Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54507322M
Compliance #: H54504600C

Date Concluded: February 5, 2026

Name, Address, and County of Licensee Investigated:
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057
Rice County

Facility Type: Nursing Home

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility and alleged perpetrators (AP)-1, and AP-2 neglected the resident when the resident fell to the floor from the mechanical full body lift.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident sustained a fall from the mechanical lift that resulted in a new fracture. The facility failed to provide training on the type of sling the resident used for transfers with the mechanical lift. AP-1 and AP-1 followed the care plan of the resident to perform the transfer of the resident but due to lack of training used connected the sling with the wrong loops.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the in-house medical provider.

The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included prosthetic right hip with surrounding fracture of the artificial joint, stroke, type two diabetes, and hemiplegia (paralysis or severe weakness affecting one side of the body.) The resident's care plan included assistance with transfers, dressing, repositioning, and toileting. The resident's assessment indicated the resident was alert, oriented, and was able to propel himself in a wheelchair.

A facility incident report indicated AP-1 and AP-2 had each connected the loops of the lift sling to the arms of the lift on the side they each stood next to. The report indicated AP-2 used the device remote control to lift the resident, AP-1 checked all the loops, and they appeared attached and correct per usual. The report indicated AP-1 removed the wheelchair from under the resident when the resident was approximately two inches above the wheelchair cushion and the resident fell out of the lift sling and landed on his left side, hit his head on the floor, then rolled to his right side. The report indicated AP-1 and AP-2 used the correct lift equipment for the procedure as care planned for the resident, and there were no physical defects noted to the equipment.

Medical provider notes indicated the provider assessed the resident at the time of the fall, and did not observe any indication of injury with assessment. The notes indicated the provider recommended the resident be evaluated in the emergency room (ER) to rule out any brain bleed and to have imaging completed on the resident's right hip and femur (upper leg). The notes indicated the provider heard the nursing staff vocalize to the emergency medical services staff the resident's numerous surgeries and needs for imaging.

Progress notes indicated the resident had CT (computed topography) scans of his head. The resident returned from the ER late that same day. The medical provider ordered to hold the blood thinner medication for five days out of caution the brain bleed on the imaging was a new bleed. Four days later the resident left the facility with family for an appointment and the next day admitted to the hospital for surgery on the right femur.

The resident's care plan indicated two staff members are required to transfer the resident in a size large hourglass sling.

The facility provided manufacturer guidelines for lift slings. The guidelines indicated loop attachment lengths impact patient positioning and safety for a regular sling, but did not include information for the use of the hourglass type sling.

AP-1's employee file did not contain evidence AP-1 received training on the hourglass sling.

AP-2's employee file did not contain evidence AP-2 received training on the hourglass sling.

During an interview, AP-1 stated all the lift equipment in the facility are of the same brand, and the resident used an hourglass sling, which is like a full sheet with loops and does not require to be crossed under resident legs like the regular lift slings do. AP-1 stated the resident used the hourglass sling, also known as the orthopedic sling, because the resident was more comfortable in it than a regular sling. AP-1 stated she was the resident's assigned caregiver the day he fell from the lift. AP-1 stated she hooked up the loops of the sling to the lift, and she controlled the movement of the lift while AP-2 worked the remote control of the lift machine. AP-1 stated when AP-2 started to raise the resident up, she checked the loops, and they appeared normal. AP-1 stated when AP-2 started to turn the resident towards the bed, one of the sling loops came unhooked and the resident rolled out of the sling on to the floor. AP-1 stated the nurse was summonsed right away to assess the resident. AP-1 stated a repeat demonstration was completed after the incident, and it was concluded that maybe one of the wrong loop colors had been used and came unhooked causing him to fall. AP-1 stated the hourglass sling has two sets of black loops, and perhaps a black loop from the right side was not the same level as the black loop used on the left side.

During an interview, AP-2 stated staff use hourglass slings and regular slings to transfer residents with the mechanical lift. AP-2 stated the regular slings have three sets of loops and the hourglass sling has four sets of loops, so you had to be sure which one you connected to the lift. AP-2 stated she was not trained on the use of the hourglass sling, which is the sling the resident used due to having a broken hip. AP-2 stated the day of the incident with the resident, she hooked up the sling loop on the right side, and AP-1 hooked up the loop on the left side. AP-2 stated the loops were checked once the resident was about two inches above his wheelchair, and they began to turn the resident towards his bed when the resident fell out of the sling. AP-2 stated she, AP-1, and management staff completed an in-service after the incident in attempt to figure out what happened. AP-2 stated she had connected the top black loop while AP-1 had connected the bottom black loop which caused the sling to not be taught when they turned the resident, which resulted in slack in the sling that caused the resident to fall.

During an interview, an unlicensed personnel (ULP) member stated since the incident with the resident, the resident no longer used the hourglass sling. The ULP stated she did not know why the resident used the hourglass sling in the first place. The ULP stated the hourglass sling had four sets of loops in colored order of red, black, green, and another black. The ULP stated the regular sling has three sets of loops in colored order of red, green, black. The ULP stated she was not sure if she received training on the hourglass sling since there was not many residents who used it. The ULP stated she did not have any concerns about the quality of work of AP-1 or AP-2. The ULP stated she believed the incident was an accident, and she believed both AP-1 and AP-2 were good caregivers.

During an interview, registered nurse (RN)-1 stated she was in the facility two to three times a week and has been provided and overseen the care of the resident since he admitted to the

facility. RN-1 stated she did not believe the resident fell from the lift because of maltreatment. RN-1 stated despite no imaging completed at the emergency room, there was absolutely a chance the fall caused the resident's fracture with how delicate the resident's bones were, and all his complications placed the resident at high risk for fracture. RN-1 stated she did not have any concerns for the resident's safety at the facility.

During an interview, a licensed practical nurse (LPN) stated there were some residents who used the hourglass sling for pain reasons, and the hourglass sling had duplicate black loops on it that were not on the same level as each other. The LPN stated there had not been any training on the hourglass sling prior to the incident with the resident. The LPN stated she had previously assisted other staff with transferring the resident using the mechanical lift, and the resident used the hourglass sling due to having pain in his leg. The LPN stated she was working the day of the fall incident, and staff had come to her and stated there had been a fall. The LPN stated when she walked in the resident's room, the resident was on the floor between the legs of the lift machine. The LPN stated she asked AP-1 and AP-2 what happened, and it did not appear they knew how the incident happened. The LPN stated she observed one of the loops of the sling had fallen off the attachment arm of the lift machine. The LPN stated there was no indication AP-1 or AP-2 had done anything wrong to cause the incident. The LPN stated she did not have any concerns about the work quality of AP-1 or AP-2.

During an interview, RN-2 stated staff received training on the mechanical lift equipment through watching videos and by in person demonstration training. RN-2 stated there was no difference between the regular sling and hourglass sling on how they connect to the lift machine as both types have loops. RN-2 stated staff are trained to look at loops when hooking them up. RN-2 stated the hourglass sling had four sets of loops and the regular sling had three sets of loops. RN-2 stated the staff did general mechanical lift training to ensure they are hooked up correctly, the loops are on, and everything was in order. RN-2 stated since the resident's fall incident, training with the staff now included showing the two different sling types and how they are used. RN-2 stated the facility investigation of the incident concluded a loop may have come unhooked while the resident was in the lift and caused the resident to fall. RN-2 stated there had been no concerns about AP-1 or AP-2's quality of work.

During an interview, a family member stated the resident admitted to the facility after part one of a two-part process for hip surgery due to chronic infections and bone deteriorations. The family member stated the resident sustained three fractures during his stay at the facility. The family member stated she went to the facility the day the resident fell out of the lift sling and asked what happened. The family member stated administrative staff told her something went wrong with the sling loops not matching up. The family member stated in the staff minds, it was all about the sling. The family member stated there was no reason the resident should have ended up on the floor. The family member stated she knew AP-2 had been in the room at the time of the incident, and AP-2 was a very good caregiver. The family member stated she went to be with the resident at the emergency department and became upset when the hospital doctor stated there was no way she was going to do any further work up on the resident's right

side and only looked at the resident's head. The family member stated she was with the resident a few days later at his routine orthopedic appointment when the doctor notified them there was a new fracture, and stated it had to have come from the fall. The family member stated this new fracture caused a delay in the resident's previous surgery schedule, caused additional infections, and increased the resident's need for more doctors' visits. The family member stated she believed the resident is now safe at the facility since staff are now on extra alert with his conditions, but felt the fall incident has shortened the resident's life and affected his overall health.

The investigator was not able to successfully contact the resident for an interview.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) AP-1 and AP-2 did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility failed to provide proper training and/or supervision of staff.

The facility provided adequate staffing levels.

AP-1 and AP-2 followed the facility directive and/or policies and procedures.

(3) The facility failed to follow professional standards and/or exercise professional judgement.

The facility failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No, unable to contact
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility provided post incident training to staff on the use of the equipment, properly maintained the equipment, and initiated interventions for prevention of future incidents of the same manner.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Rice County Attorney
Northfield City Attorney
Northfield Police Department

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/02/2026**

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
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: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H54507322M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for #H54507322M, tag identification 21850.	20000		

Office of Primary Care and Health Systems Management

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 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 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 "reviewed" 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.	20000		
21850	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 14 Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This LICENSURE REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		