity of daily living (ADL) interventions for bed mobility, oral cares, toilet use, transfers, bathing and showering, dressing and eating. Bathing and showers required a mechanical lift with assist of two staff for transfers. The plan lacked interventions to address shaving or grooming facial hair. A care sheet for July 2025 lacked documentation R31 received any type of grooming or shaving facial hair. R31's behavior assessment report dated 7/17/25, identified no physical or verbal behaviors were directed towards staff. R31's N-Adv ADL Only report (a report in the electronic medical record used by nursing staff to review or audit documentation related to ADL's which are key for MDS assessments) dated 7/17/25, identified extensive assistance for personal cares. R31's N-Adv Resident Preferences Evaluation report, dated 7/17/25, indicated an interview for daily and activity preferences was not conducted. The first question on the evaluation was, "should interview for daily and activity preferences be conducted" and a box was checked "NO". The questions on the evaluation were used to identify resident preferences, for example, time of day for bathing, dressing, or bedtime. R31's weekly bath log dated 7/15/25 and 7/29/25, indicated R31 received a bath and included a field to document the cleaning of a shaver. The report lacked documentation a shaver was cleaned. R31's admission care conference report dated 7/22/25, identified total assist with all ADLs. R31's Kardex dated 7/29/25, identified cares but lacked information that addressed grooming or shaving facial hair. During an observation on 7/28/25 at 5:01 p.m., R31 had	F0677	Continued from page 7 plan preference for shaving/grooming and ensuring we are offering shaving/grooming at bath time or as requested by resident or identified. Careplans of female residents will be audited to ensure shaving/grooming preferences are identified in careplan and that we are meeting resident preference. 3 audits for one week, 2 audits for one week, then one audit for two weeks. These audits will be reviewed at QAPI to determine compliance and ongoing need.	

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F0677 SS = D	Continued from page 8 several white chin hairs, approximately ¼ inch long and a full white mustache. During an observation on 7/29/25 at 11:50 p.m., R31's chin hairs were still present after a bath. During an interview on 7/29/25 at 12:33 p.m., licensed practical nurse (LPN)-A stated R31 had a bath this morning and it was always on Tuesday mornings. During an interview on 7/29/25 at 12:37 p.m., nursing assistant (NA)-B stated R31's bath was given that morning and they would shave her chin hair, if asked. NA-B stated they believed residents had to bring in their own shaver and R31 did not have her own, so they wouldn't do it. NA-B confirmed R31 had chin hair and a mustache but did not have a shaver. During an interview on 7/29/25 at 12:40 p.m., nursing assistant (NA)-A stated residents needed to supply their own razors, and NA-A was aware of one female resident with a razor and wanted to be shaved. NA-A indicated most residents who refused to be shaved had documentation on the care plan. NAs document baths in the tub book binder located in each tub room and if residents were shaved, NAs document the shaver was cleaned. During an interview on 7/29/25 at 12:44 p.m., NA-B reviewed the tub book and verified R31 received a bath on 7/15/25. The column with "clean shaver" was marked with a straight line indicating the task was not completed. NA-B verified a bath was completed today, 7/29/25, but not charted in the tub book, but would be before the end of the shift. NA-B verified that R31 was not shaved during their baths. During an interview on 7/29/25 at 12:45 p.m., R31 was unable to state if facial hair bothered her. During an interview on 7/29/25 at 1:25 p.m., family member (FM)-A stated R31 would be bothered by having facial hair and used to tweeze chin hairs. R31 has been confused but they would expect the facility to take care of facial hair during baths. During an interview on 7/30/25 at 7:27 a.m., registered nurse (RN)-A stated the expectation was female facial hairs were plucked or shaved during their bath. Usually the assessment identified resident preferences, but if it was not documented that a resident refused it was expected to be done during their bath. The resident must supply a razor.	F0677		

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F0677 SS = D	Continued from page 9 During an interview on 7/30/25 at 9:01 a.m., nursing assistant (NA)-C verified R31 had hair above her lip (mustache) and several white chin hairs approximately ¼ inch long. NA-C verified there was not a razor in R31's room but stated R31 would not refuse shaving if it was offered. During an interview on 7/31/25 at 10:42 a.m., the ADON stated the facility had personal care items available upon admission, but the family would need to supply specialty items. Bath aides should be offering shaving for female residents, and if a resident wanted to be shaved, the family was asked to bring in an electric razor. If a resident did not have family, they could work with the clinical coordinators for donations but wouldn't leave a resident unshaved unless it was their preference. The ADON stated she was unaware the aids were not shaving females if there wasn't a razor in the room. A policy for ADL's was requested but not received.	F0677		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control 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 §483.71 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:	F0880	RN-E was immediately re-educated on the importance of wearing EBP when entering resident rooms identified as requiring EBP. All residents will be reviewed to determine ongoing need of EBP. Re-education on the importance of remembering to don Enhanced Barrier Precautions was provided to all staff. Random audit's will be conducted to ensure staff are compliant with EBP of infection control. 3 audits for one week, 2 audits for one week, then one audit for two weeks. These audits will be reviewed at QAPI to determine compliance and ongoing need.	08/23/2025

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F0880 SS = D	Continued from page 10 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable 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 enhanced barrier precautions (EBP) were followed for 1 of 2 residents	F0880		

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F0880 SS = D	Continued from page 11 (R3) reviewed for infection control related to the management of a tube feeding. Findings include: R53's quarterly Minimum Data Set (MDS) dated 7/2/25, indicated R53 was cognitively intact, and had no behaviors or hallucinations. MDS also indicated R53 had difficulty swallowing and received enteral feeding via a tube. R53's Clinical Diagnosis Report dated 7/31/25, indicated dysphagia following cerebral infarction, pharyngeal dysphagia, diverticulum of esophagus, gastrostomy, anxiety and gastro esophageal reflux. R53's Clinical Orders Report indicated R53 had orders for enteral feeding, medications via tube feeding, and nothing per mouth. Orders Report also indicated special instructions for EBP. R53's care plan printed on 7/31/25, titled feeding tube, directed staff to use infection control precautions and related techniques following the manufacture recommendations when stopping, starting, flushing, and giving medications through the feeding tube. During observation on 7/28/25 at 3:28 p.m., a sign posted on R53's door indicated R53 was under EBP and identified staff must wear gloves and a gown for high contact resident care activities including cares or use of the feeding tube. During observation on 7/28/25 at 3:33 p.m., registered nurse (RN)-E entered R53's room, washed her hands, put on gloves, but did not put on a gown. RN-E explained to R53 she was scheduled to received Tylenol, a water flush, and it was time to start her tube feeding. RN-E did not wear a gown throughout these procedures. During interview on 7/28/25 at 4:11 p.m., RN-E stated "I was supposed to wear a gown, and I did not. I just forgot." RN-E stated R53 was on EBP precaution because she had a tube feeding and was at risk for infections. During interview on 7/31/25 at 9:40 a.m., nursing assistant (NA)-E stated staff did yearly training online, and throughout the year they did specific training for different infections. NA-E added, "we just had additional training last week about standard precautions. There are signs posted in the residents' doors instructing staff to wear protective equipment like gowns, gloves, and sometimes masks. We need to	F0880		

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F0880 SS = D	Continued from page 12 read the signs before we enter the rooms to make sure we don't spread infections. We must wear the equipment to prevent giving something to the patients that are already compromised and to protect ourselves". During interview on 7/31/25 at 9:47 a.m., licensed practical nurse (LPN)-E, stated when a resident received medications through a tube feeding, he or she would be on enhanced barrier precautions. "We will need to wash our hands, wear gloves and gown to prevent the spread of infections. We receive infection control education at least a couple times a year and at every nurses monthly meeting we talk about it". During interview on 7/31/25 at 9:54 a.m., assistant director of nursing/infection control nurse (ADON) stated, RN-E was supposed to wear a gown while caring for R53 because R53 had a tube feeding and the nurse administered a medication, flushed the tube with water and started R53's tube feeding. ADON stated the EBP was in place to protect R53 from infection or bacteria, and to protect the staff, as it was an infection control concern for the resident. Facility policy titled Enhanced Barrier Precautions dated 8/20/2024 indicated facility will apply EBP to prevent the spread of multidrug-resistant organisms (MDROs). Policy indicated EBPs shall be used when providing high contact care to residents who are colonized or are infected with an MDRO when contact or other precautions do not apply. EBP should also be used for residents with chronic wound and/or indwelling medical devices (e.g., urinary catheters, feedings tubes, central lines, tracheostomy).	F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/30/2025. At the time of this survey, THREE LINKS CARE CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		08/22/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245450	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THREE LINKS CAR... B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. THREE LINKS CARE CENTER is a 2 story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1974 and was determined to be of Type II (111) construction. In 2000, addition was constructed and was determined to be of Type V (111) construction. Because the original building and the 1 addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. Resident rooms are also outfitted with battery operated smoke alarms – these are not connected to the building fire alarm system	K0000		

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K0000	Continued from page 2 The facility has a capacity of 84 beds and had a census of 73 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0271 SS = F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview the facility failed to maintain facility discharge from exits per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.6.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/30/2025 at 11:00 AM, it was revealed by observation that the egress exit located in Bridge Wing exhibited a threshold to concrete slab vertical drop greater than 1/2 inch, presenting a trip and fall hazard. 2. On 07/30/2025 at 11:10 AM, it was revealed by observation that the egress exit located in the Chapel exhibited a threshold to concrete slab vertical drop greater than 1/2 inch, presenting a trip and fall hazard. 3. On 07/30/2025 at 11:20 AM, it was revealed by observation that the egress exit located in Daisy Wing exhibited a threshold to concrete slab vertical drop greater than 1/2 inch, presenting a trip and fall	K0271	On 8/20/2025 the three exit discharges identified as non compliant were corrected. The Environmental Services Director (ESD) conducted an inspection of all exit discharges at Three Links Care Center to ensure compliance. No other non-compliant discharges were identified. ESD updated the life safety compliance checklist to include monthly audits of all exit discharges. Results of the audits will be reported to QAPI for compliance and ongoing need. All staff involved in emergency preparedness and maintenance were retrained on NFPA 101, Section 7.7, specifically regarding exit discharges. ESD is responsible for the corrective actions and monitoring of ongoing compliance.	08/20/2025

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K0271 SS = F	Continued from page 3 hazard. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0271		
K0346 SS = C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is NOT MET as evidenced by: Based on available documentation and staff interview, the facility failed to maintain a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy did not include notification of AHJ's at the implementation of fire alarm - out-of-service fire watch. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0346	The Fire Alarm Out of Service policies was updated to include notification of AHJ's at the implementation of fire alarm out of service fire watch. Policy will be reviewed yearly for ongoing compliance. The Environmental Services Director & Administrator are responsible for the corrective action and monitoring of compliance.	08/20/2025
K0354 SS = C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management	K0354	The Fire Alarm Out of Service policy was updated to include notification of AHJ's at the implementation of sprinkler system - out of service fire watch. The Environmental Services Director & Administrator are responsible for the corrective action and monitoring of compliance.	08/22/2025

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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
K0354 SS = C	Continued from page 4 or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is NOT MET as evidenced by: Based on available documentation and staff interview, the facility failed to maintain a sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5, 15.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy did not include notification of AHJ's at the implementation of sprinkler system - out-of-service fire watch. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0354		
K0374 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	K0374	The air gap in the Daisy Wing smoke barrier door was fixed on 8/20/2025. All smoke barrier doors were inspected by the Environmental Services Director to ensure all smoke barrier doors were compliant. The ESD updated the compliance checklist to include monthly audits of all smoke barrier doors. The ESD will bring the results of these audits to QAPI to ensure compliance and ongoing need. All staff involved in emergency preparedness and maintenance were retrained on NFPA 101, Section 8.5.4, specifically opening protectives. The ESD is responsible for the corrective action and monitoring of compliance.	08/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245450	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THREE LINKS CAR... B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

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K0374 SS = F	Continued from page 5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2025 at 11:25 AM, it was revealed by observation that the smoke barrier door for Daisy Wing exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0374		
K0741 SS = C	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily	K0741	The facilities smoking policy was updated to include the location of the approved smoking of grandfathered residents. The smoking policy will be reviewed annually with the emergency disaster review. The Administrator is responsible for the corrective action and monitoring of compliance.	08/22/2025

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K0741 SS = C	Continued from page 6 available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the facility smoking policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation that the smoking policy was generic in content not providing guidance as to the approved smoking location(s) for residents, and visitors. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0741		
K0918 SS = F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily	K0918	Environmental Services Director (ESD) notified Cummin's Sales and Service that the TLHS generator will need a 2-hour load bank testing. Load bank testing is scheduled for August 28th, 2025. ESD updated the scheduled maintenance plan with Cummin's sales and Service to add yearly 2-hour load bank testing and a 4-hour load bank testing every third year. ESD is responsible for the corrective actions and monitoring of compliance.	08/28/2025

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K0918 SS = F	Continued from page 7 available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.4.2, 8.4.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2025 between 9:00 AM and 2:30 PM, it was revealed by a review of available documentation, that for 3 of the past 12 months, the emergency generator did not achieve loading of 30 percent of the nameplate Kw rating of the EPS unit. No additional documentation was available to confirm that annual 2-hour load bank testing is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0918		
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a	K0923	Upon identification during survey, the cardboard was removed. All nursing staff will be educated on this compliance. Northwest Respiratory, oxygen supplier, was also educated to ensure the oxygen representative does not leave supplies in the oxygen room when delivering. Signage in oxygen room was reviewed. Audits will be conducted to ensure there is no cardboard present and oxygen placement is compliant. 3 audits for one week, 2 audits for one week, then one audit for two weeks. These audits will be reviewed at QAPI to determine compliance and continued need. Ongoing, ESD or designee will complete a monthly audit of the space. Any identified concerns will be brought forth to the DON/ADON.	08/28/2025

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K0923 SS = F Bldg. 01	Continued from page 8 cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3, 11.6.5, 11.6.5.2, 11.6.5.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/30/2025 at 11:45 AM, it was revealed by observation that in the Med Gas (O2) Storage Room there was mixed storage of cylinders. 2. On 07/30/2025 at 11:45 AM, it was revealed by observation that in the Med Gas (O2) Storage Room there was combustible storage in the form of cardboard positioned less-than 5 feet from the O2 storage vessels. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0923	Continued from page 8 ESD, Administrator, DON are responsible for the corrective action and monitoring of compliance.	

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