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	05/23/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to comprehensively re-assess for safe self-administration of medication given via a nebulizer for 1 of 1 residents (R37) reviewed for self-adminstration of medications. Findings include: R37's quarterly Minimum Data Set (MDS) dated [DATE], indicated R37 had intact cognition and was diagnosed with respiratory failure and Chronic Obstructive Pulmonary Disease (COPD- incurable lung disease causing breathlessness, frequent coughing, and chest tightness). The MDS indicated that R37 was receiving hospice services. R37's Self Administration of Inhaled Medications assessment dated [DATE] and 5/14/24, indicated R37 was able to demonstrate correct administration of medication via a nebulizer after staff set-up. R37's Self Administration of Inhaled Medications assessment dated [DATE], indicated R37 was able to correctly demonstrate how to use a nebulizer but due to staff reports of R37 falling asleep while completing the medication administration, he is not administering medication safely. The assessment indicated the nurse would now need to observe R37's nebulizer treatments. R37's order summary indicated R37 dated 5/22/24, included the following orders: -Dated 6/28/23, one vial of ipratropium-albuterol inhalation solution (medication used to relax and open the airways) via a nebulizer six times a day for shortness of breath. -Dated 7/5/23, 2.5 milligrams of albuterol sulfate inhalation solution (medication used to relax and open the airways) via a nebulizer for shortness of breath 12 times a day. -Dated 8/13/23, R37 would like to self-administer nebulizer treatment so staff should set up the treatment and staff were to update hospice or the care coordinator with concerns. -Dated 5/22/24, indicated R37 was not consistent while self-administering his medication via a nebulizer and was occasionally falling asleep during treatment. The order indicated the nurse/trained medication aide was to observe R37's nebulizer treatments. (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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/20/24 at 6:42 p.m., R37 was observed sitting in his recliner appearing to be asleep. R37 had an audibly running handheld nebulizer that was upside down, as his hand with his nebulizer had fallen to his lap. The nebulizer medication cup appeared half full of a solution. During an interview on 5/20/24 at 6:44 p.m., licensed practical nurse (LPN)-A stated she had set up R37's nebulizer with the ipratropium-albuterol inhalation solution but R37 was able to complete the treatment by himself after set-up. LPN-A stated she had observed R37 fall asleep while completing the nebulizer treatment in the past, but she was unsure who completed the assessment to determine if R37 was safe to self-administer the medication. During an interview on 5/22/24 at 10:24 a.m., registered nurse (RN)-C, the hospice nurse, stated it was very common for R37 to fall asleep during his nebulizer treatments and it had been occurring since he was admitted to this facility in 2023. RN-C stated R37 would take his oxygen cannula off while completing the nebulizer treatments and then R37 would fall asleep, the nebulizer would fall out of his mouth, and his oxygen saturation would lower quickly but RN-C did not normally stay with R37 while he completed his treatments. RN-C stated he had thought R37 falling asleep during nebulizer treatments was a known occurrence but it was hard for nursing staff to stay with R37 during these treatments as he had 18 of them a day and took a significant amount of time to complete. During an interview on 5/22/24 at 2:09 p.m., RN-A, the nurse manager, stated she was in charge of assessing if residents could safely self-administer medications. RN-A stated floor staff had not informed her of R37 falling asleep while completing nebulizer treatments. RN-A stated R37 completed nebulizer treatments during the day and night and she had previously completed the assessment during the day so she was unsure if he was falling asleep while administering the medication at night. During an interview on 5/23/24 at 9:53 a.m., the director of nursing (DON) stated she would have expected the nursing staff to alert the nurse manager if R37 was falling asleep during treatment so methods for safe administration could have been developed after re-assessment. The DON stated it was important for nursing staff to ensure R37 was receiving these medications properly so R37 could receive the full benefits of the medication. The facility's Self-Administration of Medications by Residents policy dated 5/1/24, indicated if a resident wished to self-administer medications, facility staff would assess their ability to do so and document the findings. The policy indicated that a periodic re-assessment of the resident's continued appropriateness for self-administration would be completed. If it was determined to be unsafe for the resident to self-administer the medication, options for safe administration of the medication would be assessed.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure identified preferences for bathing routines (i.e., twice weekly) were honored to promote quality of life and resident' choice for 1 of 2 residents (R7) reviewed for choices during the survey. Findings include: R7's quarterly Minimum Data Set (MDS), dated [DATE], identified R7 had intact cognition. On 5/20/24 at 2:09 p.m., R7 was interviewed, and she expressed frustration with her bathing routine adding, I was getting two baths a week but now they [staff] told me I'd only be getting one. R7 stated staff told her this a few weeks prior and she was not given a reason for the reduced bathing schedule, at least to her recall. R7 reiterated she wanted her second (in a week) bath re-scheduled adding, That would be nice. R7 stated she assumed they reduced it due to a lack of staff adding, They got so many people [other residents] here. R7's care plan, dated 4/10/24, identified R7 needed assistance with activities of daily living (ADLs) due to weakness and difficulty with mobility. The care plan outlined R7 needed extensive assistance to complete bathing which had a recorded frequency, Weekly. The intervention was initiated 4/12/24. R7's most recent Resident Care Conference Summary - V7, dated 4/27/24, identified R7 had a care conference on 4/17/24, along with multiple sections provided and completed by various medical disciplines (i.e., social services, nursing). This summary outlined R7 and registered nurse manager (RN)-A both attended the care conference along with a section labeled, Care Plan, which had several responses listed and corresponding checkmarks placed next to the staff' recorded response. This included a checkmark placed next to, Personal preferences reviewed/updated. However, the summary lacked any more specific information on what preferences were reviewed, explained or what, if any, updates to them were made with corresponding rationale. When interviewed on 5/21/24 at 1:17 p.m., nursing assistant (NA)-A stated the facility used a bath aide who completed most baths for R7. On 5/21/24 at 2:42 p.m., RN-A and RN-B were interviewed. RN-A verified they had reviewed the facility' current bath schedule and R7 was scheduled for only a weekly bath. RN-A stated R7 had been scheduled for a twice weekly bath and, to their knowledge, should still be adding they guessed staff may have brought it upon themselves to remove the second one. RN-A stated they were unsure exactly when or why the second scheduled bath had been removed adding, I thought she was still getting it. RN-A explained bathing schedules were reviewed with each resident upon admission and reiterated R7 was supposed to be getting two baths a week adding such was also an intervention for R7's skin issues. RN-A stated they would follow-up with R7's normal bath aide when they returned to work about why the second bath had been removed. RN-A and RN-B verified bath schedule changes, such as going from two a week to once weekly, were typically for the most part done by them and reiterated they would investigate the concern with R7's bath schedule. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A provided bath schedule, untitled or dated, listed multiple residents names, including R7, along with a header reading, Wednesday. This verified R7 was only getting a weekly bath. Further, the listing identified bolded wording at the bottom, Do not change bath schedule. Update CC [mangers] with concerns. A provided listing, untitled, outlined R7's completed baths with spaces to record the date, weight, and corresponding staff initials. This identified R7 received a bath on 4/3/24, 4/6/24, and 4/10/24. Then, after 4/10/24, the written dates were listed as 4/17/24, 4/24/24, 5/1/24, 5/8/24, and 5/15/24 (i.e., once weekly). The form lacked any written evidence demonstrating rationale for the removal of the second bath nor evidence R7 had consented to such. Further, R7's medical record was reviewed and lacked evidence or justification for the removal of the second bath as had been in place and verified by nursing leadership (i.e., RN-A) as being an intervention for R7. A provided Person Centered Care Planning policy, dated 4/2023, identified the care center would develop a care plan consistent with resident's rights and needs. A facility' policy on choices and bathing preferences was requested, however, none was received.

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F 0568 Level of Harm - Potential for minimal harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure resident' trust account statements were provided on, at least, a quarterly basis for 1 of 1 resident (R29) reviewed who expressed never receiving such statement. The lack of provided statements had the potential to affect an additional 26 of 26 residents identified to have trust accounts at the care center. Findings include: R29's significant change Minimum Data Set (MDS), dated [DATE], identified R29 had intact cognition. On 5/20/24 at 3:08 p.m., R29 was interviewed and verified he had a trust account which was managed by the care center adding, It's got only like 100 bucks or so. R29 stated he opened the account many months prior, however, had never received a statement from the care center with any balance outlined adding, No, not seen that. A provided Trial Balance list, dated 5/22/24, identified 27 residents, including R29, had active accounts as of the listed date. R29 was identified as having an account with a balance recorded, [$]150.02. A grand total of $32,727.87 was listed for the 27 residents to have active accounts at the care center. During the recertification survey, from 5/20/24 to 5/23/24, evidence of a statement being provided to the residents, or their respective representatives, was requested. However, none was provided. On 5/22/24 at 12:11 p.m., accountant (A)-A was interviewed and verified they were responsible for the resident' accounts. A-A explained the role and management of them had been handed off to them at the end of 2023, and they verified R29 had an active account with a positive balance. A-A stated they, thus far in 2024, they had not mailed out any statements to the residents or their representatives but expressed their new management company had just updated them recently to do so. A-A stated the care center was in process of changing banking institutions, and voiced they would not be aware when a statement had been sent to each respective resident' with their current balance. A-A reiterated, I was just made aware recently that we would be sending out statements [by the management company]. When interviewed on 5/23/24 at 9:56 a.m., the administrator stated A-A would be the person responsible to ensure statement were mailed or provided since the previous person had resigned in 2023, but she added, I don't know if he has or hasn't. The administrator stated they were unsure exactly when the last statements had been sent due to just recently starting employment at the campus themselves; however, they voiced the care center was actively working on getting them sent now. (continued on next page)

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F 0568 Level of Harm - Potential for minimal harm Residents Affected - Some	A provided Resident Trust Accounts/Fund policy, dated 4/2020, identified the care center would administer resident' funds in accordance with Minnesota statutes. The policy outlined each resident with funds deposited would have separate, interest-bearing accounts maintained and the accountant would manage the day to day operations of the accounts. The policy included, RTA [accounts] Statements should be sent to the resident or authorized individual, including but not limited to, Quarterly to all residents and the Social Worker regardless of their account balance.

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 33925 Based on interview and document review, the facility failed to ensure resident' trust account balances above the state-required supplemental security income (SSI) threshold (i.e., $3,000) were identified and acted upon to ensure ongoing coverage and reduce the risk of complication for 2 of 2 residents (R13, R42) reviewed who had balances exceeding the threshold. Findings include: A Minnesota Medical Assistance Treatment of Assets and Income, dated 9/2023, identified a person with medical assistance (i.e., Medicaid) living in a nursing home must contribute most of their income towards the cost of such care. The article outlined, The MA [medical assistance] asset limit is $3,000 for an individual and $6,000 for a couple, plus $200 for each dependent. A provided Trial Balance list, dated 5/22/24, identified all resident' trust accounts and their subsequent balances for the care center. This list identified R13 had an active balance recorded, [$]14,648.82, and R42 had an active balance recorded, [$]12,740.57. R13's Clinical Census, printed 5/23/24, identified R13 had a current payer source recorded, Medicaid, with an effective date listed, 6/10/2024. However, R13's medical record was reviewed and lacked evidence any attempt to reduce the assets (i.e., spend down) had been discussed or attempted to ensure the Medicaid coverage was not terminated due to being over the SSI threshold. R42's Clinical Census, printed 5/23/24, identified R42 had a current payer source recorded, Medicaid, with an effective date listed, 10/1/2023. However, R42's medical record was reviewed and lacked evidence any attempt to reduce the assets had been discussed or attempted to ensure the Medicaid coverage was not terminated due to being over the SSI threshold. On 5/22/24 at 12:11 p.m., accountant (A)-A was interviewed and verified they were responsible for the resident' accounts. A-A explained the role and management of them had been handed off to them at the end of 2023, and the care center was actively working to change banking institutions. A-A acknowledged R13 and R42 had balances in excess of ten-thousand dollars, and stated R42's family had recently contacted them about the excessive amount and possibly needing to spend down. However, A-A stated this had not, to their knowledge, been acted upon yet to actually facilitate a spend down as they were unaware exactly what had to be done adding, Nobody filled me in. A-A stated they were unsure exactly what, if any, limits on personal asset or cash were allowable under Minnesota Medicaid law adding, [Someone] mentioned they [residents] needed to be at a certain limit but I never really knew what that limit was. A-A stated they were unsure if anyone had approached or discussed the need of a spend-down with either R13 or R42. On 5/22/24 at 12:45 p.m., a telephone call was attempted with each R13 and R42's family. However, neither of them were able to be reached and a return call was never received. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/24 at 8:37 a.m., R13 was interviewed, and stated he resided at the care center for going on three years now and handled his own statements and, if needed, signed his own documents still but with some input and oversight by his family member. R13 verified he was on Medicaid and stated nobody, to his recall, had ever discussed the current balance, or a subsequent spend-down of it, with him. R13 stated he was surprised to learn the account had so much in it and expressed aloud, What am I supposed to do? R13 stated he wasn't sure what, if any, items he could purchase to spend-down the funds but added, I'm sure I could find something. On 5/23/24 at 9:56 a.m., the administrator was interviewed and stated they had a telephone call placed to the social worker about R13 and R42's balances, but had not followed up on it thus far. At 10:06 a.m., A-A joined the interview and stated the care center being transitioned to a new management company combined with them seeking a new banking institution for the trust funds may have contributed to the confusion on the spend-down not happening. A-A stated they reviewed the funding sources and expressed R13 and R42's funds had likely been building awhile prior to it being identified by the survey team. A-A stated they had not typically been reviewing the balances for amounts (i.e., over $3,000) but would moving forward. The administrator stated the social services department would reach out to R13 and R42's families and ensure the funds were spent down timely. A provided Resident Trust Accounts/Funds policy, dated 4/2020, identified

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed to reflect assessed needs and interventions with pain relief for 1 of 2 residents (R7) reviewed for pain management. Findings include: R7's quarterly Minimum Data Set (MDS), dated [DATE], identified R7 had intact cognition and demonstrated no delusional behaviors. Further, the MDS outlined R7 consumed a schedule pain medication, received non-pharmacological interventions for pain, and occasionally complained of pain (including with affect on activities and sleep) during the review period. On 5/20/24 at 2:17 p.m., R7 was interviewed and expressed they had pain in their left leg from a fall weeks prior. R7 stated, It aches in this leg. R7 stated they were unsure if the physician was aware of it or not, and expressed the pain was worse with movement. R7 stated they were unsure if staff were aware of her pain or not adding, I don't know. R7's most recent Pain Data Collection - V9, dated 3/22/24, identified R7 had osteoarthritis and an active pressure injury which could cause pain. A pain assessment interview was completed, where R7 identified having pain in her buttocks, lower back and right foot. R7 rated this as happening, Occasionally, with some effect on sleep and activities. R7 was recorded as consuming scheduled pain medications, including a narcotic (i.e., Tramadol), and listed some non-medication interventions to be done including repositioning, offloading, and heel boot use. However, R7's electronic care plan, last reviewed 4/10/24, lacked any developed problem statements, goals, or what, if any, interventions were being done for R7's assessed pain. When interviewed on 5/21/24 at 1:17 p.m., nursing assistant (NA)-A stated they had worked with R7 multiple times and verified R7 did, at times, complain of pain to them adding, She does. NA-A explained the staff use a mechanical lift to transfer R7 and, usually mid-transfer, R7 would state, OK, that's enough. NA-A stated R7 was good at letting me know about pain. NA-A stated the care center used to have more consistent staffing but lately it had been a lot of different people [i.e., agency] throughout the week. Further, NA-A stated nurses would typically communicate interventions to them using a verbal report and through the electronic kardex on the computers. On 5/21/24 at 2:42 p.m., registered nurse managers (RN)-A and RN-B were interviewed. RN-A verified they had reviewed R7's care plan and it lacked a pain statement or subsequent interventions adding, You busted me. RN-A stated R7's assessed pain, and subsequent interventions, should have been care-planned adding they were not sure how it had been missed. RN-A stated R7 was very arthritic and anytime she moves or stands up, her bones crack. RN-A verified the care plan, including the interventions, pulled to the NA Kardex and expressed they use the care plan like a tool to help ensure some interventions get signed off, too. RN-A and RN-B both verified a care plan was important to have developed and updated as it was like the bible and a guide to taking care of the patient. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A provided Person Centered Care Planning policy, dated 4/2023, identified the care center would develop a comprehensive person-centered care plan which included measurable objectives and timeframes to meet specific goals and needs. The comprehensive care plan was to be developed within seven days of completion of the MDS and should describe the services to be furnished to the resident adding, Care plans are avalable to staff using the electronic medical record (EMR) system.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49893 Based on observation, interview, and document review, the facility failed to comprehensively assess for range of motion (ROM) after a significant change for 1 of 1 residents (R31) evaluated for limited mobility. Findings include: R31's significant change Minimum Data Set (MDS) dated [DATE], indicated R31 had severe cognitive impairment with no history of behaviors or rejection of cares. R31 had ROM impairment to one upper extremity, no ROM impairment to lower extremities, and was dependent on staff for all activities of daily living (ADLs). R31's diagnoses included unspecified dementia, traumatic brain injury and contracture of left hand. R31's care plan printed 5/22/2024, indicated R31 required total assist with ADL's. During an interview on 5/20/2024 at 6:03 p.m., family member (FM-A) stated they wanted R31 to participate in ROM/therapy exercises. FM-A stated she was informed by therapy R31 sleeps all the time and would not be appropriate for exercises. FM-A stated R31 is awake and participates in ball toss during visits. During observation on 5/21/24 at 1:13 p.m., R31 was observed sitting in a Broda chair (specialized wheelchair for positioning) in the common area awake and tracking conversations around her. During observation on 5/22/24 at 9:18 a.m., R31 was observed sitting in a Broda chair in the common area with eyes closed however did open eyes with conversation. During observation on 5/22/24 at 12:28 p.m., R31 was seated in a Broda chair in common area awake. R31 made eye contact during conversation however was not verbal. R31's functional ability screen dated 4/29/2024., indicated R31 had upper extremity ROM impairment to one side and no impairment to lower extremities. R31 was dependent on staff for all ADL's. A hospice communication note dated 4/22/24, indicated R31 discharged from hospice due to a prognosis of greater than 6 months. R31's progress note dated 4/22/24, indicated R31 discharged from hospice services. R31's Care Conference Summary dated 4/9/24, indicated [family] has been playing catch with her [R31] which she seems to enjoy. A review of the staff task list and nursing assistant Kardex (care sheet) lacked ROM exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 5/22/24 at 9:58 a.m., nursing assistant (NA-C) stated therapy does exercises with R31. During interview on 5/22/24 at 1228, therapy director (TD) indicated R31 was last seen in December 2023. TD stated the facility has a functional maintenance program (as opposed to a restorative program) that requires a provider order to establish. TD stated therapy staff then evaluate a resident and design a functional maintenance program for nursing staff to perform. During interview on 5/23/2024 at 8:44 a.m., nurse manager (NM-A) stated therapy screens all resident's quarterly, with changes in condition and as needed. R31 was previously evaluated by occupational therapy due to contracture to left hand. A copy of ROM exercises dated 11/29/2023, signed by occupational therapy, was provided. NM-A stated R31 enrolled in hospice in December of 2023 due to a decline in health. R31's health then stabilized. During a care conference on 4/5/2024, family was updated R31 was likely no longer going to meet qualifications for hospice and would be discharged from hospice. NM-A stated she has not spoken to FM-A since R31 was discharged from hospice because R31's next care conference is scheduled for 6/2024. A copy of a quarterly therapy communication/screen form dated 3/7/2024, indicated R31 was not a candidate due to hospice enrollment. NM-A stated she should have put a request in for a therapy screen when R31 was discharged from hospice but just missed it. During interview on 5/23/24 at 10:24 a.m., the director of nursing (DON) stated functional management plans are developed by the therapy department. DON confirmed therapy screens all resident's quarterly and makes recommendations accordingly. Therapy requests are also made with change in conditions. DON stated the facility has standing orders for therapy screens and will reach out to MD/NP for continuing orders after therapy screen. DON stated it sometimes takes a few weeks after a change in condition is noted to get things in place. A St. [NAME] Health Services of [NAME] Inc. Restorative Nursing Program policy reviewed and amended 4/6/20 indicates (Care center) will have a Restorative Nursing Program that promotes a residents' ability to achieve and/or maintain their optimal function, in accordance with the resident's comprehensive assessment and person-centered plan of care. Paragraph A under Procedure indicates: Residents will be evaluated on admission, ongoing and at least quarterly to determine the need for restorative nursing services by the Restorative Coordinator or nursing designee and/or Contracted Therapy. Paragraph C indicates: The restorative Nursing Coordinator or nursing designee will develop the program(s), in collaboration with Therapy if the program is recommended by Therapy, for residents who are identified as having the potential to benefit from the program(s). Paragraph D indicates: A Restorative Assessment will be completed by the RN Restorative Coordinator or by nursing staff under the supervision of the RNC. This will include identifying and care planning the resident's need for restorative nursing services, goal(s), and interventions to meet the goal(s). Paragraph f indicates in part: Restorative Coordinator or designee will monitor on an ongoing basis all aspects of the individualized restorative programs being offered.

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	245450	A. Building B. Wing	05/23/2024

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

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on interview and document review, the facility failed to ensure dental services were offered or provided in a timely manner to prevent complication (i.e., trouble eating, pain) for 1 of 1 resident (R39) after it was determined their dentures were loose and not fitting correctly. Findings include: R39's admission Minimum Data Set (MDS), dated [DATE], identified R39 admitted to the care center on 4/11/24 from the acute care hospital. The MDS recorded R39 as having intact cognition and demonstrating no delusional thinking. Further, a section labeled, Section L - Oral/Dental Status, identified R39 as having broken or loose fitting denture(s) and no natural teeth (i.e., edentulous). R39's Census listing, printed 5/22/24, identified R39's current payer source as, Private Pay. On 5/20/24 at 1:34 p.m., R39 was interviewed and expressed, I don't have teeth. R39 explained she had several dental implants but still had dentures, however, was not wearing them due to them being loose-fitting. R39 stated she thought, to her recall, she told staff they were loose but could not recall what, if any, options for dental care and addressing the loose dentures had been offered. R39 stated she would like to get a dental appointment arranged, if able, to address them adding, It really bothers me. R39's Ancillary Services Consent, dated 4/11/24, identified a section labeled, Apple Tree Dental, with a written X marking placed next to, No. The form was signed by R39 on 4/11/24; however, the form lacked what, if any, other dental options were offered or discussed with R39 (i.e., community services). R39's subsequent Quick Guide (i.e., initial care plan), dated 4/11/24, outlined basic care-related information including a section labeled, Dentures:[,] which had black-colored markings recorded to demonstrate upper and lower sets were used with added written dictation, at home. However, R39's initial Oral Dental Review 12-22-17 - V2, dated 4/17/24, identified R39 was edentulous. The subsection labeled, Dentures, had options to select which set was used (i.e., upper, lower) and what, if any, problems with them were identified. However, these spaces were left blank and not completed. The conclusion of the evaluation labeled, Summary, identified dictation which read, . has no natural teeth, upper and lower dentures . does not like to wear them [dentures] as not fitting properly with recent weight loss . denies oral pain, able to brush mouth herself after staff set up . Dietitian is following with resident. The form lacked what, if any, options were discussed or offered to R39 when the loose-fitting dentures were identified. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's Resident Care Conference Summary - V7, dated 4/18/24, identified each respective discipline who participated in the conference and form. This included a section labeled, Section SS. Social Service, which outlined R39's admission conference was held and dictation, Med changes, appointments, weight, intake BMs, and activity preferences reviewed. However, the form lacked evidence if a dental examination, including from outside the facility-sourced service, had been discussed or offered despite R39 being identified with a loose-fitting denture set the day prior on evaluation. In addition, R39's subsequent Oral Dental Review 12-22-17 - V2, dated 5/15/24, identified R39 had a significant change in status and remained edentulous. The subsection labeled, Dentures, now had markings placed to demonstrate R39 used an upper and lower denture, however, the spacing to record what, if any, issues with them was left blank. Further, the evaluation again concluded with a section labeled, Summary, and dictation which read, . has no natural teeth, upper and lower dentures . does not like to wear them [dentures] as not fitting properly with recent weight loss . denies oral pain, able to brush mouth herself after staff set up . Dietitian is following with resident. The form, again, lacked what, if any, options were discussed or offered to R39 despite the loose-fitting dentures still being identified. R39's medical record was reviewed and lacked specific evidence R39 had been offered or provided with a dental examination service after 4/17/24, when it was identified on evaluation that she had loose-fitting dentures; nor after 5/15/24 when the loose-fitting appliances were again identified. When interviewed on 5/21/24 at 1:08 p.m., nursing assistant (NA)-A explained R39 needed quite a bit of help to complete most cares and described her cognition as forgetful. NA-A stated R39 would, at times, do her own oral care after set-up assistance was provided and added R39 was missing most of her teeth adding further R39 doesn't put dentures in. NA-A stated they thought there was a set of dentures for R39 but reiterated, She said she never puts them in. NA-A stated R39 had never reported dental concerns to their knowledge and explained if a dental appointment was needed, then the clinical coordinator would likely set one up. On 5/21/24 at 2:42 p.m., registered nurse managers (RN)-A and RN-B were interviewed. RN-A explained R39 had been offered the Apple Tree Dental service upon admission (4/11/24) and, at the time, declined it adding R39's payer systems were, in general, was pretty complicated due to being admitted on Medicare A then, afterwards, finding out she was also a Veteran. RN-A stated R39 originally had planned to discharge back home and, on her own, pursue dental services but now was looking at more long-term placement. RN-A stated dental services had been discussed with R39 to her recall and, at one point, information had been given to R39's family member but no follow-up had been done since adding, Nothing was pursued. RN-A acknowledged the medical record lacked evidence of a dental appointment being discussed or offered after the loose dentures were identified and expressed, We talked about it but [it's] not documented. RN-A stated R39's dentures, to their knowledge, remained at home but expressed the recently completed significant change evaluation should have taken care of all this and the dental needs, if wanted or needed, re-visited adding, We missed that dental piece. RN-A stated it was important to ensure dental visits were offered and, if needed, provided timely as loose-fitting dentures could cause mouth sores or increase a residents risk of choking while eating. Further, RN-B explained they were going to review their (RN-A and RN-B) hand-off process to ensure transitions from short-term to long-term care didn't miss items like dental appointments. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A provided Dental Services policy, dated 1/2017, identified the care center would provide or obtain dental services, including both routine and emergency services, from an outside source to meet resident' needs. A procedure was listed which included, Assistance with making dental appointments, if necessary or if requested.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034 Based on observation, interview, and document review, the facility failed to ensure proper infection control practices were utilized while completing personal hygiene and urinary catheter care for 1 of 1 residents (R25) reviewed for urinary tract infections (UTI). Findings include: R25's significant change Minimum Data Set (MDS) dated [DATE], indicated R25 had intact cognition and was diagnosed with heart failure, kidney disease, and respiratory failure. The MDS indicated R25 was dependent on staff for toileting hygiene, bed mobility, and transfers. R25's care plan dated 2/22/24, indicated R25 had a history of a UTI related to an obstruction of the urinary tract and also utilized a urinary catheter. The care plan indicated that R25 required assistance with catheter care every morning and night. The care plan indicated R25 required the assistance of two staff members with bathing and dressing. R25's order summary dated 2/22/24, indicated R25 had an indwelling urinary catheter in place and output was to be assessed every shift. R25 had an order dated 3/15/24, for 500 milligrams (mg) of ciprofloxacin to be given two times a day for severe sepsis, UTI for seven days. During an observation on 5/22/24 at 7:15 a.m., nursing assistant (NA)-B was observed in R25's room with gloves on preparing a basin with soap and water while R25 lay in bed. NA-B was observed to set the basin down on the bedside table and assist R25 with removing her pajamas. NA-B then soaked the washcloth in the soapy water and cleansed under the residents' arms and breasts. The washcloth now had a pinkish/brown coloring and was dunked into the soapy water in the basin, wrung out, and then used to clean under R25's abdominal fold. NA-B then dunked the same washcloth in the soapy water, wrung it out, and cleansed the area around R25's catheter. NA-B was then observed to drop the washcloth in the basin and without changing her gloves, opened R25's closet door and grabbed a clean incontinence brief from the closet. NA-B then assisted R25 to lay on her side. NA-B took the same washcloth from the basin and in multiple strokes up towards the resident's head and back down towards the resident's catheter, washed the anal area. NA-B removed the old incontinence brief, put the new incontinence brief below the resident, and applied a skin-protecting cream to R25's anal area, without completing hand hygiene and changing gloves. During an interview on 5/22/24 at 7:37 a.m., NA-B stated she normally used one washcloth for all of the resident care including catheter care. NA-B stated she had completed hand hygiene and put on/took off gloves when entering and exiting R25's room but had not in between those times. NA-B stated she should have completed hand hygiene and changed her gloves before gathering supplies from R25's closet and applying the cream. During an interview on 5/22/24 at 2:17 p.m., the director of nursing (DON) stated she would have expected the NA to change her gloves and complete hand hygiene before and after completing catheter and perineal care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 9:58 a.m., the DON stated that a clean washcloth or a clean side of the washcloth should have been used when completing resident personal cares, especially catheter care. The DON stated that if a clean washcloth was not used for catheter care, should worry about R25 developing an infection. The undated facility Urinary Catheter Care and Management policy indicated the purpose of the policy was to maintain resident safety by following infection control practices while inserting and handling catheters. The policy indicated standard precautions should have been utilized while completing daily maintenance of urinary catheters. The policy indicated staff should have demonstrated competency in catheter care before performing the task unsupervised.