DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:
Three Links Care Center

Facility Address:
815 Forest Avenue

Facility City:
Northfield

State:	ZIP:	County:
Minnesota	55057	Rice

Report Number:
H5450028 and H5450030

Time of Visit:
9:00 a.m. - 4:00 p.m.
8:00 a.m. - 11:30 a.m.

Date of Visit:
October 18 and 19, 2017

Date Concluded:
December 29, 2017

Investigator's Name and Title:
Debora Palmer, RN, Special Investigator

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was neglected when an employee, the Alleged Perpetrator (AP), failed to follow facility policy when transferring the resident with a stand lift. The resident had a fall and sustained a fracture.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occurred when a resident fell from a standing lift, due to malfunction of the lift. The resident fell to the floor from a standing position when the rubber safety tab on the lift arm popped off and caused the resident's harness to disengage from the machine. The resident sustained a broken right leg and died four days later from complications as a result of the fall. The facility had not maintained the standing lift, in accordance with the manufacturer's instructions for safe operation of the lift.

The resident required extensive staff assistance with all activities of daily living, secondary to advanced age, weakness, and right-sided physical deficits from polio. The resident was nonambulatory but could bear weight for transfers with an EZ Stand lift and the assistance of two staff. The resident used the EZ Stand lift to toilet during the day; the resident preferred to use the bedpan after 2:00 p.m. due to difficulty bearing weight when she became tired. The resident was alert, conversant with minor forgetfulness, and expressed her care preferences to staff.

Prior to June 2017, the resident was transferred with the standing lift and the assistance of only one staff. The resident's transfer status changed in June 2017 when the facility implemented a new policy mandating that two staff assist all residents with any mechanical lift transfer.

One morning, an employee, the alleged perpetrator, (AP) was transferring the resident off the toilet, unassisted by a second staff. The AP had performed the resident's care numerous times over the years, including multiple occasions prior to June 2017 when one staff safely assisted the resident with standing lift transfers. The AP had responded to the resident's bathroom call light around 8:15 a.m. The resident wanted to be transferred off the toilet; the resident said her backside was hurting. The AP checked for another staff to help with the resident's transfer but other care givers were providing morning care to residents in their rooms and not available. The AP was aware of the policy change necessitating two staff for mechanical lift transfers but the AP assisted the resident, alone. The AP checked the resident's harness; the harness was properly attached to the resident and the standing lift. The AP assisted the resident to a standing position with the standing lift. The AP provided the resident's perineal care and conducted a skin check of the resident's perineal area and buttocks, while the resident stood and held onto the handles of the lift. Just as the AP prepared to place the resident's incontinent product, the AP heard a tearing noise; the rubber safety tab on the right side of the lift arm popped off and the right side of the resident's harness suddenly detached from the lift arm. The AP tried to support the resident as s/he fell to the floor from the right side of the lift. The rubber safety tab from the lift was on the floor underneath the sink. The resident was immediately assessed by a nurse. The resident was unable to move his/her right leg without extreme pain. X-ray confirmed a fracture above the right knee. Neither Tylenol nor Oxycodone effectively managed the resident's pain. At 12:00 p.m., the resident was transferred to the hospital for further evaluation and treatment.

On hospital arrival, the resident had significant pain as the result of an acute fracture of the right distal femur. The resident was not a surgical candidate due to comorbidities and advanced age. Comfort care was elected. The resident's right leg was immobilized. Intravenous Dilauidid and Fentynal were given for pain control and the resident was kept overnight for observation of pain status. The resident was discharged from the hospital the next day and returned to the facility on comfort care interventions, including a Fentynal patch and Roxinol for pain control. The hospital's discharge summary noted that the resident's condition was likely terminal.

Facility staff implemented comfort care measures over the next three days as the resident progressively declined with less oral intake and increased pain. The resident died three days after returning to the facility.

The resident's death certificate identified the resident's cause of death as "sequelae from right distal femur fracture." The death certificate noted that the resident "was being transferred with a standing lift when it malfunctioned and led to (his/her) fall."

The facility had six standing lifts that were shared among three care areas. Four of the six standing lifts were older models that had rubber safety tabs on the upper lift arms (#891, #238, #242, and #174) to keep the harness straps in place during resident transfer; the two newer standing lifts were equipped with metal safety clips on the upper lift arm that were more durable than the rubber safety tabs and provided

increased security of harness strap placement. Approximately fifty percent of the facility's residents use mechanical lifts and staff perform hundreds of transfers daily.

Historically, the rubber safety tabs on standing lifts #891, #238, #242, and #174 frequently loosened or cracked with wear and rendered the lift unsafe to use. Staff would take the lift to maintenance for repair when damaged safety tabs were identified. Staff took standing lift #891 to maintenance for repair in mid-October 2017, after the rubber safety tab popped off during the resident's transfer causing a fall with injury. Maintenance personnel noted that both rubber safety tabs on standing lift #891 had to be replaced because they both were loose. Maintenance personnel acknowledged frequent replacement of rubber safety tabs on four lifts (#891, #238, #242, and #174) because they would loosen with wear. The facility had no preventive maintenance program and mechanical lifts were not monitored for routine maintenance. Rather, when staff experienced an operational problem with a particular lift, such as a damaged rubber safety tab, staff removed the lift from service and took it to maintenance for repair.

The manufacturer's instructions for the standing lift indicated that "the following components and operating points be scheduled for inspection at intervals not greater than monthly and any detected deficiency must be rectified before the stand is put back into service: check all bolts on the base, pivot, rear wheel, front wheel, linkage, spreader, arm mast pivot bolt, shin pad, mounting bolts of actuator top and bottom, and foot platform assembly pins; check safety tabs to make sure they are installed correctly and not missing or torn. It is the responsibility of the purchaser to ensure that regular maintenance inspection is conducted on this device by competent staff."

The facility's maintenance records showed that standing lift #891 was last serviced on 03/21/17 but the records did not include any detail about what was checked, repaired, or replaced. The facility's hired maintenance consultant documented that standing lift #891 was "checked and operable" on 08/11/17 and 09/12/17, however, details about what was inspected on the lift was absent for both dates, including the condition of the lift's rubber safety tabs. Although the facility had initiated a preventive maintenance program on 10/01/17 per the consultant's recommendations, routine service to EZ Stand lift #891 was not performed prior to the resident's fall in mid-October 2017.

The resident's medical provider stated that had two staff transferred the resident per policy, the resident's fall from the lift in mid-October 2017 would have most likely still occurred with the same outcome, given the resident's right-sided weakness from polio, severe osteoporosis, nonambulatory status, and failure of the lift to support the resident's weight of 184 pounds. When the lift malfunctioned and the harness disengaged from the right lift arm, the resident fell to the right side which was his/her weak side.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse	☒ Neglect	☐ Financial Exploitation
☒ Substantiated	☐ Not Substantiated	☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility is responsible for the neglect. The facility did not have a preventive maintenance program that addressed routine service schedules and related lifespan replacement cycles for operational and resident service equipment. Facility staff were aware that the rubber safety tabs on four of the facility's standing lifts routinely wore out, cracked, or loosened with wear, yet the facility did not follow the manufacturer's instructions for monthly lift inspections which included evaluation of the rubber safety tabs. The resident's fall occurred as a result of equipment failure when the rubber safety tab dislodged and the resident's supportive harness suddenly disengaged from the lift arm, causing the resident to fall to the floor from the right side of the lift. The facility's maintenance records were inadequate to determine when the rubber safety tabs on standing lift #891 were last checked. After the resident fell from the lift, the facility ordered four new upper lift arms with metal clips to replace the lift arms with rubber safety tabs: Standing lifts #891, #238, #242, and #174; until the new lift arms arrive, facility staff have been assessing the rubber safety tabs on all four lifts daily.

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

Compliance:

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Nursing Homes (MN Rules Chapter 4658). No state orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Weight Records
- [x] Nurses Notes

- [x] Assessments
- [x] Physician Orders
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Laboratory and X-ray Reports

Other pertinent medical records:

- [x] Hospital Records
- [x] Death Certificate

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures
- [x] Other, specify: Manufacturer's instructions for standing lift

Number of additional resident(s) reviewed: Eleven

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: The resident was deceased.

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ◉ Yes ○ No ○ N/A

Specify:

If unable to contact reporter, attempts were made on:

Date: Time: Date: Time: Date: Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify:

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: The resident was deceased.

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Seven

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Twelve

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ◉ Yes ○ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Use of Equipment
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Transfers
☒ Facility Tour

Was any involved equipment inspected: ◉ Yes ○ No ○ N/A

Was equipment being operated in safe manner: ◉ Yes ○ No ○ N/A

Were photographs taken: ◉ Yes ○ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Northfield Police Department

Rice County Attorney

Northfield City Attorney

Electronically delivered
February 23, 2018

Ms. Deanna Pierzina, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

RE: Project Numbers H5450026, H5450027, H5450028, and H5450030

Dear Ms. Pierzina:

On November 22, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 27, 2017. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of November 22, 2017:

- Civil Money Penalty for the deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on November 15, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On January 5, 2018, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on November 15, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 4, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard extended survey, completed on November 15, 2017, as of January 5, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 5, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of November 22, 2017:

- Civil Money Penalty for the deficiency cited at F323, be imposed. (42 CFR 488.430 through

488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

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 _____	R-C 01/05/2018

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 000}	INITIAL COMMENTS A Post Certification Revisit (PCR) was completed, to follow up on deficiencies issued related to complaints H5450028 and H5450030. Three Links Care Center is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. 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.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/05/2018

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.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 23, 2018

Ms. Deanna Pierzina, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

Re: Reinspection Results - Complaint Numbers H5450026, H5450027, H5450028, and H5450030

Dear Ms. Pierzina:

On January 5, 2018 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on November 15, 2018. At this time these correction orders were found corrected.

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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

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 _____	R-C 01/05/2018

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) COMPLETE DATE
{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: A licensing order follow-up was completed to follow up on correction orders issued related to complaints H5450028 and H5450030. Three Links Care Center is in compliance with state regulations for long term care facilities. The facility is enrolled in ePOC and therefore a	{2 000}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/05/18

Minnesota Department of Health

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 _____	R-C 01/05/2018

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) COMPLETE DATE
{2 000}	Continued From page 1 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.	{2 000}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 22, 2017

Mr. Mark Anderson, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

RE: Project Number H5450026, H5450027, H5450028 and H5450030

Dear Mr. Anderson:

On November 15, 2017, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Lindsey Krueger, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: lindsey.krueger@state.mn.us
Phone: (651) 201-4135
Fax: (651) 281-9796

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; **OR**
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 27, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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, Office of Health Facility Complaints staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 February 15, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 15, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 11/15/2017

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 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate complaints #H5450026, #H5450027, #H5450028, and #H5450030. The following deficiency is issued in connection with complaint #H5450028 and #H5450030. 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. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		12/4/17

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

Electronically Signed | 12/04/2017

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 323	Continued From page 1 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement a preventive maintenance program to reduce avoidable accidents, for 1 of 5 residents reviewed (R3), who required transfer with the aid of an EZ Stand lift. During a routine transfer, the EZ Stand lift malfunctioned and R3 fell from the lift to the floor. R3 sustained a broken femur from the fall and died four days later from sequelae as a result of the fall. Findings include: Observations on 10/18/17 at 10:45 a.m. established that the facility had a total of eleven mechanical lifts that were shared among three care areas, including long-term care residents, transitional care residents, and memory care residents. Five of the mechanical lifts were full body lifts; six of the mechanical lifts were EZ Stand lifts like the type R3 used. Four of the six EZ Stand lifts were older models that had rubber safety tabs on the upper lift arms (#891, #238, #242, and #174), whereas, the two newer EZ Stand lifts were equipped with metal safety clips on the upper lift arms. The purpose of the rubber safety tabs and metal safety clips was to keep the resident's harness straps properly secured to the lift arm, during lift use. At the time of the investigation, the rubber safety tabs on EZ Stand lifts #891, #238, #242, and #174 were installed correctly, firm, and not tattered. R3's care plan, dated 08/14/17, indicated that R3 required extensive staff assistance with all	F 323	K000 Although Three Links Care Center objects to and disagrees with both the findings of non-compliance and the level of deficiency cited, we will work with the Department of Health to remedy the deficiencies imposed. We do not believe that the conditions at Three Links Care Center have caused substandard quality of care. This Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of	

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F 323	Continued From page 2 activities of daily living, secondary to advanced age, weakness, and right-sided physical deficits from polio. R3 was nonambulatory but could bear weight for transfers with an EZ Stand lift and the assistance of two staff. R3 used the EZ Stand lift to toilet during the day; R3 preferred to use a bedpan after 2:00 p.m. due to difficulty bearing weight when she became tired. R3 was alert, conversant with minor forgetfulness, and expressed her care preferences to staff. This information was consistent with the medical provider's progress note regarding R3's status, dated 09/05/17, and interview of R3's family member. The progress notes, dated 10/12/17 at 8:20 a.m. indicated that R3 fell to the floor during a transfer off the toilet when the EZ Stand lift malfunctioned. The rubber safety tab popped off the lift arm and released the right harness strap, causing R3 to fall to the side that came unhooked. The lift was being operated by one nursing assistant instead of two staff. R3 was immediately assessed by a nurse. R3 was unable to move her right leg without extreme pain. X-ray confirmed a fracture above the right knee. Neither Tylenol nor Oxycodone effectively managed R3's pain. At 12:00 p.m., R3 was transferred to the hospital for further evaluation and treatment. The hospital record, dated 10/12/17 at 12:41 p.m., indicated that R3 presented with significant pain due to an acute fracture of the right distal femur. R3 was not a surgical candidate due to comorbidities and advanced age. Comfort care was elected. R3's right leg was immobilized. Intravenous Dilaudid and Fentanyl were given for pain control and R3 was kept overnight for observation of pain status. R3 was discharged	F 323	Compliance within ten (10) days of receipt of the Statement of deficiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. F323 SS=G FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES It is the policy of Three Links Care Center to provide a safe place for residents to reside and receive care, and to ensure adequate supervision for a safe environment. Resident R1 passed away comfortably in the facility. Family decided not to treat injury and resident attained goal of a peaceful death. The employee that transferred resident with EZ stand has been disciplined by Chief Executive Officer and Director of Nursing. This employee was re-educated immediately by Clinical Coordinator and Director of Nursing. In addition, this employee received special training with Education Coordinator on 10/16/17 in reference to safe resident handling and transfers. An EZ Way representative came to facility	

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F 323	Continued From page 3 back to the facility on 10/13/17 on comfort care interventions, including a Fentanyl patch and Roxanol for pain control. The discharge summary noted that R3's condition was likely terminal. The progress notes indicated that R3 returned to the facility on 10/13/17 at 3:19 p.m. Comfort care measures were administered over the next three days as R3 progressively declined with less oral intake and increased pain. R3 died on 10/16/17 at 5:00 a.m. R3's death certificate identified R3's cause of death as "sequelae from right distal femur fracture." The death certificate noted that R3 "was being transferred with an EZ Stand when it malfunctioned and led to her fall." Nursing Assistant (NA)-E was interviewed on 10/18/17 at 1:20 p.m. NA-E stated she had performed R3's care many times over the years. R3 had always been transferred with the EZ Stand lift. Prior to June 2017, only one staff assisted R3 with EZ Stand lift transfers. NA-E had independently transferred R3 multiple times prior to June 2017. In June 2017, the facility implemented a new policy requiring two staff to assist all residents with any type of mechanical lift transfers. NA-E was aware of the policy change and that two staff were necessary to transfer R3 with the EZ Stand lift. On the morning of 10/12/17, R3 had been transferred to the toilet by two staff and provided with privacy, per usual; R3 activated the call light when she was finished, per usual. NA-E responded to R3's call light around 8:15 a.m. R3 wanted to be transferred off the toilet; R3 said her backside was hurting. NA-E checked for another staff to help with R3's transfer but other care givers were providing	F 323	and educated nursing staff on 10/30/17. Training was completed by all nursing staff by 12/4/17. DON or designee is responsible for compliance. The facility held a campus wide skills fair on the following dates: 11/16/17, 11/20/17, and 12/4/17. EZ stand and lifts were a mandatory skill to be performed with competency checklist. All staff requiring use of lifts in job duties will need to be tested out for compliance by 12/4/17 or they will be removed from the schedule until they have been tested for competency. Facility will continue test outs yearly at skills fair for competency and upon hire. The competencies listed above will assist in prevention of possible deficiencies in lifting residents with mechanical lifts and following policy and procedures. DON or designee is responsible for compliance. On 10/12/17 EZ WAY stand #891 was brought to maintenance. Maintenance inspected and replaced rubber black safety stops. Maintenance also inspected all EZ Way Stands with black safety tabs. These were stands numbered #238, #891, #174, and #242. All four of these stands were inspected by maintenance staff regularly, this was documented. Per EZ Way suggestion, an option for improved metal clips to replace black safety stops was introduced. New U-arms	

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F 323	Continued From page 4 morning care to residents in their rooms and not available. NA-E then assisted R3, alone. NA-E checked R3's harness; the harness was properly attached to R3 and the EZ Stand lift. NA-E then assisted R3 to a standing position with the EZ stand lift. NA-E provided R3's peri care and conducted a skin check of R3's perineal area and buttocks, while R3 stood and held onto the handles of the lift. Just as NA-E was preparing to place R3's incontinent product, NA-E heard a tearing noise; the rubber safety tab on the right side of the lift arm popped off and the right side of R3's harness suddenly detached. NA-E tried to support R3 as she fell to the floor from the right side of the lift. NA-E yelled for a nurse. The rubber safety tab from the lift was on the floor underneath the sink. RN-C was interviewed on 10/19/17 at 8:55 a.m. RN-C stated she assessed R3 on 10/12/17 when R3 was on the bathroom floor. R3, who never complains, said her right leg hurt and R3 appeared distressed. R3's right foot flopped over so RN-C did not attempt range of motion. RN-C medicated R3 with Oxycodone and applied an ice pack while waiting for x-ray to arrive. X-ray confirmed a femur fracture and R3 was transferred to the hospital. R3 came back to the facility the next day (Friday) on comfort measures. Staff provided R3 with total care throughout the weekend and R3 passed away Monday morning. The EZ Stand lift that malfunctioned was sent to maintenance along with the rubber safety tab that came off during the transfer. RN-C was unsure if the facility had a preventive maintenance program for mechanical lifts. At least fifty percent of the residents use mechanical lifts and staff perform hundreds of mechanical lift transfers daily.	F 323	with new style metal safety clips were ordered on 10/17/17. On 10/23/17 U arms arrived and were installed on stands: #238, #891, #174 & #242. All stands now have new style metal safety clips. Regular lift inspections were performed 10/12/17-10/23/17 ensuring that lifts with rubber stops would be safe for use. On 11/7/17 EZ Way service tech came on site and inspected all EZ Way stands and lifts using a 40 point check list. Any issues were corrected and documented. EZ Way service tech annual onsite inspection will be performed in the future. Maintenance is responsible for this compliance, and was compliant 11/7/17. Upon hire, the CEO/Administrator identified the need for a Preventative Maintenance Program. A consultant was recruited in August and worked with maintenance staff to implement a Preventative Maintenance Program. The preventive Maintenance Program had been previously implemented on 10/1/17. This consisted of: Inspection of EZ Way Lifts in accordance with the EZ Way maintenance 13 point checklist, and EZ Way Stands inspected in accordance to EZ Way maintenance 14 point check list. The preventative maintenance record is automatically be produced monthly, documented, and records are secured in computer program 'Maintenance Care'. Reports of all preventative maintenance documents (including EZ Way Stands &	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 323	Continued From page 5 NA-G, NA-H, and NA-J were interviewed on 10/18/17 after observations of their resident care with a mechanical lift transfer. All three nursing assistants stated they used mechanical lifts routinely throughout each day, including the four EZ Stand lifts that had rubber safety tabs. All three nursing assistants denied ever having a rubber safety tab completely dislodge from a lift during a transfer, but all three nursing assistants had experienced situations when the rubber safety tabs were either loose, cracked, or worn out, so the lift could not be used safely and they took it to maintenance for repair. Geriatric Nurse Practitioner (GNP)-B was interviewed on 10/19/17 at 9:35 a.m. GNP-B stated R3 was nonambulatory for years and had always required transfer with the aid of an EZ Stand lift. Historically, staff had safely transferred R3 with the EZ Stand lift and the assistance of one staff until the policy recently changed and mandated two staff to assist residents with all mechanical lift transfers. If R3's transfer had been completed by two care givers, R3's fall from the lift on 10/12/17 would have most likely still occurred with the same outcome, given R3's right-sided weakness from polio, nonambulatory status, severe osteoporosis, and failure of the lift to support R3's weight of 184 pounds. When the lift malfunctioned and the harness disengaged from the right lift arm, R3 fell to the right side, which was her weak side. R3 sustained a broken femur, did not recover, and died four days later. The coroner determined that R3 died from the effects of the fall. Environmental Services Director (ESD)-F was interviewed on 10/18/17 at 11:25 a.m. ESD-F	F 323	Lifts) will be given to CEO, DON and QA. Maintenance is responsible for compliance effective 10/1/17. Maintenance consultant previously used in August and September EZ Way inspections will be returning to facility 11/30/17 for further education and compliance with maintenance department. All of the above implementations and improvements to lift equipment and preventative maintenance program will act to protect all residents and maintain safety in the facility. Compliance will be tracked and reported at weekly Quality meetings, and monthly QA meetings with Medical Director for 2 months. The Director of Nurses or designee is responsible for overall compliance. Overall compliance will be 12/4/17	

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F 323	Continued From page 6 stated his role was to oversee the facility's maintenance needs. On 10/12/17, staff brought an EZ Stand lift (#891) to the maintenance department for repair after one of the rubber safety tabs dislodged during a resident's transfer. The rubber safety tabs on both sides of the lift arm were loose, due to wear. ESD-F replaced both rubber safety tabs and inspected the lift; no other operational issues were identified during the lift's inspection. ESD-F's records showed that the lift was last serviced on 03/21/17 but the records did not include any details about what was checked, repaired, or replaced. Prior to October 2017, the facility did not have a preventive maintenance program. Mechanical lifts were not monitored for routine maintenance. When staff had operational problems with a lift, staff would bring the lift to maintenance for repair. ESD-F frequently replaced rubber safety tabs on four lifts (#891, #238, #242, and #174) because they would loosen with wear. After the 10/12/17 event with R3, the facility ordered four new lift arm hangers with metal safety clips to replace the existing lift arms that had rubber safety tabs; the lift arms with metal safety clips are more durable and increase security of the sling strap placement. Until the new lift arms arrive, ESD-F has been conducting daily inspections of the rubber safety tabs on all four of the older lifts, to ensure the rubber safety tabs are functional. The facility hired a consultant during August and September 2017, who helped the facility develop a preventive maintenance program. The preventive maintenance program was implemented on October 1, 2017 and includes monthly inspections of every lift, with a documented full exam and documented necessary repairs.	F 323		

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F 323	Continued From page 7 Administrator (ADM)-A was interviewed on 10/19/17 at 10:15 a.m. ADM-A stated he hired a consultant in August 2017 to fully review the facility's maintenance needs and assist in the development of a preventive maintenance program, which was absent prior to 10/01/17. ADM-A received feedback from the consultant on 09/15/17; the facility implemented a preventive maintenance program on 10/01/17. R3's fall from the #891 EZ Stand Lift occurred on day 12 of the preventive maintenance plan. The #891 EZ Stand Lift had not yet been serviced after the preventive maintenance program started. The consultant, who was onsite at the facility during August and September 2017, had checked all eleven of the lifts in August 2017 and again in September 2017. The consultant's written report, dated 09/22/17, indicated the facility needed to fully implement a preventive maintenance program to anticipate, track, and verify routine service schedules and related lifespan replacement cycles for operational and resident service equipment. The report indicated that EZ Stand lift #891 was "checked and operable" on 08/11/17 and 09/12/17, however, details about what was inspected on the lift was absent on both dates, including the condition of the lift's rubber safety tabs. The manufacturer's instructions for the EZ Way Stand lift, dated 03/11/09, indicated that "the following components and operating points be scheduled for inspection at intervals not greater than one month and any detected deficiency must be rectified before the stand is put back into service: check all bolts on the base, pivot, rear wheel, front wheel, linkage, spreader, arm mast pivot bolt, shin pad, mounting bolts of actuator top	F 323		

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F 323	Continued From page 8 and bottom, and foot platform assembly pins; check safety tabs to make sure they are installed correctly and not missing or torn. It is the responsibility of the purchaser to ensure that regular maintenance inspection is conducted on this device by competent staff."	F 323		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 22, 2017

Mr. Mark Anderson, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

Re: State Nursing Home Licensing Orders - Complaint Number H5450026, H5450027, H5450028 and H5450030

Dear Mr. Anderson:

A complaint investigation was completed on November 15, 2017. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the enclosed Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Lindsey Krueger, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: lindsey.krueger@state.mn.us
Phone: (651) 201-4135
Fax: (651) 281-9796

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Minnesota Department of Health

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 11/15/2017

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) COMPLETE DATE
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: A complaint investigation was conducted to investigate complaints #H5450026, #H5450027, #H5450028 and H5450030. The following correction orders are issued in connection with complaint #H5450028 and #H5450030. The facility has agreed to participate in the electronic receipt of State licensure orders	2 000	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.	

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

Electronically Signed | 12/04/17

Minnesota Department of Health

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2 000	Continued From page 1 consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional	21850		12/4/17

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21850	Continued From page 2 distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, neglect occurred when a resident fell from an EZ Stand lift, due to malfunction of the lift. The resident fell to the floor from a standing position when the rubber safety tab on the lift arm popped off and caused the resident's harness to disengage from the machine. The resident sustained a broken right leg and died four days later from sequelae as a result of the fall. The facility had not maintained the EZ Stand lift, in accordance with the manufacturer's instructions for safe operation of the lift. Findings include: Observations on 10/18/17 at 10:45 a.m. established that the facility had a total of eleven mechanical lifts that were shared among three care areas. Five of the mechanical lifts were full body lifts; six of the mechanical lifts were EZ Stand lifts like the type R3 used. Four of the six EZ Stand lifts were older models that had rubber safety tabs on the upper lift arms (#891, #238, #242, and #174), whereas, the two newer EZ Stand lifts were equipped with metal safety clips on the upper lift arms. The purpose of the rubber safety tabs and metal safety clips was to keep the resident's sling straps properly secured to the lift arm, during lift use. At the time of the	21850	Corrected	

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21850	Continued From page 3 investigation, the rubber safety tabs on EZ Stand lifts #891, #238, #242, and #174 were installed correctly, firm, and not tattered. R3's care plan, dated 08/14/17, indicated that R3 required extensive staff assistance with all activities of daily living, secondary to advanced age, weakness, and right-sided physical deficits from polio. R3 was nonambulatory but could bear weight for transfers with an EZ Stand lift and the assistance of two staff. R3 used the EZ Stand lift to toilet during the day; R3 preferred to use a bedpan after 2:00 p.m. due to difficulty bearing weight when she became tired. R3 was alert, conversant with minor forgetfulness, and expressed her care preferences to staff. This information was consistent with the medical provider's progress note regarding R3's status, dated 09/05/17. The progress notes, dated 10/12/17 at 8:20 a.m. indicated that R3 fell to the floor during a transfer off the toilet when the EZ Stand lift malfunctioned. The rubber safety tab popped off the lift arm and released the right sling strap, causing R3 to fall to the side that came unhooked. The lift was being operated by one nursing assistant instead of two staff. R3 was immediately assessed by a nurse. R3 was unable to move her right leg without extreme pain. X-ray confirmed a fracture above the right knee. Neither Tylenol nor Oxycodone effectively managed R3's pain. At 12:00 p.m., R3 was transferred to the hospital for further evaluation and treatment. The hospital record, dated 10/12/17 at 12:41 p.m., indicated that R3 presented with significant pain due to an acute fracture of the right distal femur. R3 was not a surgical candidate due to comorbidities and advanced age. Family elected	21850		

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21850	Continued From page 4	21850		

comfort care. R3's right leg was immobilized. Intravenous Dilaudid and Fentanyl were given for pain control and R3 was kept overnight for observation of pain status. R3 was discharged back to the facility on 10/13/17 on comfort care interventions, including a Fentanyl patch and Roxanol for pain control. The discharge summary noted that R3's condition was likely terminal.

The progress notes, dated 10/13/17 at 3:19 p.m., indicated that R3 returned to the facility. Comfort care measures were administered over the next three days as R3 progressively declined with less oral intake and increased pain. R3 died on 10/16/17 at 5:00 a.m.

R3's death certificate identified R3's cause of death as "sequelae from right distal femur fracture." The death certificate noted that R3 "was being transferred with an EZ Stand when it malfunctioned and led to her fall."

Nursing Assistant (NA)-E was interviewed on 10/18/17 at 1:20 p.m. NA-E stated she had performed R3's care many times over the years. R3 was always transferred with the EZ Stand lift. Prior to June 2017, only one staff assisted R3 with EZ Stand lift transfers. NA-E had independently transferred R3 many times. In June 2017, the facility implemented a new policy requiring two staff to assist all residents with any type of mechanical lift transfers. NA-E was aware of the policy change and that two staff were necessary to transfer R3 with the EZ Stand lift. On the morning of 10/12/17, R3 had been transferred to the toilet by two staff and provided with privacy, per usual; R3 activated the call light when she was finished, per usual. NA-E responded to R3's call light around 8:15 a.m. R3 wanted to be transferred off the toilet but other

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21850	Continued From page 5 care givers were assisting other residents and not available. NA-E then assisted R3 alone. NA-E assisted R3 to a standing position with the EZ stand lift. NA-E provided R3's peri care and conducted a skin check of R3's bottom, while R3 stood and held onto the handles. Just as NA-E was preparing to place R3's incontinent product, NA-E heard a tearing noise; the rubber safety tab on the right side of the lift arm popped off and the right side of the sling suddenly detached. NA-E tried to support R3 as she fell to the floor on the right side. NA-E yelled for a nurse. The rubber safety tab from the lift was on the floor underneath the sink. RN-C was interviewed on 10/19/17 at 8:55 a.m. RN-C stated she assessed R3 on 10/12/17 when R3 was on the bathroom floor. R3, who never complains, said her right leg hurt and R3 appeared distressed. R3's right foot flopped over so RN-C did not attempt range of motion. RN-C medicated R3 with Oxycodone and applied an ice pack while waiting for x-ray to arrive. X-ray confirmed a femur fracture and R3 was transferred to the hospital. R3 came back to the facility the next day (Friday) on comfort measures. Staff provided R3 with total care throughout the weekend and R3 passed away Monday morning. The EZ Stand lift that malfunctioned was sent to maintenance along with the rubber safety tab that came off during the transfer. RN-C was unsure if the facility had a preventive maintenance program for mechanical lifts. At least fifty percent of the residents use mechanical lifts and staff perform hundreds of mechanical lift transfers daily. NA-G, NA-H, and NA-J were interviewed on 10/18/17 after observations of their resident care with a mechanical lift transfer. All three nursing	21850		

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21850	Continued From page 6 assistants stated they used mechanical lifts routinely throughout each day, including the four EZ Stand lifts that had rubber safety tabs. All three nursing assistants denied ever having a rubber safety tab completely dislodge from a lift during a transfer, but all three nursing assistants had experienced situations when the rubber safety tabs were loose, cracked, or worn out, so the lift could not be used safely and was taken to maintenance for repair. Geriatric Nurse Practitioner (GNP)-B was interviewed on 10/19/17 at 9:35 a.m. GNP-B stated R3 was nonambulatory for years and had always required transfer with the aid of an EZ Stand lift. Historically, staff had safely transferred R3 with the EZ Stand lift and the assistance of one staff until the policy recently changed for two staff to assist residents with all mechanical lift transfers. If R3's transfer had been completed by two care givers, R3's fall from the lift on 10/12/17 would have most likely still occurred with the same outcome, given R3's right-sided weakness from polio, nonambulatory status, severe osteoporosis, and failure of the lift to support R3's weight of 184 pounds. When the lift malfunctioned and the sling disengaged from the right lift arm, R3 fell to the right side, which was her weak side. R3 sustained a broken femur, did not recover, and died four days later. The coroner determined that R3 died from the effects of the fall. Environmental Services Director (ESD)-F was interviewed on 10/18/17 at 11:25 a.m. ESD-F stated his role was to oversee the facility's maintenance needs. On 10/12/17, staff brought an EZ Stand lift (#891) to the maintenance department for repair after one of the rubber safety tabs dislodged during a resident's transfer.	21850		

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21850	Continued From page 7 The rubber safety tabs on both sides of the lift arm were loose, due to wear. ESD-F replaced both rubber safety tabs and inspected the lift; no other operational issues were identified during the lift's inspection. ESD-F's records showed that the lift was last serviced on 03/21/17 but the records did not include any details about what was checked, repaired, or replaced. Prior to October 2017, the facility did not have a preventive maintenance program. Mechanical lifts were not monitored for routine maintenance. When staff had operational problems with a lift, staff would bring the lift to maintenance for repair. ESD-F frequently replaced rubber safety tabs on four lifts (#891, #238, #242, and #174) because they would loosen with wear. After the 10/12/17 event with R3, the facility ordered four new lift arm hangers with metal safety clips to replace the existing lift arms that had rubber safety tabs; the lift arms with metal safety clips are more durable and increase security of the sling strap placement. Until the new lift arms arrive, ESD-F has been conducting daily inspections of the rubber safety tabs on all four of the older lifts, to ensure the rubber safety tabs are functional. The facility hired a consultant during August and September 2017, who helped the facility develop a preventive maintenance program. The preventive maintenance program was implemented on October 1, 2017 and includes monthly inspections of every lift, with a documented full exam and documented necessary repairs. Administrator (ADM)-A was interviewed on 10/19/17 at 10:15 a.m. ADM-A stated he hired a consultant to fully review the facility's maintenance needs and assist in the development of a preventive maintenance program, which was absent prior to 10/01/17.	21850		

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21850	Continued From page 8 ADM-A received feedback from the consultant on 09/15/17; the facility implemented a preventive maintenance program on 10/01/17. R3's fall from the #891 EZ Stand Lift occurred on day 12 of the preventive maintenance plan. The #891 EZ Stand Lift had not yet been serviced after the preventive maintenance program started. The consultant, who was onsite at the facility during August and September 2017, had checked all eleven of the lifts in August 2017 and again in September 2017. The consultant's written report, dated 09/22/17, indicated the facility needed to fully implement a preventive maintenance program to anticipate, track, and verify routine service schedules and related lifespan replacement cycles for operational and resident service equipment. The report indicated that EZ Stand lift #891 was "checked and operable" on 08/11/17 and 09/12/17; full exams of the lift were absent and void of details about what was checked, repaired, or replaced on either date, including the condition of the lift's rubber safety tabs. The manufacturer's instructions for the EZ Way Stand lift, dated 03/11/09, indicated that "the following components and operating points be scheduled for inspection at intervals not greater than one month and any detected deficiency must be rectified before the stand is put back into service: check all bolts on the base, pivot, rear wheel, front wheel, linkage, spreader, arm mast pivot bolt, shin pad, mounting bolts of actuator top and bottom, and foot platform assembly pins; check safety tabs to make sure they are installed correctly and not missing or torn. It is the responsibility of the purchaser to ensure that regular maintenance inspection is conducted on this device by competent staff."	21850		

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21850	Continued From page 9 A Suggested Method Of Correction: 1) Develop and implement a preventive maintenance program that includes routine inspection and service of all resident equipment, consistent with the manufacturer's instructions; educate relevant staff. 2) Keep accurate records of equipment inspections, repairs, or replacements; educate relevant staff. 3) Devise a system that ensures sufficient oversight of the preventive maintenance program and related lifespan replacement cycles of equipment. 4) Document all corrective action taken. Time Period for Correction: Thirty (30) days.	21850		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 22, 2017

Mr. Mark Anderson, Administrator
Three Links Care Center
815 Forest Avenue
Northfield, MN 55057

Re: State Nursing Home Licensing Orders - Complaint Number H5450026, H5450027, H5450028 and H5450030

Dear Mr. Anderson:

A complaint investigation was completed on November 15, 2017. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the enclosed Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Lindsey Krueger, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: lindsey.krueger@state.mn.us
Phone: (651) 201-4135
Fax: (651) 281-9796

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

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Licensing and Certification Program
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