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	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Links Care Center	815 Forest Avenue Northfield, MN 55057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure safe transfers with a full body mechanical lift for 1 of 3 residents (R1) reviewed for falls/safety. The facility's failure resulted in an immediate jeopardy situation for R1 when he slipped out the full body mechanical lift sling and fell from an elevated height. R1 was hospitalized due to a new fracture of the right femur and needed surgical intervention. The IJ began on 9/12/25, when 2 of 2 nursing assistants (NA)-A and NA-B did not follow manufacturer's recommendations for a safe lift transfer using the full body mechanical lift and the sling was not attached properly. As a result, R1 fell from the lift and sustained a new fracture of the right femur that needed surgical intervention. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 9/19/25 at 8:59 a.m. The facility implemented immediate corrective action on 9/12/25 to prevent reoccurrence, so the deficient practice was issued at past non-compliance (PNC).Findings include: R1's face sheet dated 9/12/25, identified diagnoses of unspecified fracture of the shaft of right femur (long bone located in the thigh) with routine healing, artificial hip joint, hemiplegia (a condition characterized by paralysis or weakness on one side of the body) and hemiparesis (one sided muscle weakness), and cerebral infarction (a condition where blood flow to the brain is interrupted, leading to tissue damage to the brain). R1's Significant Change Minimum Data Set (MDS) dated [DATE], identified R1 had a diagnosis of fracture of shaft of right femur, was dependent on staff for all transfers, had no falls since admission/readmission, and was cognitively intact. R1's care plan activities of daily living focus, identified R1 had a self-care performance deficit related to hemiplegia-stroke. Interventions initiated on 5/3/25, were as follows: assist of two with total mechanical lift between surfaces using a large hourglass sling. R1's progress note dated 9/12/25, identified R1 had a fall from the total mechanical lift and had to be sent to the emergency department (ED) due to hitting head. The root cause of R1's fall seemed to be that there were two black loops on the sling and each aide picked different black loops causing slack to be in the sling which made one side of the sling fall off the arm of the total mechanical lift. R1's fall risk management report dated 9/12/25 at 12:05 p.m., indicated two staff placed R1 in a sling to transfer from wheelchair to bed. Staff positioned R1 to turn to begin transfer and during that time, the sling loop slid off the lift arm and resident slid to the ground. R1 struck his head and was sent to the ED for evaluation. Interdisciplinary team (IDT) intervention: Immediate education completed with all staff on different loops of the sling, mechanical lifts and Inservice scheduled with lift company and slings.R1's facility post-fall evaluation dated 9/12/25, indicated that R1 had a fall during a transfer in a lift and the reason for the fall was evident, due to upper black loop used and lower black loop used.R1's hospital ED note dated 9/12/25, indicated R1 was seen following a fall in the nursing home, and unfortunately there was equipment failure, and the strap slipped off the lift they were using and R1 fell to the ground and struck the back of his head. Two computed tomography (CT) done of the head and no significant findings and no palpable defects or tenderness noted to the hips or femur. R1's hospital ED did not identify imaging of his or femur was completed. R1's progress note dated 9/12/25 at 9:19 p.m., identified R1 was seen in ED for evaluation for head strike and had two computed tomography (CT) scans six hours apart to make sure no new head bleed. Repeat CT was stable and no new orders. R1's clinic orthopedic visit note dated 9/16/25, indicated R1 was seen for a post operative visit to evaluate a right hip resection that was done 2 months prior and Unfortunately, there was an accident at R1's nursing facility 4 days ago where there was a malfunction with the total mechanical lift that resulted in a fall from an elevation for R1. R1's x-rays of the right hip and femur identified a new fracture of the mid shaft of his right femur at the site of prior cerclage (internal fixation method using wires around bone) wires and recommended admission to hospital for surgical intervention. R1's hospital operative note dated 9/18/25, indicated R1 had a complicated history of recalcitrant (resistant to treatment) requiring multiple revisions in the past, ultimately leading to a [NAME] (removal of the upper portion of the femur) resection. Unfortunately, there was an accident in R1's nursing facility 6 days ago and R1 was dropped from the full body lift when there was an equipment malfunction. This resulted in a femoral shaft fracture at the mid-diaphysis (middle section of the long bone) of his remaining femur. At this time there is no functionality of his femur given the prior [NAME] and recommended resection (removal of all or part) of his remaining proximal (situated near) femur, proximal to the site of the fracture. During an interview on 9/18/25 at 11:44 a.m., NA-A and NA-B stated they engaged in the transfer of R1 when he fell out of the sling on 9/12/25. NA-A stated she believed she attached the top slings to R1, but did not verify that the same