Electronically Delivered
August 16, 2021

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

RE: CCN: 245450
Cycle Start Date: July 13, 2021

Dear Administrator:

On August 13, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

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

Electronically delivered
July 19, 2021

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

RE: CCN: 245450
Cycle Start Date: July 13, 2021

Dear Administrator:

On July 13, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

## DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

## FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 13, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 13, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245450 | A. BUILDING _____ B. WING _____ | C 07/13/2021 |

| 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 |
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| F 000 | INITIAL COMMENTS<br><br>On 7/13/21, a standard abbreviated survey was conducted at your facility. Your facility was found not to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were found to be SUBSTANTIATED:<br>H5450060C (MN74437, MN74432) with deficiency cited at F689.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance.<br><br>Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000 | | |
| F 689 SS=E | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced | F 689 | | 8/10/21 |

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

Electronically Signed | 07/28/2021

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| F 689 | Continued From page 1<br>by:<br>Based on interview and document review, the facility failed to ensure routine device monitoring was completed for their wanderguard door systems. This practice had the potential to affect all residents whom had wanderguard devices in place at the time of the onsite visit for 5 of 5 residents (R1, R2, R3, R4, R5).<br><br>Findings include:<br><br>R1's face sheet printed 7/13/21, indicated diagnoses of mild cognitive impairment and ataxia (condition where muscle control or coordination of voluntary movements, such as walking or picking up objects is affected) following a cerebral infarction (stroke).<br><br>R1's care plan dated 5/13/21, indicated R1 could self-propel himself in manual wheelchair without assist. R1's care plan dated 7/1/21, indicated R1 was at risk for wandering/elopement and wanderguard was placed under his wheelchair on 6/30/21.<br><br>R2's face sheet printed 7/13/21, indicated symptoms and signs involving cognitive functions following cerebral infarction (stroke).<br><br>R2's care plan dated 5/16/21, indicated R2 was at risk for wandering/elopement and a wanderguard was placed under his wheelchair. R2 would self-propel in his wheelchair around the facility.<br><br>R3 face sheet printed 7/13/21, indicated diagnoses of dementia with behavioral disturbance and muscle weakness. R3's care plan dated 6/28/19, indicated R3 was at risk for wandering/elopement and a wanderguard had | F 689 | F000 Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.<br><br>F689<br><br>Preparation, submission, and implementation of this plan of correction does not constitute an admission of, or agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed the alleged deficiencies and licensing violations. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and compliance with all applicable state and federal regulatory requirements and it constitutes the facility□s compliance.<br><br>Upon notification of the deficient practice whereas environmental services failed to ensure routine device monitoring for the Wanderguard door system at Three Links Care Center, the Director of Environmental Services (DES) notified Maintenance Care (a web-based task | |

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| F 689 | Continued From page 2<br>been placed. R3 would wander in her wheelchair.<br><br>R4's face sheet printed 7/13/21, indicated a diagnosis of dementia. R4's care plan dated 9/25/20, indicated R4 was at risk for wandering/elopement and a wanderguard had been placed. R4's care plan dated 10/4/18, indicated R4 would self propel in her manual wheelchair.<br><br>R5's face sheet printed 7/13/21, indicated diagnoses of Parkinson's disease and mild cognitive impairment.<br>R5's care plan dated 7/1/21, indicated R5 was at risk for wandering and a wanderguard had been placed. R5 would self-propel in her manual wheelchair.<br><br>During interview on 7/13/21, at 11:10 a.m. the director of environmental services (DES) stated when a new wanderguard tag was put into service it was checked at the front door to ensure functionality. He stated he did not know if all of the doors were connected to the wanderguard system as he had not checked them.<br><br>During interview on 7/13/21, at 11:37 a.m. DES stated the front door was the only door armed with the wanderguard system.<br><br>During interview on 7/13/21, at 12:17 p.m. the assistant director of nursing (ADON) stated there were three exits armed with the wanderguard system: the front door, the dining room door, and the door by the chapel. She stated she did not know when they were last tested, nor did she have a log to document testing by nursing staff, but they were tested when a resident got close to the doors and the alarm would sound. She stated | F 689 | tracking system utilized by the environmental services department) to add a task in the preventative maintenance system that would routinely alert maintenance staff to check the Wanderguard system. A check on the Wanderguard system itself was done immediately and was found to be in proper working order that would have potentially affected all residents whom had Wanderguard devices in place at the time of the onsite visit (R1, R2, R3, R4, R5).<br><br>Oversight of the Wanderguard system checks will be the DES. Wanderguard system checks will consist of obtaining an activated pendant and testing the system at each exit that houses the Wanderguard sensor per manufacturer□s guidance. Testing the system will consist of checks on the alarm sounding and if the system is adequately alerting the nurse call light system. The DES will create and maintain a master list indicating all exits that have Wanderguard sensor equipment. The Elopement Risk Policy and Procedure will be updated to reflect that after the initial period of auditing takes place preventative maintenance checks will take place monthly by the environmental services staff.<br><br>Documentation including name, date, and time that the task is completed for the Wanderguard system checks will be stored in the Maintenance Care system.<br><br>The DES will educate all of the | |

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| F 689 | Continued From page 3<br>she did not know if testing was recommended by the manufacturer.<br><br>During interview on 7/13/21, at 12:58 p.m. Accutech technician stated wanderguard system door functionality should be tested once per month.<br><br>During interview on 7/13/21, at 2:38 p.m. the administrator stated his expectation was for environmental services to check the functionality of the wanderguard systems for the three armed exit doors in the facility. The administrator stated the DES had been in his position for about a year.<br><br>During interview together on 7/13/21, at 2:59 p.m. the DES stated he had not checked the functionality of the wanderguard system on the three exit doors in the facility that were armed. The ADON stated nursing had not checked the functionality of the wanderguard system on the three doors that were armed, except when a resident came close to it, and the alarm would have alerted staff. The administrator provided documentation that showed the door locks were checked on a monthly basis but not the wanderguard functionality.<br><br>Facility policy titled Elopement Risk dated 7/19, indicated a door security alarm was in place and environmental services staff would monitor all door alarms per manufacturer's guidelines or recommendations.<br><br>Accutech wanderguard manufacturer's instructions provided by the facility, dated 12/15/21, lacked recommendations for assessing door system functionality. | F 689 | maintenance staff on Wanderguard system, standards, policies and procedure for checks on the Wanderguard system. All staff will have education completed on the Wanderguard system and the Elopement Risk Policy and Procedure.<br><br>Audits of the preventative maintenance tasks documentation associated with Wanderguard system completed by maintenance department will be done by the Administrator or designee. Checks and audits will be done weekly for 2 weeks, every 2 weeks for one month, then monthly thereafter if acceptable practice is seen. If acceptable practice is not obtained, every 2 week checks and audits will continue.<br><br>Any concerns and concern follow-up from Wanderguard system checks will be reported in the monthly safety committee meeting by the DES. The safety committee with report further to QAPI if trends indicate a need for a PIP.<br><br>Education of policies, procedures and expectations will be completed for all staff.<br><br>The administrator or designee will be responsible for compliance on this tag by August 10th, 2021. | |

Electronically delivered
July 19, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: GWHP11

Dear Administrator:

The above facility was surveyed on July 13, 2021 through July 13, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112  Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00564 | A. BUILDING: _____ B. WING _____ | C 07/13/2021 |

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

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|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 7/13/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. | 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. The assigned tag number appears in the far-left column entitled "ID | |

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| 2 000 | Continued From page 1<br><br>The following complaint was found to be SUBSTANTIATED: H5450060C (MN74437, MN74432) with a licensing order issued at S830. | 2 000 | Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction.<br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS | |

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| 2 000 | Continued From page 2 | 2 000 | WILL APPEAR ON EACH PAGE | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure routine device monitoring was completed for their wanderguard door systems. This practice had the potential to affect all residents whom had wanderguard devices in place at the time of the onsite visit for 5 of 5 residents (R1, R2, R3, R4, R5).<br><br>Findings include:<br><br>R1's face sheet printed 7/13/21, indicated diagnoses of mild cognitive impairment and ataxia (condition where muscle control or coordination of voluntary movements, such as walking or picking up objects is affected) following a cerebral infarction (stroke). | 2 830 | Corrected | 8/10/21 |

| 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 07/13/2021 |

| 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 |
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| 2 830 | Continued From page 3<br><br>R1's care plan dated 5/13/21, indicated R1 could self-propel himself in manual wheelchair without assist. R1's care plan dated 7/1/21, indicated R1 was at risk for wandering/elopement and wanderguard was placed under his wheelchair on 6/30/21.<br><br>R2's face sheet printed 7/13/21, indicated symptoms and signs involving cognitive functions following cerebral infarction (stroke).<br><br>R2's care plan dated 5/16/21, indicated R2 was at risk for wandering/elopement and a wanderguard was placed under his wheelchair. R2 would self-propel in his wheelchair around the facility.<br><br>R3 face sheet printed 7/13/21, indicated diagnoses of dementia with behavioral disturbance and muscle weakness. R3's care plan dated 6/28/19, indicated R3 was at risk for wandering/elopement and a wanderguard had been placed. R3 would wander in her wheelchair.<br><br>R4's face sheet printed 7/13/21, indicated a diagnosis of dementia. R4's care plan dated 9/25/20, indicated R4 was at risk for wandering/elopement and a wanderguard had been placed. R4's care plan dated 10/4/18, indicated R4 would self propel in her manual wheelchair.<br><br>R5's face sheet printed 7/13/21, indicated diagnoses of Parkinson's disease and mild cognitive impairment.<br>R5's care plan dated 7/1/21, indicated R5 was at risk for wandering and a wanderguard had been placed. R5 would self-propel in her manual wheelchair.<br><br>During interview on 7/13/21, at 11:10 a.m. the | 2 830 | | |

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| 2 830 | Continued From page 4 | 2 830 | | |

director of environmental services (DES) stated when a new wanderguard tag was put into service it was checked at the front door to ensure functionality. He stated he did not know if all of the doors were connected to the wanderguard system as he had not checked them.

During interview on 7/13/21, at 11:37 a.m. DES stated the front door was the only door armed with the wanderguard system.

During interview on 7/13/21, at 12:17 p.m. the assistant director of nursing (ADON) stated there were three exits armed with the wanderguard system: the front door, the dining room door, and the door by the chapel. She stated she did not know when they were last tested, nor did she have a log to document testing by nursing staff, but they were tested when a resident got close to the doors and the alarm would sound. She stated she did not know if testing was recommended by the manufacturer.

During interview on 7/13/21, at 12:58 p.m. Accutech technician stated wanderguard system door functionality should be tested once per month.

During interview on 7/13/21, at 2:38 p.m. the administrator stated his expectation was for environmental services to check the functionality of the wanderguard systems for the three armed exit doors in the facility. The administrator stated the DES had been in his position for about a year.

During interview together on 7/13/21, at 2:59 p.m. the DES stated he had not checked the functionality of the wanderguard system on the three exit doors in the facility that were armed. The ADON stated nursing had not checked the

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| 2 830 | Continued From page 5<br>functionality of the wanderguard system on the three doors that were armed, except when a resident came close to it, and the alarm would have alerted staff. The administrator provided documentation that showed the door locks were checked on a monthly basis but not the wanderguard functionality.<br><br>Facility policy titled Elopement Risk dated 7/19, indicated a door security alarm was in place and environmental services staff would monitor all door alarms per manufacturer's guidelines or recommendations.<br><br>Accutech wanderguard manufacturer's instructions provided by the facility, dated 12/15/21, lacked recommendations for assessing door system functionality.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies, procedures and manufacturers guidance for wanderguard system maintenance; then revise as needed to ensure the required system checks are in place; then educate staff and audit to ensure ongoing compliance and report to quality assurance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |