DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2022

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

RE: CCN: 245450
Cycle Start Date: May 19, 2022

Dear Administrator:

On May 19, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
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: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 August 19, 2022 (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 November 19, 2022 (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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 05/19/2022

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 On 5/16/22 to 5/19/22, a survey for compliance with appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/16/22 to 5/19/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be unsubstantiated: H5450067C (MN82034), H5450068C (MN81921) H5450066C (MN82950) H5450069C (MN78792) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an	F 000		

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

Electronically Signed | 06/06/2022

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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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Atrium dining room cleaning chemicals were secured away in a locked cabinet or cart, which had the potential to affect 26 of 50 residents who could access the Atrium dining room. Findings include: On 5/16/22, at 2:15 p.m. during observation of the Atrium dining room, a three-quarter full bottle labeled Ecolab Sink Surface Cleaner, a half full container of Diversity Oxivir Tb, a three-quarter full bottle of Clorox Fusion Cleaner Disinfectant, a half full bottle of 3M neutral cleaner, a half-full bottle of Alpha Hp Bathroom Cleaner, and a three-quarter full bottle of TrueKleen Lime off were in the Atrium dining room unsecured in a lower-level cabinet to the left of the sink. One resident was observed walking with a walker and another resident was observed propelling self in his wheelchair in and around near the cabinets in	F 689	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. Preparation, submission and implementation of this plan of correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and compliance with all applicable state and federal	7/13/22

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F 689	Continued From page 2 dining room where the chemicals were in an unsecured cabinet. On 5/16/22, at 2:30 p.m. nursing assistant (NA)-C verified the chemicals were in the cabinet unlocked and unsecured. NA-C further stated she was unsure if the chemicals needed to be locked up in a cabinet. On 5/16/22, at 2:42 p.m. health unit coordinator (HUC)-A verified the six bottles of chemicals were in an unlocked unsecured cabinet in the Atrium dining room. On 5/16/22, at 2:43 p.m. registered nurse (RN)-G verified the chemicals were in the dining room cabinet and the door was unsecured and unlocked. RN-G further stated the facility has residents who are independent with mobility and wander into the dining room throughout the day. On 5/17/22, at 8:54 a.m. the certified dietary manager (CDM) stated the dietary staff go into the dining room cabinet frequently, and no staff mentioned to her the cabinet lock was broken. CDM further stated staff should have reported concerns about the lock being broken as soon as they noticed it not locking. CDM stated it was a concern to have chemicals unsecured in an area residents can access. On 5/19/22, at 9:18 a.m. the environmental service director (ESD) stated he thinks someone used a wrong key and forced the cam-style lock to stay unlocked. ESD further stated no staff reported concerns regarding the lock not working in the Atrium dining room. ESD stated the chemicals are not supposed to be stored in the dining room and should only be in the designated	F 689	regulatory requirements and it constitutes the facility□s compliance. F689 Upon notification of the unsecured chemicals, the lock was fixed and all chemicals were removed. Facility began actively educating all staff regarding storage of hazardous chemicals. An audit will be completed on all facility locks securing hazardous chemicals. Results of the audit will be reviewed at the monthly Quality Assurance Meeting. All staff will receive education on storage of safe chemicals and facility process for notifying personnel responsible for fixing locks. The administrator or designee will be responsible for compliance on this deficiency by July 13, 2022.	

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F 689	Continued From page 3	F 689		

secured areas away from resident ability to access. ESD further stated it was a safety risk and there are residents who wander into the dining room alone.

On 5/18/22, at 9:40 a.m. the director of nursing (DON) stated the locked was fixed, and all chemicals were removed, and the facility was actively working on education with staff regarding the storage of hazardous chemicals.

The facility Environmental Audit dated 5/9/22, lacked indication the cabinet lock was not intact or broken.

The Ursource material safety data sheet (MSDS) for TruKleen Lime-Off dated 5/5/15, indicated the descaler was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to seek immediate medical attention if ingestion or eye or skin contact occurred.

The Ecolab MSDS for Neutral Cleaner dated 5/22/18, indicated the cleanser was hazardous to a person's physical health. The MSDS indicated to avoid contact with eyes. The MSDS further indicated to seek immediate medical attention if eye contact occurred.

The Ecolab S&S Sanitizer MSDS dated 5/12/20, indicated S&S Sanitizer was hazardous to a person's health. The MSDS indicated to avoid contact with skin, eyes, skin, inhaled, or ingestion.

The Diversey Oxivir TB Cleaner MSDS dated 2/2/18, indicated S&S Sanitizer was hazardous to a person's health. The MSDS indicated to avoid

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F 689	Continued From page 4 contact with skin, eyes, skin, or ingestion. The facility policy Safe and Secure Environment undated, indicated there are designated storage areas for items which could pose a risk or danger such as chemicals and toxic materials. The facility policy lacked indication chemicals should be secured away from residents.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the head of bed (HOB) was properly elevated during infusion	F 693	F693 Upon notification of the concern surrounding bed positioning and head of	7/13/22

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F 693	Continued From page 5 of a gastrostomy tube (GT) feeding for 1 of 1 resident (R36) reviewed for tube feeding. Findings include: R36's admission Minimum Data Set (MDS) dated 3/30/22, revealed R36 was on a gastrostomy feeding tube (GT-a medical device used to provide liquid nourishment, fluids, and medications by bypassing the oral intake). R36's Care Area Assessment (CAA) dated 3/3/22, indicated R36 was a total assist of two staff for all activities of daily living (ADL's), and received all of her feeding, medication, and hydration by tube feeding. R36 CAA further indicated R36 needed her head of bed (HOB) elevated to 30 to 40 degrees related to her continous tube feeding. R36's Admission Record dated 5/19/22, indicated R36 had diagnoses of traumatic subdural hemorrhage (brain injury causing bleeding within the space of the brain) with loss of consciousness, diabetes, dementia, gastrostomy (artificial external opening into the stomach for nutritional support). R36's Speech Therapy Evaluation dated 3/24/22, indicated R36 was "nothing by mouth", and had a diagnosis of dysphagia. R36's medication administration record (MAR) dated 5/22, indicated on 5/17/22, staff were to keep head of bed elevated 30 degrees when enteral feeding is running, during medication administration and for 30 minutes afterwards. R36's current nursing assistant Kardex indicated	F 693	bed angle for resident R36, policy was reviewed and feeding tube order set in the electronic health record was adjusted for both Nursing and Nursing Assistant to include prompts in the documentation for head of bed to be at least 30 degrees. Audits on bed positioning for those with a feeding tube will be done by members of the nursing leadership team, daily for 1 week, then three times weekly for 3 weeks at random times of day until acceptable practice is observed. Results of audits will be reported at weekly quality team meetings and at the monthly Quality Assurance Meeting. All staff will receive education on bed positioning for those with a feeding tube. The administrator or designee will be responsible for compliance on this deficiency by July 13, 2022.	

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F 693	Continued From page 6 R36 was nothing by mouth for eating and had tube feeding. Kardex lacked indication staff should maintain R36's head of bed to at least 30 degree angle while feeding was infusion. R36's care plan dated 5/22, indicated R36 had tube feeding for nutritional needs related a subdural hematoma (bleed inside the brain) but lacked indication she had an intervention for the head of the bed to be elevated. During an observation on 5/16/22, at 4:26 p.m. R36 was observed in her room, lying in bed with the bed raised to roughly a 5-degree angle and appeared to be lying flat. R36 had shifted down in her bed to the crease and was lying on her right side. R36 had tube feeding being administered during that time. On 5/16/22, at 4:30 p.m. registered nurse (RN)-C verified R36's head of bed (HOB) was elevated at less than a 5 degree angle while her tube feeding was running. RN-C stated R36 could be at risk for aspiration pneumonia (condition in which foods, stomach contents, or fluids are breathed into the lungs through the wind pipe causing infection) while hooked up to the tube feeding. RN-C did elevate the HOB but only to a 20 degree angle. On 5/16/22, at 4:34 p.m. RN-F stated R36's HOB should be elevated at least at a 30-degree angle while tube feeding was infusing. RN-F verified elevating the head of the bed was not on the nursing assistant Kardex or care plan. On 5/16/22, at 4:39 p.m. nursing assistant (NA)-C stated she normally repositioned R36 from side to side, and when asked regarding the head of the bed being elevated NA-C stated she was	F 693		

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F 693	Continued From page 7 unaware of the need to have the head of the bed elevated during tube feeding. On 5/16/22, at 6:20 p.m. director of nursing (DON) stated her expectations for staff were to ensure R36 had her head of the bed elevated at least at a 30-degree angle during tube feeding to reduce the risk of aspiration pneumonia. DON further stated nursing staff are responisble for ensuring R36 is positioned correctly during feedings. Review of the facility's policy Care and Management of a Feeding Tube dated 1/18, indicated the procedure guidelines were for the safe administration of enteral feeding and medications through an enteral tube. The policy directed staff to place resident head of bed to at least a 30-degree angle during administration of enteral feeds and for a minimum of 30 minutes afterward.	F 693		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate interventions were taken to reduce the risk of infection for 1 of 2 residents (R36) who used tube feeding and the equipment was observed soiled while R36 was administered tube feeding. Findings include:	F 921	F921 Upon notification of the concern surrounding cleanliness of feeding pump for R36, policy was reviewed and edited to include cleaning of the pump daily and as needed. Tube feeding tube order set in the electronic health record was adjusted for Nursing to include a prompt in the	7/13/22

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F 921	Continued From page 8 Review of R36's admission Minimum Data Set (MDS) dated 3/30/22, revealed R36 was on a gastrostomy feeding tube (GT-a medical device used to provide liquid nourishment, fluids, and medications by bypassing the oral intake). R36's Admission Record dated 5/19/22, indicated R36 had diagnoses of traumatic subdural hemorrhage (brain injury causing bleeding within the space of the brain) with loss of consciousness, diabetes, dementia, gastrostomy (artificial external opening into the stomach for nutritional support). R36's care plan dated 3/24/22, indicated R36 was on tube feeding for nutritional needs but lacked direction to staff to ensure tube feeding equipment was kept clean. R36's nursing Kardex dated 5/16/22, indicated R36 was to have tube feeding as prescribed, but lacked indication to ensure tube feeding equipment was kept clean. On 5/16/22, at 6:13 p.m. R36 was observed in her room not connected to her tube feeding. The tube feeding pole, base, hook, and infusion pump were soiled with dry caked on tan colored tube feeding formula. R36's nightstand was also found to have dry caked on tan colored tube feeding formula on the top and on the drawers. On 5/17/22, at 8:14 a.m. R36 was seated in her wheelchair in the common area near the nurse's station, connected to and receiving her tube feeding. The tube feeding pole, base, hook, and infusion pump were soiled with dry caked on tan colored tube feeding formula. The locking collar	F 921	documentation record for this task to be completed. Audits on cleanliness of feeding pump will be done by members of the nursing leadership team, daily for 1 week, then three times weekly for 3 weeks at random times of day until acceptable practice is observed. Results of audits will be reported at weekly team meetings and at monthly Quality Assurance Meeting. All staff will receive education on expectations surrounding cleaning of this equipment type. The administrator or designee will be responsible for compliance on this deficiency by July 13, 2022.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 9	F 921		

had a piece of tissue paper protruding halfway out and appeared to be helping with holding the position to stay in place. Remove sentence?

On 5/18/22, at 8:53 a.m. licensed practical nurse (LPN)-A verified the infusion pole, infusion pump and handle were soiled with what LPN-A identified as dried caked on tube feeding formula. LPN-A further stated the pump and pole should be kept cleaned for infection control reasons but was unable to answer who was responsible for ensuring the poles were kept clean and in good repair. LPN-A stated, "I am not sure how frequently or who is responsible for cleaning."

On 5/18/22, at 8:57 a.m. registered nurse (RN)-A verified the infusion pole and infusion pump was soiled with dried tube feeding formula. She stated it was the responsibility of the nursing staff to ensure the R36 tube feeding equipment was kept clean and in good repair. RN-A further stated the equipment should be wiped down daily and as needed when it becomes soiled. RN-A stated the unclean equipment could present a risk for bacteria to grow and transmit an infection.

On 5/18/22, at 11:20 a.m. RN-A confirmed there were no interventions on R36 care plan to wipe down or clean R36 tube feeding equipment. She further stated she had made sure both residents on tube feeding in the facility had their tube feeding equipment cleaned after the surveyor had alerted of concerns.

During interview on 5/18/22, at 12:22 p.m. director of nursing (DON) stated her expectation for nursing staff was to ensure resident equipment including tube feeding poles and pump was kept clean and when visibly soiled with

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 05/19/2022

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F 921	Continued From page 10 formula to clean it up immediately. DON further stated concerns regarding not keeping the equipment clean would present an infection control risk for residents. A facility policy was requested on cleaning tube feeding equipment, but none was provided.	F 921		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: Z6PQ11

Dear Administrator:

The above facility was surveyed on May 16, 2022 through May 19, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
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: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

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 05/19/2022

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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: On 5/16/22 to 5/19/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. The following complaints were found to be	2 000		

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2 000	Continued From page 1 unsubstantiated: H5450067C (MN82034) H5450068C (MN81921) H5450066C (MN82950) H5450069C (MN78792) 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 Nursing 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	2 000		

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the head of bed (HOB) was properly elevated during infusion of a gastrostomy tube (GT) feeding for 1 of 1 resident (R36) reviewed for tube feeding.	2 930	Corrected	7/13/22

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2 930	Continued From page 3 Findings include: R36's admission Minimum Data Set (MDS) dated 3/30/22, revealed R36 was on a gastrostomy feeding tube (GT-a medical device used to provide liquid nourishment, fluids, and medications by bypassing the oral intake). R36's Care Area Assessment (CAA) dated 3/3/22, indicated R36 was a total assist of two staff for all activities of daily living (ADL's), and received all of her feeding, medication, and hydration by tube feeding. R36 CAA further indicated R36 needed her head of bed (HOB) elevated to 30 to 40 degrees related to her continous tube feeding. R36's Admission Record dated 5/19/22, indicated R36 had diagnoses of traumatic subdural hemorrhage (brain injury causing bleeding within the space of the brain) with loss of consciousness, diabetes, dementia, gastrostomy (artificial external opening into the stomach for nutritional support). R36's Speech Therapy Evaluation dated 3/24/22, indicated R36 was "nothing by mouth", and had a diagnosis of dysphagia. R36's medication administration record (MAR) dated 5/22, indicated on 5/17/22, staff were to keep head of bed elevated 30 degrees when enteral feeding is running, during medication administration and for 30 minutes afterwards. R36's current nursing assistant Kardex indicated R36 was nothing by mouth for eating and had tube feeding. Kardex lacked indication staff should maintain R36's head of bed to at least 30	2 930		

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2 930	Continued From page 4 degree angle while feeding was infusion. R36's care plan dated 5/22, indicated R36 had tube feeding for nutritional needs related a subdural hematoma (bleed inside the brain) but lacked indication she had an intervention for the head of the bed to be elevated. During an observation on 5/16/22, at 4:26 p.m. R36 was observed in her room, lying in bed with the bed raised to roughly a 5-degree angle and appeared to be lying flat. R36 had shifted down in her bed to the crease and was lying on her right side. R36 had tube feeding being administered during that time. On 5/16/22, at 4:30 p.m. registered nurse (RN)-C verified R36's head of bed (HOB) was elevated at less than a 5 degree angle while her tube feeding was running. RN-C stated R36 could be at risk for aspiration pneumonia (condition in which foods, stomach contents, or fluids are breathed into the lungs through the wind pipe causing infection) while hooked up to the tube feeding. RN-C did elevate the HOB but only to a 20 degree angle. On 5/16/22, at 4:34 p.m. RN-F stated R36's HOB should be elevated at least at a 30-degree angle while tube feeding was infusing. RN-F verified elevating the head of the bed was not on the nursing assistant Kardex or care plan. On 5/16/22, at 4:39 p.m. nursing assistant (NA)-C stated she normally repositioned R36 from side to side, and when asked regarding the head of the bed being elevated NA-C stated she was unaware of the need to have the head of the bed elevated during tube feeding. On 5/16/22, at 6:20 p.m. director of nursing	2 930		

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2 930	Continued From page 5 (DON) stated her expectations for staff were to ensure R36 had her head of the bed elevated at least at a 30-degree angle during tube feeding to reduce the risk of aspiration pneumonia. DON further stated nursing staff are responisble for ensuring R36 is positioned correctly during feedings. Review of the facility's policy Care and Management of a Feeding Tube dated 1/18, indicated the procedure guidelines were for the safe administration of enteral feeding and medications through an enteral tube. The policy directed staff to place resident head of bed to at least a 30-degree angle during administration of enteral feeds and for a minimum of 30 minutes afterward. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure residents with tube feedings have the correct body positioning during tube feeding. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.	21665		7/13/22

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21665	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate interventions were taken to reduce the risk of infection for 1 of 2 residents (R36) who used tube feeding and the equipment was observed soiled while R36 was administered tube feeding. Findings include: Review of R36's admission Minimum Data Set (MDS) dated 3/30/22, revealed R36 was on a gastrostomy feeding tube (GT-a medical device used to provide liquid nourishment, fluids, and medications by bypassing the oral intake). R36's Admission Record dated 5/19/22, indicated R36 had diagnoses of traumatic subdural hemorrhage (brain injury causing bleeding within the space of the brain) with loss of consciousness, diabetes, dementia, gastrostomy (artificial external opening into the stomach for nutritional support). R36's care plan dated 3/24/22, indicated R36 was on tube feeding for nutritional needs but lacked direction to staff to ensure tube feeding equipment was kept clean. R36's nursing Kardex dated 5/16/22, indicated R36 was to have tube feeding as prescribed, but lacked indication to ensure tube feeding equipment was kept clean. On 5/16/22, at 6:13 p.m. R36 was observed in her room not connected to her tube feeding. The tube feeding pole, base, hook, and infusion pump	21665	Corrected	

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21665	Continued From page 7	21665		

were soiled with dry caked on tan colored tube feeding formula. R36's nightstand was also found to have dry caked on tan colored tube feeding formula on the top and on the drawers.

On 5/17/22, at 8:14 a.m. R36 was seated in her wheelchair in the common area near the nurse's station, connected to and receiving her tube feeding. The tube feeding pole, base, hook, and infusion pump were soiled with dry caked on tan colored tube feeding formula. The locking collar had a piece of tissue paper protruding halfway out and appeared to be helping with holding the position to stay in place. Remove sentence?

On 5/18/22, at 8:53 a.m. licensed practical nurse (LPN)-A verified the infusion pole, infusion pump and handle were soiled with what LPN-A identified as dried caked on tube feeding formula. LPN-A further stated the pump and pole should be kept cleaned for infection control reasons but was unable to answer who was responsible for ensuring the poles were kept clean and in good repair. LPN-A stated, "I am not sure how frequently or who is responsible for cleaning."

On 5/18/22, at 8:57 a.m. registered nurse (RN)-A verified the infusion pole and infusion pump was soiled with dried tube feeding formula. She stated it was the responsibility of the nursing staff to ensure the R36 tube feeding equipment was kept clean and in good repair. RN-A further stated the equipment should be wiped down daily and as needed when it becomes soiled. RN-A stated the unclean equipment could present a risk for bacteria to grow and transmit an infection.

On 5/18/22, at 11:20 a.m. RN-A confirmed there were no interventions on R36 care plan to wipe down or clean R36 tube feeding equipment. She

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21665	Continued From page 8 further stated she had made sure both residents on tube feeding in the facility had their tube feeding equipment cleaned after the surveyor had alerted of concerns. During interview on 5/18/22, at 12:22 p.m. director of nursing (DON) stated her expectation for nursing staff was to ensure resident equipment including tube feeding poles and pump was kept clean and when visibly soiled with formula to clean it up immediately. DON further stated concerns regarding not keeping the equipment clean would present an infection control risk for residents. A facility policy was requested on cleaning tube feeding equipment, but none was provided. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff on cleaning tube feeding equipment and conduct periodic audits of tube feeding equipment to ensure a clean and home like environment is obtained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21665		
21720	MN Rule 4658.1415 Subp. 9 Plant Housekeeping, Operation, & Maintenance Subp. 9. Storage of supplies. Supplies must be stored above the floor to facilitate cleaning of the storage area. Supplies must be identified. Toxic substances must be clearly identified and stored in a locked enclosure. Sterile supplies must be stored to maintain sterility and integrity in packaging. All substances, such as cleaning	21720		7/13/22

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21720	Continued From page 9 agents, bleaches, detergents, disinfectants, pesticides, paints, and flammable liquids, must be stored separately from all food and drugs. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Atrium dining room cleaning chemicals were secured away in a locked cabinet or cart, which had the potential to affect 26 of 50 residents who could access the Atrium dining room. Findings include: On 5/16/22, at 2:15 p.m. during observation of the Atrium dining room, a three-quarter full bottle labeled Ecolab Sink Surface Cleaner, a half full container of Diversity Oxivir Tb, a three-quarter full bottle of Clorox Fusion Cleaner Disinfectant, a half full bottle of 3M neutral cleaner, a half-full bottle of Alpha Hp Bathroom Cleaner, and a three-quarter full bottle of TrueKleen Lime off were in the Atrium dining room unsecured in a lower-level cabinet to the left of the sink. One resident was observed walking with a walker and another resident was observed propelling self in his wheelchair in and around near the cabinets in dining room where the chemicals were in an unsecured cabinet. On 5/16/22, at 2:30 p.m. nursing assistant (NA)-C verified the chemicals were in the cabinet unlocked and unsecured. NA-C further stated she was unsure if the chemicals needed to be locked up in a cabinet. On 5/16/22, at 2:42 p.m. health unit coordinator (HUC)-A verified the six bottles of chemicals were	21720	Corrected	

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21720	Continued From page 10 in an unlocked unsecured cabinet in the Atrium dining room. On 5/16/22, at 2:43 p.m. registered nurse (RN)-G verified the chemicals were in the dining room cabinet and the door was unsecured and unlocked. RN-G further stated the facility has residents who are independent with mobility and wander into the dining room throughout the day. On 5/17/22, at 8:54 a.m. the certified dietary manager (CDM) stated the dietary staff go into the dining room cabinet frequently, and no staff mentioned to her the cabinet lock was broken. CDM further stated staff should have reported concerns about the lock being broken as soon as they noticed it not locking. CDM stated it was a concern to have chemicals unsecured in an area residents can access. On 5/19/22, at 9:18 a.m. the environmental service director (ESD) stated he thinks someone used a wrong key and forced the cam-style lock to stay unlocked. ESD further stated no staff reported concerns regarding the lock not working in the Atrium dining room. ESD stated the chemicals are not supposed to be stored in the dining room and should only be in the designated secured areas away from resident ability to access. ESD further stated it was a safety risk and there are residents who wander into the dining room alone. On 5/18/22, at 9:40 a.m. the director of nursing (DON) stated the locked was fixed, and all chemicals were removed, and the facility was actively working on education with staff regarding the storage of hazardous chemicals. The facility Environmental Audit dated 5/9/22,	21720		

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 05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21720	Continued From page 11 lacked indication the cabinet lock was not intact or broken. The Ursource material safety data sheet (MSDS) for TruKleen Lime-Off dated 5/5/15, indicated the descaler was hazardous to a person's health. The MSDS indicated to health hazards with exposure to eye, skin, or ingestion. The MSDS further indicated to seek immediate medical attention if ingestion or eye or skin contact occurred. The Ecolab MSDS for Neutral Cleaner dated 5/22/18, indicated the cleanser was hazardous to a person's physical health. The MSDS indicated to avoid contact with eyes. The MSDS further indicated to seek immediate medical attention if eye contact occurred. The Ecolab S&S Sanitizer MSDS dated 5/12/20, indicated S&S Sanitizer was hazardous to a person's health. The MSDS indicated to avoid contact with skin, eyes, skin, inhaled, or ingestion. The Diversey Oxivir TB Cleaner MSDS dated 2/2/18, indicated S&S Sanitizer was hazardous to a person's health. The MSDS indicated to avoid contact with skin, eyes, skin, or ingestion. The facility policy Safe and Secure Environment undated, indicated there are designated storage areas for items which could pose a risk or danger such as chemicals and toxic materials. The facility policy lacked indication chemicals should be secured away from residents. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, or designee could ensure safe storage of chemicals was maintained and inspection program was	21720		

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21720	Continued From page 12 developed, scheduled and audited. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21720		

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	245450	A. BUILDING **01 - THREE LINKS CARE CENTER** B. WING _____	**05/18/2022**

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THREE LINKS CARE CENTER	**815 FOREST AVENUE** **NORTHFIELD, MN 55057**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/18/2022. At the time of this survey, THREE LINKS CARE CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 06/06/2022

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 Healthcare 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 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. THREE LINKS CARE CENTER is a 2-story building with no basement. The building was constructed at two different times. The original building was constructed in 1974 and was determined to be of Type II (111) construction. In 2000, an addition was constructed and was determined to be of Type V (111) construction.	K 000		

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K 000	Continued From page 2 Because the original building and the one addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. Resident rooms are also outfitted with battery-operated smoke alarms - these are not connected to the building fire alarm system. The facility has a capacity of 92 beds and had a census of 69 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=C	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test operability of emergency lighting devices in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 291	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based and it is also not to be construed as an admission against interest of the facility, the	6/30/22

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K 291	Continued From page 3 1. On 05/18/2022 between 09:00 AM to 01:00 PM, it was revealed by a review of available documentation that documentation presented for review did not identify the dates on which emergency lighting devices were tested. 2. On 05/18/2022 between 09:00 AM to 01:00 PM, it was revealed by a review of available documentation that documentation presented for review did not identify the date(s) on which annual 90 min testing was completed. 3. On 05/18/2022 between 09:00 AM to 01:00 PM, it was revealed by a review of available documentation that documentation presented for review had no record that emergency light testing occurred in January, February, and March of 2022. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 291	administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. Preparation, submission and implementation of this plan of correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and compliance with all applicable state and federal regulatory requirements and it constitutes the facility□s compliance. K291 Revised documentation to include date of emergency lighting tested on each devise. Revised documentation to include dates of annual 90 minutes testing for each devise. Reviewed and revised emergency lighting testing schedule to ensure monthly test is completed. Monitoring for compliance will be done by administrator or designee and findings presented to QAPI. Completion date: 6/30/22	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		6/13/22

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K 345	Continued From page 4 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect and maintain initiating devices of fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4 and 9.6.2, and NFPA 72 (2010 edition) National Fire Alarm and Signal Code, sections 14.1.1 and 14.2.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/18/2022 between 9:00 AM to 01:00 PM, it was revealed during documentation review that the fire alarm system servicing vendor had noted defects and malfunctions found in the course of servicing the system. No supporting documentation was provided or available for review to confirm the noted defect and malfunction had been repaired An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	K345 Found supporting documentation that devices were inspected. Monitoring for compliance will be done by administrator or designee. Results of the monitoring will be reviewed at the monthly Quality Assurance Meeting. The administrator or designee will be responsible for compliance on this deficiency by June 13, 2022	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are	K 761		6/30/22

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K 761	Continued From page 5 routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation the facility failed to maintain, inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 4.6.12, 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1, 6.1, 6.1.4.2 This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 05/18/2022 between 09:00 AM to 01:00 PM, it was revealed during documentation review that documentation presented for review identified that the annual door inspections was last completed in 2019. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	K761 Facility maintenance staff will perform annual inspections. Monitoring for compliance will be done by administrator or designee. Results of the monitoring will be reviewed at the monthly Quality Assurance Meeting. The administrator or designee will be responsible for compliance on this deficiency by June 30, 2022	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial	K 914		6/30/22

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K 914	Continued From page 6 installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain electrical receptacles in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4.1.3, 6.3.4.1.4, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/18/2022 between 9:00 AM to 01:00 PM, it was revealed during documentation review that documentation presented for review identified that electrical outlet testing was last completed in 2019. An interview with the Maintenance Director verified this deficient finding at the time of	K 914	K914 Will perform annual testing/inspections of receptacles. Monitoring for compliance will be done by administrator or designee. Results of the monitoring will be reviewed at the monthly Quality Assurance Meeting. The administrator or designee will be responsible for compliance on this deficiency by 6/30/2022.	

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K 914	Continued From page 7 discovery.	K 914		
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 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)	K 918		6/30/22

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K 918	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test and inspect the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 5.4.4.1 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.9. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/18/2022 between 9:00 AM to 01:00 PM, it was revealed during documentation review that documentation presented for review, annual vendor inspection reports of the emergency generator, had no record of load-bank testing -or- a once every 36 months, 4 hour continuous run of the emergency generator was being completed. 2. On 05/18/2022 between 9:00 AM to 01:00 PM, it was revealed during documentation review that the most recent emergency generator vendor report (07/14/2021) identified the need to replace the generator air filter. No follow-up documentation was presented for review to confirm that the air filter has been replaced. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 918	K918 Will perform the 4-hour continuous run of the generator. Will change generator air filter and have all noted recommended repairs completed. Monitoring for compliance will be done by administrator or designee. Results of the monitoring will be reviewed at the monthly Quality Assurance Meeting. The administrator or designee will be responsible for compliance by 6/30/2022.	