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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 1IZ6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00564

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245450**
2.STATE VENDOR OR MEDICAID NO.
(L2) **770343100**

3. NAME AND ADDRESS OF FACILITY
(L3) **THREE LINKS CARE CENTER**
(L4) **815 FOREST AVENUE**
(L5) **NORTHFIELD, MN** (L6) **55057**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2017**

6. DATE OF SURVEY **01/16/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **92** (L18)
13.Total Certified Beds **92** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	92			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date:
Eva Loch, Unit Supervisor 01/17/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 01/18/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
09/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 17, 2019

Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

RE: Project Number S5450030

Dear Administrator:

On December 24, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 6, 2018 that included an investigation of complaint number H5450037. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 16, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 10, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 6, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 3, 2019. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 6, 2018, effective January 3, 2019 and therefore remedies outlined in our letter to you dated December 24, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245450

January 17, 2019

Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 3, 2019 the above facility is certified for:

92 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 92 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1IZ6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00564

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245450**

2.STATE VENDOR OR MEDICAID NO.
(L2) **770343100**

3. NAME AND ADDRESS OF FACILITY
(L3) **THREE LINKS CARE CENTER**
(L4) **815 FOREST AVENUE**
(L5) **NORTHFIELD, MN** (L6) **55057**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2017**

6. DATE OF SURVEY **12/06/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **92** (L18)

13.Total Certified Beds **92** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	92			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date:
Sandra Tatro, HFE NE II 01/11/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 01/17/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
09/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 24, 2018

Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

RE: Project Number S5450030

Dear Administrator:

On December 6, 2018, a standard survey was completed at your facility by the Minnesota Department(s) 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. In addition, at the time of the December 6, 2018 standard survey, the Minnesota Department of Health completed an investigation of complaint number H5450037 that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is January 15, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (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 a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 March 6, 2019 (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 June 6, 2019 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245450	A. BUILDING _____ B. WING _____	C 12/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 12/3/18 through 12/6/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 12/3/18 through 12/6/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Complaint H 5450037 was investigated during survey and found to be unsubstantiated.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 637		1/3/19

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

Electronically Signed | 01/03/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245450	A. BUILDING _____ B. WING _____	C 12/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 1 resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a Significant Change in Status Assessment (SCSA) when two or more areas of change in resident status were noted on the Minimum Data Set (MDS) for 1 of 1 resident (R77) reviewed for pressure ulcer. Findings include: R77's quarterly MDS dated 8/22/18, identified R77 required extensive assistance with transfers, had one unhealed stage 3 pressure ulcer and answered "no" to not on physician prescribed weight loss regimen of 5% or more in the last month or 10% or more in 6 months. The MDS revealed R77's weight at the time of the MDS was 106 pounds. R77's quarterly MDS dated 11/22/18, identified R77 required total dependence for transfers, had four unhealed stage 2 pressure ulcers and answered "yes" to not on physician prescribed weight loss regimen of 5% or more in the last month or 10% or more in 6 months. The MDS revealed R77's weight at the time of the MDS was 97 pounds, a 9 pound and 8.49% weight loss since R77's last MDS dated 8/22/18, which was	F 637	Although Three Links Care Center does not necessarily agree with the findings of non-compliance, however in the spirit of cooperation, Three Links will work with the Department of Health to remedy the deficiencies cited. F637: Upon notification, a significant change MDS was initiated for the resident of concern due to weight loss, increased staff assistance, unhealed pressure ulcers. A significant change policy will be written and implemented to assist in determining when a significant change MDS is needed. All IDT staff who attend the weekly Quality Improvement meeting will be educated regarding this policy. The Assistant Director of Nursing and Dietitian will meet weekly to discuss residents with skin concerns and weight loss. Documentation will be completed at each meeting. Residents of concern will be discussed at the weekly Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245450	A. BUILDING _____ B. WING _____	C 12/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 2 not coded for significant weight loss. Review of the above assessments indicated a 9 pound weight loss, increase need for staff assistance with transfers and four unhealed stage 2 pressure ulcers that were not noted on previous MDS. During an interview on 12/6/18, at 11:21 a.m. the facility MDS coordinator, registered nurse (RN)-B reviewed both of R77's aforementioned MDSs and stated R77 should have had a SCSA completed instead of a quarterly on 11/22/18. RN-B identified she was unaware R77 had been assessed with weight loss. RN-B revealed she was not aware of the weight loss due to R77's assessment reference date (ARD) ending on 11/22/18, and the section K of the MDS which addressed swallowing and nutritional status was not completed until 11/28/18. During an interview on 12/6/18, at 1:32 p.m. registered dietitian (RD) confirmed she did not complete R77's nutritional status section of the MDS until 11/28/18. The RD identified R77's current weight at the time of the 11/22/18 MDS indicated a 9 pound weight loss since the last MDS. The RD stated she was aware R77's ARD ended 11/22/18, however was unable to complete the MDS. During an interview on 12/6/18, at 3:12 p.m. the director of nursing (DON) stated it was her expectation to complete a SCSA for a resident when there were two or more areas of change identified. The DON indicated it was also her expectation for all resident assessment data collected to be entered into the MDS prior or on the ARD. The DON further stated the	F 637	Improvement meeting and Monthly Quality Assurance meeting with the Medical Director. Weekly audits will be completed once a week for four weeks, once a month for four months, until acceptable practice is observed. Outcomes will be observed at our Quality Improvement IDT meeting. The Administrator or designee will be responsible for compliance by January 15th, 2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245450	A. BUILDING _____ B. WING _____	C 12/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 3 interdisciplinary team met weekly to discuss resident's changes and was unaware of the weight loss. A facility policy related to significant change MDS was requested but not received. The CMS's (Centers for Medicaid and Medicare Services) Resident Assessment Instrument manual dated 10/17, included the definition of a significant change as a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting"; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. The manual further directed when the IDT determined that a significant change occurred, the nursing home should document the initial identification of the significant change in the clinical record. The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. The manual clarified that MDS assessments are not required for minor or temporary variations in resident status.	F 637		
F 677 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	F 677		1/3/19

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F 677	Continued From page 4 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assist feeding a resident with dysphagia (difficulty swallowing) per care planned interventions for 1 of 3 residents (R26) reviewed for activities of daily living. Findings include: R26's medical diagnoses included dysphagia, aphasia (difficulty speaking) and cerebral infarction (necrotic tissue in the brain). R26's care plan dated 11/13/18, indicated altered nutrition related to dysphagia due to brain injury requiring occasional use of G (gastrostomy)-tube as a focus. R26 took food by mouth currently. Interventions included to feed R26 from her right side; support her head as needed to keep it vertical, especially when giving liquids; massage her right cheek as needed to help move food that has pocketed there; strictly alternate between food and liquid; and pause in between bites and sips to allow R26 time to swallow and to tap lip again to double swallow. On 12/3/18, at 5:53 p.m. R26 was observed being brought in the dining room and placed at a dining room table. R26 was observed leaning about 45 degrees to her right side. No attempts were observed by staff to reposition R26 before she began eating. At 6:06 p.m. nursing assistant (NA) -A began to assist R26 with eating. NA-A sat on her left side. NA-A began feeding R26 spoonfuls of pureed chicken. NA-A continued to feed R26 spoonfuls of pureed chicken until it was half gone. At 6:12 p.m. then began to give R26 thickened	F 677	F677: Upon notification, nursing staff were immediately educated regarding the affected resident'□s eating assistance recommendations and the ability to find them in the kardex on Point Click Care (PCC). Resident of concern is currently being seen by speech therapy to determine which speech therapy recommendations are still current. To assist with better communication in regards to eating assistance/preferences, the instructions will be indicated to nursing staff on each resident'□s dietary card for assistance. These cards will indicate the level of assistance needed, specialty equipment, resident preferences, and therapy recommendations. Dietary cards are printed daily and available for each meal. Dietary cards will be updated as needed. All nursing staff will receive education regarding changes being made to the dietary cards. All dietary staff will receive education regarding providing dietary cards to the nursing staff at meal times. Weekly audits will be completed at various meals once a week for four weeks, once a month for four months, until acceptable practice is observed. Outcomes will be observed at our Quality Improvement IDT meeting and dining	

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F 677	Continued From page 5 white liquid using large spoonfuls until the full cup was half gone. At 6:15 p.m. NA-A returned to feeding R26 pureed chicken with large spoonfuls. At 6:20 p.m. NA-A began feeding R26 mashed potatoes using full spoonfuls until it was gone. During this time R26 continued to lean about 45 degrees to the right side with no attempts made by staff to reposition her. On 12/3/18, at 7:00 p.m. NA-B stated sometimes she fed R26 dinner. NA-B stated she was not aware of specific feeding assistance instructions for R26. NA-B explained that she found it helpful to hold R26's head more upright because R26 leaned to the right and sometimes pocketed food her right cheek. R26 was unable to communicate with surveyor at this time. On 12/6/18, at 10:10 a.m. registered nurse (RN) -A stated any of the nursing staff could feed R26. RN-A stated her expectations for staff to feed R26 were as listed in her care plan including thickened liquids, to give very small bites, hold up her head up so she was more aligned, and to tap her lip to cue for more foods., RN-A further stated there should be instruction cards in the dining room for R26 also. On 12/6/18, at 10:42 a.m. the dietician stated speech therapy (ST) was who determined feeding recommendations for R26. The dietician stated ST assessed R26 earlier this year and wrote a list of recommendations, including to have staff sit on her right side to feed her, reposition her head as needed because it tended to lean to the right side, and do a double tap on her lip to help remind her to swallow. The dietician also stated it was helpful if she was sitting as upright as possible. The dietician explained that there was	F 677	room focus group. The Director of Nursing or designee will be responsible for compliance by January 15th, 2019.	

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F 677	Continued From page 6 not a specific person that fed R26 but if a new staff member was feeding her, she would try to give them tips. Also the dietician stated staff could refer to R26's care plan for instructions on how to feed her. R26's ST note dated 2/27/18, indicated that caregivers were provided with a new protocol for feeding. The new protocol specified R26 was to fed from her right side, staff was to support her head as needed to approximate vertical midline as much as possible, to massage her right cheek to move any food pockets out to the middle of her mouth for swallowing, to alternate food and liquid presentations and to check her mouth after feeding to clear any food that had not yet been swallowed. R26's ST note dated 3/12/18, indicated her feeding protocol had been presented to dietary. It further indicated the dietary department would laminate it and make it available during meals for staff. It further indicated the protocol was accompanied by a sign-off sheet that each staff would sign to confirm they have read the protocol and knew how to implement it. A facility policy titled Assisting with Meals updated 11/2018, was provided. It indicated that for residents who could not feed themselves will be fed with attention to safety, comfort and dignity.	F 677		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692		1/3/19

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F 692	Continued From page 7 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, intervention and document review, the facility failed to implement appropriate nutrition interventions for 1 of 6 residents reviewed for nutrition (R28). Findings include: R28's medical diagnosis included dementia, intellectual disability and congestive heart failure. On 12/3/18 at 5:50 p.m. R28 was observed to be in the dining room and have her meal in front of her. R28 was observed awake, alert and smiling while interacting with another resident at her table. At 6:06 p.m. R28 was observed picking at her food which consisted of chicken, potatoes and vegetables. R28 would occasionally stab pieces of food and eat bites of food. At this time approximately 25% of food was noted to be eaten. At 6:12 p.m. the director of culinary services (DCS) asked R28 how she was doing	F 692	F692: Upon notification, a nutritional assessment was immediately completed for the resident of concern and appropriate nutritional interventions were implemented. The Nutritional Risk policy will be reviewed and revised to better meet the needs of Three Links Care Center residents. The nutritional risk assessment will be revised following the changes from the Nutritional Risk policy. All nursing staff will be educated regarding providing cues/assistance to residents at meals who are not eating. Residents who refuse to eat or eat 0% will be documented in a progress note in Point Click Care (PCC) by the wing nurse. Resident meal intakes (food and fluid) will	

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F 692	Continued From page 8 and if she wanted anything else to eat. At 6:17 p.m. R28 rolled herself back from the table and closed her eyes and did not eat any additional food. R28 stayed sitting there with eyes closed until she was brought back to her room. During this observation no staff was observed to sit down with R28 and offer feeding assistance. At 12/5/18, at 7:22 a.m. was observed awake in her room sitting in her wheelchair. On 12/5/18, at 9:43 a.m. licensed practical nurse (LPN)-a stated R28 could have a lot of behaviors such as hitting and enjoyed being in her room. LPN-A stated R28 also liked talking to the men in the dining room. LPN-A was not aware of any nutrition or eating concerns for R28. LPN-A explained R28 usually ate well to her knowledge but sometimes liked to sleep in late in the morning and would then have a room tray delivered. When asked if R28 had ate breakfast this morning, LPN-A asked NA-D if R28 had ate breakfast. NA-D stated "she got a room tray." On 12/5/18, at 12:36 p.m. R28 was noted in room with door closed and breakfast tray was at bedside. R28 ate all of her oatmeal and none of her eggs. R28 stated "I'm all done eating." R28 was unable to elaborate on her eating habits. At 12:56 p.m. NA-D asked R28 if she wanted lunch and R28 responded "not yet." On 12/6/18, at 9:47 a.m. NA-C stated R28 has behaviors that can happen at any time during the day or night. NA-C stated R28 did not usually have room trays and ate in the dining room. NA-C stated she had not been in the dining room in the last few weeks and therefore did not know how R28's eating had been recently and was not	F 692	continue to be documented following each meal in PCC. Weekly audits will be completed once a week for four weeks, once a month for four months, until acceptable practice is observed. Outcomes will be observed at our Quality Improvement IDT meeting. The Administrator or designee will be responsible for compliance by January 15th, 2019.	

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F 692	Continued From page 9	F 692		

aware of any concerns.

On 12/6/18, at 10:03 a.m. registered nurse (RN) -A who was also the unit manager stated R28 had no behaviors documented in the behavior report. RN-A was not aware of any weight loss issues regarding R28. RN-A explained that since R28 was independent after set up with meals the nursing staff would not necessarily assist her with cueing and that the DCS would round on residents to monitor their intake and provide cueing as needed. RN-A stated the DCS should bring up any eating concerns to her. RN-A further stated weight loss concerns should also be brought up in weekly interdisciplinary team meetings and be reviewed in care conferences.

R28's progress notes were reviewed:
-A care conference note dated 10/30/18 indicated R28 weight was down 8 pounds. R28 was resistive to assistance on meals and had snacks available. The care conference team reviewed for 6 month palliative note and at that time R28 did not appear to meet criteria.
-A dietician note dated 10/31/18 indicated R28 had recent weight change. It indicated meal intakes varied related to falling asleep at meals and not being receptive to being awoken. It further indicated R28 would swat out and hit often when cares were being provided. It further indicated R28 ate most of her food with cues during an hour and would allow feeding assistance when she was pleasant.

R28's weight log was reviewed from 6/1/18-12/5/18. It indicated R28's weight was stable until R28 experienced a significant weight loss of over 5% from 9/19/18 when R28's weight was 164 pounds (lbs.) to 10/24/18 when R28's

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F 692	Continued From page 10	F 692		

weight was 156.5 lbs. R28's weight log revealed that R28 further lost weight at last date of 12/5/18 with a weight of 145 lbs.

R28's care plan dated 11/13/18 indicated nutrition as a focus due to diuretic (medication that causes fluid loss from the body) use. Interventions indicated mechanical soft diet. R28's care plan indicated activities of daily living as a focus. It indicated R28 required set up assistance for eating. It further indicated to offer meals upon rising and snacks as she will accept.

R28's dietary intake log was reviewed from 11/1/18-12/5/18. It indicated R28 ate less than 50% of meals 12 times, with 5 refusals. In addition it indicated 29 times when no data had been recorded.

R28's nutritional assessments dated 1/8/18, 4/11/18, 7/11/18 and 12/6/18 were reviewed. They all indicated R28 was at a low nutritional risk. Interventions were to offer soft textured food, offer choices for meals including extra protein if she would accept and to set up meals. Nutritional Goal/Evaluation/Monitoring included to monitor food intakes daily and for R28 to eat at least 50-75% of meals.

On 12/6/18, at 10:46 a.m. the dietician stated R28's food intake was "fair" and depended on how awake she was. The dietician stated R28 needed reapproaching in order to finish her meal but sometimes was not receptive to staff assisting her. The dietician explained that various staff might document food intakes. The dietician further explained sometimes she did it, sometimes the NAs did it and sometimes the dietary staff documented on cards when they

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F 692	Continued From page 11 were clearing the tables. The dietician stated sometimes those cards became misplaced and that the system needed some work. The dietician stated she did nutrition assessments quarterly and then as needed. The dietician stated she thought R28's weight loss was due to her low food intakes and had discussed the weight loss with the nurse practitioner. The dietician stated that R28 typically ate in the dining room or another common area so she could be monitored. A facility policy titled Nutritional Assessment updated 11/2018 was provided. It indicated if nutritional assessment goals are not attainable, explain reasons why weight loss is unavoidable and goal is not being met.	F 692		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		1/3/19

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F 761	Continued From page 12 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to dispose of expired medications and ensure residents did not receive expired medications for 3 residents (R15, R40, R49) on 2 of 3 medication carts reviewed. Findings include: The medication cart on Iris unit on 12/5/18, at 9:49 a.m. with licensed practical nurse (LPN)-A was observed. There was an insulin pen (Novolog) unlabeled with name of resident (R15) and dated (open date) of 10/26/18, handwritten on it . LPN-A verified the insulin pen for R15 was opened, unlabeled from pharmacy, had 60 of 250 units of insulin left, and was dated 10/26/18. LPN-A verified the Novolog had expired as it was only good for 28 days after opening. LPN-A stated she followed the Merwin guide to know how long the Novolog could be used after opening. LPN-A stated R15's Novolog pen had expired on 11/23/18, and was 12 days expired and should have been disposed of on 11/23/18, and a new one used. LPN-A stated she was unsure if the insulin pen needed a pharmacy label or not and would have to check the facility policy. LPN-A stated she would dispose of the insulin pen. LPN-A verified there was no other Novolog insulin pens for R15 on the medication cart. LPN-A verified there were three additional	F 761	F761: Upon notification, the resident medications of concern were removed from the medication carts and appropriately disposed of. New insulin and eye drops were dated and labeled. Nurses and TMAs received immediate education regarding the correct eye drop expiration dates of 28 days after opening, and 42 days for Xalantan. They also received education stating that insulin was good for 28 days from the date of opening. All nursing staff will receive education regarding all medications to be labeled with resident name, medication, and date of opening. Pharmacy has been contacted to ensure all insulin pens will have a label on them. Audits of the nursing carts will be conducted at various times once a week for four weeks, once a month for four months, until acceptable practice is observed. Outcomes will be observed at our Quality Improvement meeting. The Director of	

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F 761	Continued From page 13 Novolog pens for R15 in the medication refrigerator in the medication room and were unopened and each individual pen not labeled. The medication cart on Marigold unit on 12/5/18, at 10:36 a.m. with LPN-B was observed. There was a bottle of eye drops (Systane) for R49. LPN-B verified the eye drop bottle was opened, 1/3 full, handwritten dated 7/11/18. LPN-B stated she believed the Systane eye drops were good for six months after opening. Also observed was a a bottle of eye drops (SM lubricant) for R40. LPN-B verified the eye drops for R40 was opened, approximately 1/7 full, and handwritten date on bottle was smeared and illegible. LPN-B stated she did not know how long the bottle had been opened as the open date was unidentifiable. LPN-B verified on the pharmacy label the refill date for the SM Lubricant indicated 11/6/18. LPN-B verified no other eye drop bottles for either R49 or R40 were on the medication cart or in the medication refrigerator. LPN-B stated she followed the Merwin Pharmacy guidelines for how long eye drops were good after opening. On 12/5/18, at 1:11 p.m. registered nurse (RN)-A verified on the e-mar (electronic medication administration record) that R15 had received Novolog insulin on 11/27/18, and 12/4/18, both times after the insulin had expired. RN-A stated the staff should always check the date insulin was opened before given. RN-A stated staff should have gotten a label from pharmacy for the Novolog insulin for R15. RN-B verified on the e-mar R49 had been given the eye drops Systane 11/1/18, 11/6, 11/15, 11/19, 11/22, 11/29 and 11/30/18, after expiration. RN-A verified on the e-mar that R40 had been given the eye drops SM Lubricant 12/5/18, one day after expiration.	F 761	Nursing or designee will be responsible for compliance by January 15th, 2019.	

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F 761	Continued From page 14 On 12/6/18, at 10:02 a.m. RN-B who was also assistant director of nursing (ADON) stated R15's Novolog pen should have had a pharmacy label so staff could do their double or triple check for right resident, medication, dosage and route. RN-B stated R15's Novolog should have been disposed on 11/23/18, and a new one used. RN-B stated R49's and R40's eye drops were good to be used until the expiration date on the bottles (R49's Systane exp date on bottle 11/19 and R40's SM Lubricant exp date on bottle 6/20). RN-B stated staff should always check dates before administering medication. On 12/6/18, at 10:31 a.m. DON stated staff should always check for expiration dates before administering medications. On 12/6/18, at 11:08 a.m. consultant pharmacist (CP) stated the Novolog pen for R15 should have been labeled with a pharmacy label, stated Novolog was good for 28 days after opening, and should have been discarded. CP stated he did not agree with CMS (Centers for Medicare & Medicaid Services) guidelines for eye drops only lasting 28 days when manufacturer instructions did not address; and CP stated stated the eye drops (Systane and SM Lubricant) were good until the expiration date on each bottle. Facility guidelines from Merwin Pharmacy for Medication Storage and Expiration Guidelines dated 8/2015, indicated Insulin Pens opened at room temperature were good for 28 days after 1st use. The same guidelines indicated Unspecified eye drops at room temperature were good until the Manufacturer's labeled date. The guidelines also indicated Specified medications found	F 761		

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F 761	Continued From page 15	F 761		

undated when opened would be presumed to have been opened as of the date of dispensing.

Facility policy MEDICATION LABELS dated 1/27/15, indicated, "All prescription medications must be kept in their original container with the original label as received from the pharmacy and ... The contents of any medication container having no label or with an illegible label shall be destroyed immediately..." The same policy indicated medications having a specific expiration date should not be used after the date of expiration.

Facility provided manufacturer instructions for Novolog dated March 16, 2017, indicated Novolog insulin pen was "In-use (opened) for 28 days". Manufacturer instructions for Systane and SM Lubricant were not made available by the facility. On 12/6/18, at 10:02 a.m. ADON stated there were no manufacturer instructions for Systane (just the back side of the box which did not address how long was good for after opened) or any manufacturer instructions for SM Lubricant.

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	245450	A. BUILDING **01 - THREE LINKS CARE CENTER** B. WING _____	**12/05/2018**

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K 000	INITIAL COMMENTS	K 000		

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 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Three Links Care Center) was found 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to: fm.hc.Inspections@state.mn.us

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/03/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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. The facility has a capacity of 92 beds and had a census of 88 at the time of the survey.	K 000		
K 223 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Doors with Self-Closing Devices CFR(s): NFPA 101	K 223		1/3/19

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K 223	Continued From page 2 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.2.2.2.7, 19.2.2.2.8) This deficient practice could affect the safety of all (88) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 0900 AM and 01:00 PM on 12/05/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: During facility walk-through observed: Kitchen exit door did not self-close and latch when tested; Break-room exit door did not self-close and latch when testing This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 223	K223 Following the evaluation by the Fire Marshal, the kitchen exit door closure and latch was adjusted on 12/6/18. The break-room exit door was adjusted and new door handle installed on 12/14/18. Since the corrections were made to the doors, both doors have been tested and are in proper working condition and the exit doors are now on an annual preventive maintenance schedule. Education will be provided to maintenance pertaining to expectations for door closure. Weekly audits will be completed once a week for four weeks, once a month for four months, until acceptable practice is observed.	

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K 223	Continued From page 3	K 223	Outcomes will be observed at the Safety Meeting. The Maintenance Director or designee will be responsible for compliance by January 15th, 2019.	
K 271 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 REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (7.7, 7.7.1, 19.2.7) This deficient practice could affect the safety of all (88) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 0900 AM and 01:00 PM on 12/05/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: During facility walk-through observed: Kitchen Exit and Daisy Wing Exit at egress path had uneven transition to grade This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 271	K271 Following the evaluation by the Fire Marshal, the kitchen exit of concern was closed and an aluminum ramp was ordered and will be installed by January 4, 2019. The Daisy wing emergency exit had an aluminum ramp ordered and will be installed by January 4, 2019. In Spring 2019, the aluminum ramps and old concrete will be removed from both exits. New concrete will be laid to be level with both doorways. Education will be provided to maintenance pertaining to expectations for exits. The exits and sidewalk from each exit will be included in new exit door annual preventive maintenance.	1/3/19

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K 271	Continued From page 4	K 271	Outcomes will be observed at the Safety Meeting. The Maintenance Director or designee will be responsible for compliance by January 15th, 2019.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (NFPA 70. NFPA 72,19.3.4.1, 9.6, 9.6.1.8) This deficient practice could affect the safety of all (88) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 0900 AM and 01:00 PM on 12/05/2018, observations and staff interview revealed, or observation and documentation	K 341	K341 It was noted during the Fire Marshal evaluation that an air exchanger room had a missing cover plate on fire alarm system junction box. Following this notification, a proper plate was installed on 12/5/18. Education will be provided to maintenance pertaining to expectations for proper fire alarm systems.	1/3/19

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K 341	Continued From page 5 reviewed revealed the following: During facility walk-through observed: the Air Exchanger room had a missing cover-plate on the fire alarm system junction-box This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 341	And audit of all mechanical rooms were inspected for missing covers on electrical junction boxes. Weekly audits of all mechanical rooms and electrical junction boxes will be completed once a week for four weeks, once a month for four months, until acceptable practice is observed. Outcomes will be observed at the Safety Meeting. The Maintenance Director or designee will be responsible for compliance by January 15th, 2019.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		1/3/19

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K 353	Continued From page 6 The facility failed to comply with Life Safety Code (9.7.5, 9.7.7, 9.7.8, and NFPA 25) This deficient practice could affect the safety of all (88) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 0900 AM and 01:00 PM on 12/05/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: During facility walk-through observed: Rm 269A had high storage This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	K-353 Following the inspection with the Fire Marshal, ROOM 269A, closets were cleaned out to provide 18 clearance from bottom of sprinkler heads. Labels were installed marking do not block above 18 line. All rooms were audited for compliance. All Staff personnel will receive education on leaving 18 clearance. A biannual preventive maintenance audit was set-up to inspect all storage areas for sprinkler clearance and obstruction. Outcomes will be observed at the Safety Meeting. The Maintenance Director or designee will be responsible for compliance by January 15th, 2019.	
K 918 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	K 918		1/3/19

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K 918	Continued From page 7 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 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 REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)) This deficient practice could affect the safety of all (88) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 0900 AM and 01:00 PM on 12/05/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: During facility walk-through observed: Emergency generator batteries had an install date of 2014 This deficient practice was confirmed by the	K 918	K918 Following the inspection with the Fire Marshal, Cummins installed new batteries on 12/10/18 in the facility generators. A 24 month change out schedule has been instituted. Education will be provided to maintenance pertaining to expectations for emergency generators. A preventive maintenance audit was created for Emergency Generator battery change out every 24 months in the maintenance department. Outcomes will be observed at the Safety Meeting. The Maintenance Director or	

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K 918	Continued From page 8 Facility Maintenance Director at the time of discovery.	K 918	designee will be responsible for compliance by January 15th, 2019.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (10.2.4.,10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5) This deficient practice could affect the safety of all (88) the residents, staff and visitors within the smoke compartment/ Facility.	K 920	K920 Following the inspection with the Fire Marshal, Room 217 chained power strips were removed and proper power strip set-up was installed. The refrigerator noted in the Gift shop was removed from power strip and was relocated to plug	1/3/19

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K 920	Continued From page 9 Findings Include: On facility tour between 0900 AM and 01:00 PM on 12/05/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: During facility walk-through observed: Rm 217 had power strips daisy-chained together; Gift Shop had refrigerator connected to power strip; Rm 230 had 6-plex adapter and power strip interconnected to wall duplex; Rm 205 had refrigerator connected to power strip; Rm 240 had tri-tap adapter in use and providing power to refrigerator This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	directly into wall receptacle. In Room 230, the 6-plex was removed and cords plugged into proper relocatable power tap. Room 205 had the refrigerator removed from the power strip and plugged directly into wall receptacle. Room 240 removed tri-tap and a relocatable power tap was placed. The Power Cords and Extension Cords Policy was revised. Resident families will be provided education upon admission in regards to the policy. Staff were educated regarding not allowing tri-taps, 6-plex, daisy chained power strips and no motors in power strips. Maintenance has created a preventive maintenance audit to inspect offices twice a year. Maintenance has created a preventive maintenance audit to inspect resident rooms quarterly. Outcomes will be observed at the Safety Meeting. The Maintenance Director or designee will be responsible for compliance by January 15th, 2019.	
K 923 SS=F	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	K 923		1/3/19

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K 923	Continued From page 10 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 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 REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (5.1.3.3.2 and 5.1.3.3.3, 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)) This deficient practice could affect the safety of all (88) the residents, staff and visitors within the smoke compartment/ Facility.	K 923	K923 Following the inspection with the Fire Marshal, separate locations were made in oxygen storage room for storage of oxygen tanks. Permanent signage was installed for FULL and EMPTY cylinder storage. There is no other location with	

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K 923	Continued From page 11 Findings Include: On facility tour between 0900 AM and 01:00 PM on 12/05/2018, observations and staff interview revealed, or observation and documentation reviewed revealed the following: During facility walk-through observed: Oxygen storage room did not have signage to identify empty / full location and separation This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923	oxygen cylinder storage. Education will be provided to all staff pertaining to expectations for oxygen storage. An annual audit will be completed by maintenance to ensure signage is in place. Outcomes will be observed at the Safety Meeting. The Maintenance Director or designee will be responsible for compliance by January 15th, 2019.	

Electronically delivered
December 24, 2018

Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

Re: State Nursing Home Licensing Orders - Project Number S5450030

Dear Administrator:

The above facility was surveyed on December 3, 2018 through December 6, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5450037 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00564	A. BUILDING: _____ B. WING _____	C 12/06/2018

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2 000	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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/3/18 through 12/6/18, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Board and Care Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a Significant Change in Status Assessment (SCSA) when two or more areas of change in resident status were noted on the Minimum Data Set (MDS) for 1 of 1 resident (R77) reviewed for pressure ulcer. Findings include: R77's quarterly MDS dated 8/22/18, identified R77 required extensive assistance with transfers, had one unhealed stage 3 pressure ulcer and answered "no" to not on physician prescribed weight loss regimen of 5% or more in the last month or 10% or more in 6 months. The MDS revealed R77's weight at the time of the MDS was 106 pounds. R77's quarterly MDS dated 11/22/18, identified R77 required total dependence for transfers, had four unhealed stage 2 pressure ulcers and	2 545	Corrected	1/3/19

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2 545	Continued From page 3 answered "yes" to not on physician prescribed weight loss regimen of 5% or more in the last month or 10% or more in 6 months. The MDS revealed R77's weight at the time of the MDS was 97 pounds, a 9 pound and 8.49% weight loss since R77's last MDS dated 8/22/18, which was not coded for significant weight loss. Review of the above assessments indicated a 9 pound weight loss, increase need for staff assistance with transfers and four unhealed stage 2 pressure ulcers that were not noted on previous MDS. During an interview on 12/6/18, at 11:21 a.m. the facility MDS coordinator, registered nurse (RN)-B reviewed both of R77's aforementioned MDSs and stated R77 should have had a SCSA completed instead of a quarterly on 11/22/18. RN-B identified she was unaware R77 had been assessed with weight loss. RN-B revealed she was not aware of the weight loss due to R77's assessment reference date (ARD) ending on 11/22/18, and the section K of the MDS which addressed swallowing and nutritional status was not completed until 11/28/18. During an interview on 12/6/18, at 1:32 p.m. registered dietitian (RD) confirmed she did not complete R77's nutritional status section of the MDS until 11/28/18. The RD identified R77's current weight at the time of the 11/22/18 MDS indicated a 9 pound weight loss since the last MDS. The RD stated she was aware R77's ARD ended 11/22/18, however was unable to complete the MDS. During an interview on 12/6/18, at 3:12 p.m. the director of nursing (DON) stated it was her expectation to complete a SCSA for a resident	2 545		

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2 545	Continued From page 4	2 545		

when there were two or more areas of change identified. The DON indicated it was also her expectation for all resident assessment data collected to be entered into the MDS prior or on the ARD. The DON further stated the interdisciplinary team met weekly to discuss resident's changes and was unaware of the weight loss.

A facility policy related to significant change MDS was requested but not received.

The CMS's (Centers for Medicaid and Medicare Services) Resident Assessment Instrument manual dated 10/17, included the definition of a significant change as a decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

The manual further directed when the IDT determined that a significant change occurred, the nursing home should document the initial identification of the significant change in the clinical record. The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. The manual clarified that MDS assessments are not required for minor or temporary variations in resident status.

SUGGESTED METHOD OF CORRECTION:

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2 545	Continued From page 5 The DON or designee could educate staff on identifying significant change. The DON or designee could develop and implement policy and procedure regarding significant change not limited to monitoring and justification. Conduct audits of residents who present with a change in condition to ensure a significant change was captured. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 545		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assist feeding a resident with dysphagia (difficulty swallowing) per care planned interventions for 1 of 3 residents (R26) reviewed for activities of daily living. Findings include: R26's medical diagnoses included dysphagia, aphasia (difficulty speaking) and cerebral infarction (necrotic tissue in the brain). R26's care plan dated 11/13/18, indicated altered nutrition related to dysphagia due to brain injury	2 920	Corrected	1/3/19

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2 920	Continued From page 6 requiring occasional use of G (gastrostomy)-tube as a focus. R26 took food by mouth currently. Interventions included to feed R26 from her right side; support her head as needed to keep it vertical, especially when giving liquids; massage her right cheek as needed to help move food that has pocketed there; strictly alternate between food and liquid; and pause in between bites and sips to allow R26 time to swallow and to tap lip again to double swallow. On 12/3/18, at 5:53 p.m. R26 was observed being brought in the dining room and placed at a dining room table. R26 was observed leaning about 45 degrees to her right side. No attempts were observed by staff to reposition R26 before she began eating. At 6:06 p.m. nursing assistant (NA) -A began to assist R26 with eating. NA-A sat on her left side. NA-A began feeding R26 spoonfuls of pureed chicken. NA-A continued to feed R26 spoonfuls of pureed chicken until it was half gone. At 6:12 p.m. then began to give R26 thickened white liquid using large spoonfuls until the full cup was half gone. At 6:15 p.m. NA-A returned to feeding R26 pureed chicken with large spoonfuls. At 6:20 p.m. NA-A began feeding R26 mashed potatoes using full spoonfuls until it was gone. During this time R26 continued to lean about 45 degrees to the right side with no attempts made by staff to reposition her. On 12/3/18, at 7:00 p.m. NA-B stated sometimes she fed R26 dinner. NA-B stated she was not aware of specific feeding assistance instructions for R26. NA-B explained that she found it helpful to hold R26's head more upright because R26 leaned to the right and sometimes pocketed food her right cheek. R26 was unable to communicate with surveyor at this time.	2 920		

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2 920	Continued From page 7 On 12/6/18, at 10:10 a.m. registered nurse (RN) -A stated any of the nursing staff could feed R26. RN-A stated her expectations for staff to feed R26 were as listed in her care plan including thickened liquids, to give very small bites, hold up her head up so she was more aligned, and to tap her lip to cue for more foods., RN-A further stated there should be instruction cards in the dining room for R26 also. On 12/6/18, at 10:42 a.m. the dietician stated speech therapy (ST) was who determined feeding recommendations for R26. The dietician stated ST assessed R26 earlier this year and wrote a list of recommendations, including to have staff sit on her right side to feed her, reposition her head as needed because it tended to lean to the right side, and do a double tap on her lip to help remind her to swallow. The dietician also stated it was helpful if she was sitting as upright as possible. The dietician explained that there was not a specific person that fed R26 but if a new staff member was feeding her, she would try to give them tips. Also the dietician stated staff could refer to R26's care plan for instructions on how to feed her. R26's ST note dated 2/27/18, indicated that caregivers were provided with a new protocol for feeding. The new protocol specified R26 was to fed from her right side, staff was to support her head as needed to approximate vertical midline as much as possible, to massage her right cheek to move any food pockets out to the middle of her mouth for swallowing, to alternate food and liquid presentations and to check her mouth after feeding to clear any food that had not yet been swallowed. R26's ST note dated 3/12/18, indicated her feeding protocol had been presented to dietary. It further indicated the	2 920		

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2 920	Continued From page 8 dietary department would laminate it and make it available during meals for staff. It further indicated the protocol was accompanied by a sign-off sheet that each staff would sign to confirm they have read the protocol and knew how to implement it. A facility policy titled Assisting with Meals updated 11/2018, was provided. It indicated that for residents who could not feed themselves will be fed with attention to safety, comfort and dignity. SUGGESTED METHOD OF CORRECTION: The DON or designee could re-educate staff on feeding residents with dysphagia. The DON or designee could conduct random audits of the dining room to ensure residents with special feeding needs are being fed according to their care plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by:	2 965		1/3/19

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2 965	Continued From page 9 Based on observation, intervention and document review, the facility failed to implement appropriate nutrition interventions for 1 of 6 residents reviewed for nutrition (R28). Findings include: R28's medical diagnosis included dementia, intellectual disability and congestive heart failure. On 12/3/18 at 5:50 p.m. R28 was observed to be in the dining room and have her meal in front of her. R28 was observed awake, alert and smiling while interacting with another resident at her table. At 6:06 p.m. R28 was observed picking at her food which consisted of chicken, potatoes and vegetables. R28 would occasionally stab pieces of food and eat bites of food. At this time approximately 25% of food was noted to be eaten. At 6:12 p.m. the director of culinary services (DCS) asked R28 how she was doing and if she wanted anything else to eat. At 6:17 p.m. R28 rolled herself back from the table and closed her eyes and did not eat any additional food. R28 stayed sitting there with eyes closed until she was brought back to her room. During this observation no staff was observed to sit down with R28 and offer feeding assistance. At 12/5/18, at 7:22 a.m. was observed awake in her room sitting in her wheelchair. On 12/5/18, at 9:43 a.m. licensed practical nurse (LPN)-a stated R28 could have a lot of behaviors such as hitting and enjoyed being in her room. LPN-A stated R28 also liked talking to the men in the dining room. LPN-A was not aware of any nutrition or eating concerns for R28. LPN-A explained R28 usually ate well to her knowledge but sometimes liked to sleep in late in the	2 965	Corrected	

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2 965	Continued From page 10	2 965		

morning and would then have a room tray delivered. When asked if R28 had ate breakfast this morning, LPN-A asked NA-D if R28 had ate breakfast. NA-D stated "she got a room tray."

On 12/5/18, at 12:36 p.m. R28 was noted in room with door closed and breakfast tray was at bedside. R28 ate all of her oatmeal and none of her eggs. R28 stated "I'm all done eating." R28 was unable to elaborate on her eating habits. At 12:56 p.m. NA-D asked R28 if she wanted lunch and R28 responded "not yet."

On 12/6/18, at 9:47 a.m. NA-C stated R28 has behaviors that can happen at any time during the day or night. NA-C stated R28 did not usually have room trays and ate in the dining room. NA-C stated she had not been in the dining room in the last few weeks and therefore did not know how R28's eating had been recently and was not aware of any concerns.

On 12/6/18, at 10:03 a.m. registered nurse (RN) -A who was also the unit manager stated R28 had no behaviors documented in the behavior report. RN-A was not aware of any weight loss issues regarding R28. RN-A explained that since R28 was independent after set up with meals the nursing staff would not necessarily assist her with cueing and that the DCS would round on residents to monitor their intake and provide cueing as needed. RN-A stated the DCS should bring up any eating concerns to her. RN-A further stated weight loss concerns should also be brought up in weekly interdisciplinary team meetings and be reviewed in care conferences.

R28's progress notes were reviewed:
-A care conference note dated 10/30/18 indicated R28 weight was down 8 pounds. R28 was

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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) COMPLETE DATE
2 965	Continued From page 11	2 965		

resistive to assistance on meals and had snacks available. The care conference team reviewed for 6 month palliative note and at that time R28 did not appear to meet criteria.
-A dietician note dated 10/31/18 indicated R28 had recent weight change. It indicated meal intakes varied related to falling asleep at meals and not being receptive to being awoken. It further indicated R28 would swat out and hit often when cares were being provided. It further indicated R28 ate most of her food with cues during an hour and would allow feeding assistance when she was pleasant.

R28's weight log was reviewed from 6/1/18-12/5/18. It indicated R28's weight was stable until R28 experienced a significant weight loss of over 5% from 9/19/18 when R28's weight was 164 pounds (lbs.) to 10/24/18 when R28's weight was 156.5 lbs. R28's weight log revealed that R28 further lost weight at last date of 12/5/18 with a weight of 145 lbs.

R28's care plan dated 11/13/18 indicated nutrition as a focus due to diuretic (medication that causes fluid loss from the body) use. Interventions indicated mechanical soft diet. R28's care plan indicated activities of daily living as a focus. It indicated R28 required set up assistance for eating. It further indicated to offer meals upon rising and snacks as she will accept.

R28's dietary intake log was reviewed from 11/1/18-12/5/18. It indicated R28 ate less than 50% of meals 12 times, with 5 refusals. In addition it indicated 29 times when no data had been recorded.

R28's nutritional assessments dated 1/8/18, 4/11/18, 7/11/18 and 12/6/18 were reviewed.

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	00564	A. BUILDING: _____ B. WING _____	C 12/06/2018

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2 965	Continued From page 12 They all indicated R28 was at a low nutritional risk. Interventions were to offer soft textured food, offer choices for meals including extra protein if she would accept and to set up meals. Nutritional Goal/Evaluation/Monitoring included to monitor food intakes daily and for R28 to eat at least 50-75% of meals. On 12/6/18, at 10:46 a.m. the dietician stated R28's food intake was "fair" and depended on how awake she was. The dietician stated R28 needed reapproaching in order to finish her meal but sometimes was not receptive to staff assisting her. The dietician explained that various staff might document food intakes. The dietician further explained sometimes she did it, sometimes the NAs did it and sometimes the dietary staff documented on cards when they were clearing the tables. The dietician stated sometimes those cards became misplaced and that the system needed some work. The dietician stated she did nutrition assessments quarterly and then as needed. The dietician stated she thought R28's weight loss was due to her low food intakes and had discussed the weight loss with the nurse practitioner. The dietician stated that R28 typically ate in the dining room or another common area so she could be monitored. A facility policy titled Nutritional Assessment updated 11/2018 was provided. It indicated if nutritional assessment goals are not attainable, explain reasons why weight loss is unavoidable and goal is not being met. SUGGESTED METHOD FOR CORRECTION: The DON or designee could improve consistency in the system of documenting resident food intake especially in the dining room. The DON or	2 965		

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2 965	Continued From page 13 designee could implement a system of improved communication between dietary staff and nursing staff so nursing staff is aware if a resident has decreased food intake in the dining room. TIME PERIOD FOR CORRECTION: 21 (Twenty-One) days.	2 965		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to dispose of expired medications and ensure residents did not receive expired medications for 3 residents (R15, R40, R49) on 2 of 3 medication carts reviewed. Findings include: The medication cart on Iris unit on 12/5/18, at 9:49 a.m. with licensed practical nurse (LPN)-A was observed. There was an insulin pen (Novolog) unlabeled with name of resident (R15) and dated (open date) of 10/26/18, handwritten on it . LPN-A verified the insulin pen for R15 was opened, unlabeled from pharmacy, had 60 of 250 units of insulin left, and was dated 10/26/18. LPN-A verified the Novolog had expired as it was only good for 28 days after opening. LPN-A stated she followed the Merwin guide to know how long the Novolog could be used after opening. LPN-A stated R15's Novolog pen had expired on 11/23/18, and was 12 days expired and should have been disposed of on 11/23/18,	21620	Corrected	1/3/19

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21620	Continued From page 14 and a new one used. LPN-A stated she was unsure if the insulin pen needed a pharmacy label or not and would have to check the facility policy. LPN-A stated she would dispose of the insulin pen. LPN-A verified there was no other Novolog insulin pens for R15 on the medication cart. LPN-A verified there were three additional Novolog pens for R15 in the medication refrigerator in the medication room and were unopened and each individual pen not labeled. The medication cart on Marigold unit on 12/5/18, at 10:36 a.m. with LPN-B was observed. There was a bottle of eye drops (Systane) for R49. LPN-B verified the eye drop bottle was opened, 1/3 full, handwritten dated 7/11/18. LPN-B stated she believed the Systane eye drops were good for six months after opening. Also observed was a a bottle of eye drops (SM lubricant) for R40. LPN-B verified the eye drops for R40 was opened, approximately 1/7 full, and handwritten date on bottle was smeared and illegible. LPN-B stated she did not know how long the bottle had been opened as the open date was unidentifiable. LPN-B verified on the pharmacy label the refill date for the SM Lubricant indicated 11/6/18. LPN-B verified no other eye drop bottles for either R49 or R40 were on the medication cart or in the medication refrigerator. LPN-B stated she followed the Merwin Pharmacy guidelines for how long eye drops were good after opening. On 12/5/18, at 1:11 p.m. registered nurse (RN)-A verified on the e-mar (electronic medication administration record) that R15 had received Novolog insulin on 11/27/18, and 12/4/18, both times after the insulin had expired. RN-A stated the staff should always check the date insulin was opened before given. RN-A stated staff should have gotten a label from pharmacy for the	21620		

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21620	Continued From page 15 Novolog insulin for R15. RN-B verified on the e-mar R49 had been given the eye drops Systane 11/1/18, 11/6, 11/15, 11/19, 11/22, 11/29 and 11/30/18, after expiration. RN-A verified on the e-mar that R40 had been given the eye drops SM Lubricant 12/5/18, one day after expiration. On 12/6/18, at 10:02 a.m. RN-B who was also assistant director of nursing (ADON) stated R15's Novolog pen should have had a pharmacy label so staff could do their double or triple check for right resident, right medication, right dosage and right route. RN-B stated R15's Novolog should have been disposed on 11/23/18, and a new one use. RN-B stated R49's and R40's eye drops were good to be used until the expiration date on the bottles (R49's Systane exp date on bottle 11/19 and R40's SM Lubricant exp date on bottle 6/20). RN-B stated staff should always check dates before administering medication. On 12/6/18, at 10:31 a.m. DON stated staff should always check for expiration dates before administering medications. On 12/6/18, at 11:08 a.m. consultant pharmacist (CP) stated the Novolog pen for R15 should have been labeled with a pharmacy label, stated Novolog was good for 28 days after opening, and should have been discarded. CP stated he did not agree with CMS (Centers for Medicare & Medicaid Services) guidelines for eye drops only lasting 28 days when manufacturer instructions did not address; and CP stated stated the eye drops (Systane and SM Lubricant) were good until the expiration date on each bottle. Facility guidelines from Merwin Pharmacy for Medication Storage and Expiration Guidelines dated 8/2015, indicated Insulin Pens opened at	21620		

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21620	Continued From page 16 room temperature were good for 28 days after 1st use. The same guidelines indicated Unspecified eye drops at room temperature were good until the Manufacturer's labeled date. The guidelines also indicated Specified medications found undated when opened would be presumed to have been opened as of the date of dispensing. Facility policy MEDICATION LABELS dated 1/27/15, indicated, "All prescription medications must be kept in their original container with the original label as received from the pharmacy and ... The contents of any medication container having no label or with an illegible label shall be destroyed immediately..." The same policy indicated medications having a specific expiration date should not be used after the date of expiration. Facility provided manufacturer instructions for Novolog dated March 16, 2017, indicated Novolog insulin pen was "In-use (opened) for 28 days". Manufacturer instructions for Systane and SM Lubricant were not made available by the facility. On 12/6/18, at 10:02 a.m. ADON stated there were no manufacturer instructions for Systane (just the back side of the box which did not address how long was good for after opened) or any manufacturer instructions for SM Lubricant. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff on labeling of medications. The DON or designee could revise and implement policy and procedure regarding labeling. Audits could be conducted and monitoring performed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		

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