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: September 19, 2025

Dear Administrator:

On September 19, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On September 12, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

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

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/ Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 19, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of

care. Therefore, Three Links Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 19, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3B 3rd Floor
625 Robert Street North
St. Paul, MN 55155
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 09/19/2025

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
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure safe transfers with a full body mechanical lift for 1 of 3 residents (R1) reviewed for falls/safety. The facility's failure resulted in an immediate jeopardy situation for R1 when he slipped out the full body mechanical lift sling and fell from an elevated height. R1 was hospitalized due to a new fracture of the right femur and needed surgical intervention. The IJ began on 9/12/25, when 2 of 2 nursing assistants (NA)-A and NA-B did not follow manufacturer's recommendations for a safe lift transfer using the full body mechanical lift and the sling was not attached properly. As a result, R1 fell from the lift and sustained a new fracture of the right femur that needed surgical intervention. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 9/19/25 at 8:59 a.m. The facility implemented immediate corrective action on 9/12/25 to prevent reoccurrence, so the deficient practice was issued at past non-compliance (PNC). Findings include: R1's face sheet dated 9/12/25, identified diagnoses of unspecified fracture of the shaft of right femur (long bone located in the thigh) with routine healing, artificial hip joint, hemiplegia (a condition	F0689	"Past Noncompliance - no plan of correction required"	

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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F0689 SS = SQC-J	Continued from page 1 characterized by paralysis or weakness on one side of the body) and hemiparesis (one sided muscle weakness), and cerebral infarction (a condition where blood flow to the brain is interrupted, leading to tissue damage to the brain). R1's Significant Change Minimum Data Set (MDS) dated 8/5/25, identified R1 had a diagnosis of fracture of shaft of right femur, was dependent on staff for all transfers, had no falls since admission/readmission, and was cognitively intact. R1's care plan activities of daily living focus, identified R1 had a self-care performance deficit related to hemiplegia-stroke. Interventions initiated on 5/3/25, were as follows: assist of two with total mechanical lift between surfaces using a large hourglass sling. R1's progress note dated 9/12/25, identified R1 had a fall from the total mechanical lift and had to be sent to the emergency department (ED) due to hitting head. The root cause of R1's fall seemed to be that there were two black loops on the sling and each aide picked different black loops causing slack to be in the sling which made one side of the sling fall off the arm of the total mechanical lift. R1's fall risk management report dated 9/12/25 at 12:05 p.m., indicated two staff placed R1 in a sling to transfer from wheelchair to bed. Staff positioned R1 to turn to begin transfer and during that time, the sling loop slid off the lift arm and resident slid to the ground. R1 struck his head and was sent to the ED for evaluation. Interdisciplinary team (IDT) intervention: Immediate education completed with all staff on different loops of the sling, mechanical lifts and Inservice scheduled with lift company and slings. R1's facility post-fall evaluation dated 9/12/25, indicated that R1 had a fall during a transfer in a lift and the reason for the fall was evident, due to upper black loop used and lower black loop used. R1's hospital ED note dated 9/12/25, indicated R1 was seen following a fall in the nursing home, and unfortunately there was equipment failure, and the strap slipped off the lift they were using and R1 fell to the ground and struck the back of his head. Two computed tomography (CT) done of the head and no significant findings and no palpable defects or tenderness noted to the hips or femur. R1's hospital ED did not identify imaging of his or femur was completed.	F0689		

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F0689 SS = SQC-J	Continued from page 2 R1's progress note dated 9/12/25 at 9:19 p.m., identified R1 was seen in ED for evaluation for head strike and had two computed tomography (CT) scans six hours apart to make sure no new head bleed. Repeat CT was stable and no new orders. R1's clinic orthopedic visit note dated 9/16/25, indicated R1 was seen for a post operative visit to evaluate a right hip resection that was done 2 months prior and "Unfortunately, there was an accident at R1's nursing facility 4 days ago where there was a malfunction with the total mechanical lift that resulted in a fall from an elevation for R1." R1's x-rays of the right hip and femur identified a new fracture of the mid shaft of his right femur at the site of prior cerclage (internal fixation method using wires around bone) wires and recommended admission to hospital for surgical intervention. R1's hospital operative note dated 9/18/25, indicated R1 had a complicated history of recalcitrant (resistant to treatment) requiring multiple revisions in the past, ultimately leading to a girdlestone (removal of the upper portion of the femur) resection. Unfortunately, there was an accident in R1's nursing facility 6 days ago and R1 was dropped from the full body lift when there was an equipment malfunction. This resulted in a femoral shaft fracture at the mid-diaphysis (middle section of the long bone) of his remaining femur. At this time there is no functionality of his femur given the prior girdlestone and recommended resection (removal of all or part) of his remaining proximal (situated near) femur, proximal to the site of the fracture. During an interview on 9/18/25 at 11:44 a.m., NA-A and NA-B stated they engaged in the transfer of R1 when he fell out of the sling on 9/12/25. NA-A stated she believed she attached the top slings to R1, but did not verify that the same length loops were attached on the other side. NA-B stated she attached the bottom sling loops, making sure they were the same color. NA-A and NA-B then began lifting R1 out of his wheelchair and NA-B stated she verified that two black loops were attached, but did not verify that the loops were the same length and only looked at the color of the loops. R1's right leg was sticking out, so NA-B bent down to move R1's leg and as NA-A and NA-B began to turn R1 towards the bed, there was a release of tension on the sling on the left arm and the sling came off of the lift. R1 began to fall out of the sling and hit his head on the ground. R1's right leg was still in the sling as he was on the ground for a few seconds and then he fell completely out of the sling on his right	F0689		

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F0689 SS = SQC-J	Continued from page 3 side. NA-A and NA-B further stated they had not noticed that the type of sling R1 used (hourglass) sling had two separate black loops, however, NA-A and NA-B stated they were aware that the same length loops needed to be attached during a transfer to prevent release of tension, but did not ensure the same lengths were used. NA-B and NA-A stated they had not received any specific training on the specific type of sling that R1 used on the day of the fall. During an interview on 9/18/25 at 9:48 a.m., administrator stated the facility did a re-enactment of the transfer of R1. During the re-enactment, NA-A and NA-B stated they hooked up R1's hourglass sling using the correct length loops, however, could not replicate any release of tension from the full body mechanical lift arms. Because R1's sling had two sets of black loops, we attempted the transfer using two different length black loops on the lift, and upon doing so we noticed a release of tension on one of the shoulder loops and it came off the arm of the lift. After this finding, the facility determined the use of the two different length black loops on the sling was the root cause of R1 falling out of the sling to the ground. The facility then placed a tape on the second set of black loops on all of the hourglass slings and began immediate education with nursing staff on the type of sling with different color loops to ensure the same length was used for all transfers. During an interview on 9/18/25 at 8:57 a.m., ADON stated R1's hourglass total mechanical lift sling that NA-A and NA-B used prior to R1's fall on 9/12/25, had 2 sets of black loops (one set on the top of the sling and one set on third set of loops), however, she was not aware this type of sling had two sets of black loops and could cause a risk for placing the incorrect length when attaching the sling. ADON stated, "The loops of the sling do not just slip off" and during the re-recreation of the transfer when using two different lengths of black loops, we noted a tension release and caused the sling to come off the arm of the lift. ADON further stated, " She was 99% sure the incorrect loops were used by NA-A and NA-B and this is why R1 fell out of the sling to the ground." During an interview on 9/18/25 at 2:56 p.m., R1's medical doctor (MD)-C stated if any resident fell from a lift at two feet would put that resident at risk for serious injury or harm. During an interview on 9/19/25 at 11:37 a.m., orthopedic surgeon medical doctor (OS-MD) stated R1 had been seen on 9/16/25, for a scheduled follow-up and had	F0689		

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F0689 SS = SQC-J	Continued from page 4 been informed R1 had a fall from a total mechanical lift four days prior. R1 had imaging done of right hip and right femur and was found to have a new transverse (according to the Cleveland Clinic a transverse fracture are a type of broken bones, usually caused by falls or car accidents) fracture of the femur. OS-MD further stated, “most definitely the fall from the lift caused the fracture of R1’s femur and put him at risk for serious risk for harm and did cause serious harm for R1 due to needing surgery.” Review of the facility’s Mechanical Lift Policy dated 5/28/25, identified facility staff would use appropriate techniques and processes when utilizing mechanical lift devices to lift and move residents, to protect the safety and well-being of staff and residents, to promote quality care, and to follow applicable laws regarding use of power-driven mechanical lifts. Review of the facility’s Fall Prevention and Management Policy dated 6/5/23, identified The interdisciplinary team (IDT) would evaluate the fall by reviewing the fall incident report to determine a Root Cause Analysis (RCA) of the fall and further interventions may be put into place according to the determined cause of the fall, to help prevent further falls. Any further interventions that were developed would be documented. The immediate jeopardy was issued at PNC after it was verified the facility implemented the following prior to survey: -R1 was sent to ER for evaluation following fall on 9/12/25, and will be reassessed on return from the hospital for proper sling size and care plan updated. -Sling and lift used for R1’s transfer was removed from use until inspected and found to be free of malfunction. -NA-A and NA-B had return demonstration competency testing done on 9/12/25, for safe lifting using the mechanical lift. -The facility reviewed their policy and procedure for safe mechanical lift transfers and developed a plan to ensure identification via color coding the sling loops to ensure the correct one being used. Policy will be adjusted after mechanical lift representative reviews policy on 9/23/25, if needed.	F0689		

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F0689 SS = SQC-J	Continued from page 5 -All residents utilizing similar slings like R1 have had the proper sling to use marked with the colored tape to identify the same loops. -All residents who utilized the mechanical lifts had slings inspected, care plans reviewed to ensure the proper sling size in the care plan. -The facility began re-education with return demonstration, to nursing staff on manufacturer's recommendations of using the full body mechanical lift to include checking the straps for tension and using proper sling size according to the care plan beginning on 9/12/25, and will be having mechanical lift representative provide education on 9/23/25, to all of the nursing staff.	F0689		
F0000	INITIAL COMMENTS On 9/17/25, 9/18/25, 9/19/25, a standard abbreviated 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 following complaints were reviewed. H54504600C (2616844) and H54504600C (2618691) with a deficiency issued at F689 at IJ at past non-compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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		

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: Event ID: 1D73A9-H1

Dear Administrator:

The above facility survey was completed on September 19, 2025, 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 - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any 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

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20000	Initial Comments *****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: On 9/17/25, 9/18/25, and 9/19/25, a standard abbreviated survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with MN State Licensure. The following complaints were reviewed: H54504600C (2618691) and H54504600C (2616844). NO licensing orders were issued.	20000		

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

Minnesota State Department of Health

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		