



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
April 15, 2020

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

**SUBJECT:** SURVEY RESULTS  
CCN: 245450  
Cycle Start Date: April 7, 2020

Dear Administrator:

### **SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES**

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with *Memorandum QSO-20-20-All*, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit <https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0>.

### **SURVEY RESULTS**

On April 7, 2020, the Minnesota Department of Health completed a COVID-19 Focused Survey at Three Links Care Center to determine if your facility was in compliance with Federal requirements related to the implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the electronically delivered form CMS 2567.

No additional action is required on the facility's part.

### **QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES**

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at <https://qioprogram.org/>. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at <https://qioprogram.org/locate-your-qio>.

Three Links Care Center

April 15, 2020

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a loop at the end of the last name.

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](mailto:Kamala.Fiske-Downing@state.mn.us)

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

PRINTED: 04/22/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245450</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/07/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>THREE LINKS CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 FOREST AVENUE</b> <b>NORTHFIELD, MN 55057</b>		
(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	E 000			
F 000	<p>A COVID-19 Focused Infection Control survey was conducted 4/7/20 at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance .</p> <p>Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.</p> <p>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p> <p>INITIAL COMMENTS</p> <p>On 4/7/20, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.</p> <p>The following complaint was found to be SUBSTANTIATED with NO deficiencies cited due to actions implemented by the facility prior to survey.</p> <p>H5450046C</p> <p>In addition, A COVID-19 Focused Infection Control survey was conducted on 4/7/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was in full compliance.</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/16/2020

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 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			



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April 15, 2020

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

Re: Event ID: IQBX11

Dear Administrator:

The above facility survey was completed on April 7, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "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](mailto:Kamala.Fiske-Downing@state.mn.us)

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00564</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/07/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THREE LINKS CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 FOREST AVENUE NORTHFIELD, MN 55057</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b> On 4/7/2020, surveyors of this Department's staff visited the above provider for an abbreviated survey complaint investigation to investigate complaint: H5450046C</p> <p>No correction orders were issued.</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>04/16/20</b>
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00564</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/07/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THREE LINKS CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>815 FOREST AVENUE NORTHFIELD, MN 55057</b>
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2 000	Continued From page 1  The facility is enrolled in the electronic Plan of Correction (ePOC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		