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	07/31/2025

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 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. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure resident choices for bathing preferences were assessed and honored for 1 of 1 residents (R1) reviewed for choices. Findings Include: R1's admission Minimum Data Set (MDS), dated [DATE], indicated R1 had intact cognition with no hallucinations or delusions. The assessment indicated R1 needed moderate staff assistance with dressing, toileting hygiene, personal hygiene and footwear. On 7/28/25 at 6:33 p.m., R1 stated that she preferred to have a shower in the evening. R1 stated the facility had always given her showers during the day except for one time when they did not have time to complete it during the day and gave her a shower in the evening. R1 stated how much she enjoyed the shower in the evening and I have told everybody how much I liked the shower in the evening. R1's care plan, printed 7/29/25, identified the following: -Resident preferences will be considered when providing care with the following preferences: bedtime preference of 10 p.m., music preference of inspirational/religious the importance of being around animal such a s pets was very important. -BATHING/SHOWERING: I am able to: Limited A-1 with 2WW and gait belt- HS ROUTINE: I am a night owl. I prefer to call for assistance when I am ready for bed. On 7/29/25 at 11:34 a.m., licensed practical nurse (LPN)-C provided a copy of the shower/bath schedule and stated this was the schedule the facility used for resident showers/baths. Facility shower schedule, printed 7/29/25, identified R1 prefers shower only and R1's showers were offered weekly on Mondays. The facility shower schedule lacked identification of R1's preference for an evening shower. Furthermore, the shower schedule indicated, Day bath aide 6-2pm and any leftover baths would be coordinated with evening staff to complete, and the nurse would continue to do weekly bath audits day/eves. R1's July 2025 medication and treatment administration record (MAR), printed 7/29/25, identified the following order:-Total body skin assessment every Monday AM (day) shift starting 5/26/25. Per record, was completed 7/7/25, 7/21/25, and 7/28/25. On 7/14/25, it was documented with a 9 which indicated other/see progress notes. R1's Resident Preferences Evaluation, dated 5/29/25, identified R1 had a sponge bath bathing preference. Furthermore, the assessment indicated R1 preferred an afternoon or evening time of day for bathing. R1's progress notes, dated 5/22/25 to 7/29/25, were reviewed. R1's progress notes, dated 5/29/25, indicated a resident preference evaluation had been completed which identified R1 preferred to bathe in the afternoon or evening and preferred a sponge bath. The progress notes lacked evidence of any additional conversations of R1's preferences or how the facility was going to help meet resident's preferences. During an interview on 7/30/25 at 8:55 a.m., nursing assistant (NA)-D stated that she did majority of the showers for residents in the facility. NA-D stated the shower schedule was determined by the care coordinators and the days were set, typically, by room numbers. NA-D stated when residents moved into the facility they were assessed to determine if they preferred day or evening showers or if they preferred baths or showers. NA-D stated there were no residents who had a preference for evening showers. NA-D stated she did as many showers as she could during the day but occasionally, she was unable to complete a shower and then it got done in the evening, but the showers were not scheduled in the evenings. NA-D reviewed the shower schedule and verified there was not an identified preference for R1 to have an evening or afternoon shower. NA-D stated R1 got one shower a week on Mondays and preferred to have a shower, not a bath. NA-D stated she had always given R1 her showers in the mornings and verified she has given R1 almost 75% of her showers. During an interview on 7/30/25 at 11:45 a.m., registered nurse coordinator (RN)-B stated an assessment was completed on admission to identify resident preferences. RN-B stated if a preference for bathing times was identified, the information would be passed along to the rest of the team and the bath schedule would be updated. RN-B stated she was aware of one resident that preferred an evening bath and verified it was not R1. RN-B reviewed Resident Preferences Evaluation, dated 5/29/25 and verified R1 had identified a preference for an afternoon/evening sponge bath. RN-B stated some of the assessment forms had changed since May, the life enrichment department had completed this assessment, and she was not aware of this. RN-B stated since the preference had been identified during an assessment, the expectation would be R1 would be offered her bathing preference in the afternoon or evening. During an interview on 7/31/25 at 8:59 a.m., life enrichment director (LED) verified she completed the Resident Preference Evaluation for R1 on 5/29/25. LED stated this was a newer form for the facility. LED reviewed the form and verified R1 had identified a bathing preference. LED stated she had not passed this information along as this was information nursing had always evaluated, and she thought nursing had this

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded, with the potential for inaccurate federal reimbursement and resident care planning for 1 of 5 residents (R48) reviewed for MDS accuracy. Findings include:The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2024, indicates clinical standards do not support reverse staging or back-staging as a way to document healing as it does not accurately characterize what is occurring physiologically as the ulcer heals, as the tissues lost will never be replaced with the same type of tissue (page M-7). The manual instructs that once a pressure ulcer is healed, it should be documented as a healed pressure ulcer at its highest numerical stage, as it would remain at an increased risk for future breakdown and require continued monitoring and preventative care (page M-8). The manual indicates that a previously closed pressure ulcer that reopens should be reported at its worst stage, unless currently presenting at a higher stage or unstageable (page M-7). The manual indicates that healed versus unhealed ulcers in the section refer to whether or not an ulcer is closed versus open (page M-2). The manual further defined a healed pressure ulcer as completely closed, fully epithelialized [to be covered by the tissue type typically making up the outer layer of healthy skin], covered completely with epithelial tissue or resurfaced new skin (page M-2).R48's quarterly Minimum Data Set (MDS) dated [DATE], indicated R48 had one stage two pressure ulcer that was not present on admission and no stage three pressure ulcers. R48's provider note dated 3/11/25, indicated the provider was able to visualize the depth of the wound, and R48 had a stage 3 pressure ulcer on her right foot between her toes. R48's wound note dated 6/19/25, indicated R48 had a recurrent stage two pressure ulcer on her right foot between her great and second toe that was currently unhealed with the presence of slough and increased drainage. R48's progress note dated 6/24/25, indicated the wound between the toes on the right foot remained open. R24's Comprehensive Skin Risk assessment dated [DATE], indicated R48 had a healed stage two pressure ulcer on her right foot between her right and second toe as the area was scabbed. During an interview on 7/29/25 at 1:27 p.m., registered nurse (RN)-C stated R48 had a recurrent skin injury that was between the great and next toe on her right foot. RN-C reviewed his notes and stated that the last time he saw that the wound was open was on 7/11/25.During an interview on 7/30/25 at 8:12 a.m., RN-D, an MDS coordinator, confirmed she had completed R48's latest quarterly MDS. RN-D confirmed R48's wound had not been healed at the time of assessment. RN-D stated she had coded the wound as a stage two but had not realized at the time that R48 previously had a stage three pressure ulcer in that spot. RN-D stated that usually, when someone has a pressure ulcer, they will add a diagnosis indicating this to the diagnosis list. RN-D stated that this was not completed, so she had not realized R48 previously had a stage three pressure ulcer in that same spot. RN-D stated that if she had known, she would have coded the wound as a stage three. During an interview on 7/30/25 at 12:46 p.m., nurse practitioner (NP)-A stated she had assessed R48's right foot pressure ulcer when it had first been found multiple months ago and had staged it as a stage three related to the wound's depth. NP-A stated the wound was between R48's in the crease between her first and second toe, was caused by pressure from her contracture, and had since recurred in the same spot. During an interview on 7/31/25 at 10:29 a.m., the director of nursing (DON) stated she would defer questions regarding the MDS to the MDS coordinator.The Facility's MDS 3.0 Assessment policy dated 8/20/24, indicated all interdisciplinary team members involved in completing portions of the MDS record must review and under the current version of the RAI user's manual. The policy indicated the MDS coordinator was responsible for conducting audits to identify errors and make appropriate corrections during the encoding period to ensure accurate information was submitted.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the dignity of 1 of 2 residents (R31) reviewed who were cognitively impaired and had facial hair. Findings include:R31's admission Minimum Data Set (MDS) assessment dated [DATE], identified admission to the facility on 7/10/25, with diagnoses of non-Alzheimer's dementia, arthritis, depression, and cataracts. R31 had moderate cognitive impairment, used a wheelchair for mobility, required substantial assistance from staff for hygiene to include combing hair, shaving, washing/drying face and hands, baths, showers, and oral hygiene.R31's care plan dated 7/10/25, identified activity of daily living (ADL) interventions for bed mobility, oral cares, toilet use, transfers, bathing and showering, dressing and eating. Bathing and showers required a mechanical lift with assist of two staff for transfers. The plan lacked interventions to address shaving or grooming facial hair. A care sheet for July 2025 lacked documentation R31 received any type of grooming or shaving facial hair.R31's behavior assessment report dated 7/17/25, identified no physical or verbal behaviors were directed towards staff. R31's N-Adv ADL Only report (a report in the electronic medical record used by nursing staff to review or audit documentation related to ADL's which are key for MDS assessments) dated 7/17/25, identified extensive assistance for personal cares.R31's N-Adv Resident Preferences Evaluation report, dated 7/17/25, indicated an interview for daily and activity preferences was not conducted. The first question on the evaluation was, should interview for daily and activity preferences be conducted and a box was checked NO. The questions on the evaluation were used to identify resident preferences, for example, time of day for bathing, dressing, or bedtime.R31's weekly bath log dated 7/15/25 and 7/29/25, indicated R31 received a bath and included a field to document the cleaning of a shaver. The report lacked documentation a shaver was cleaned.R31's admission care conference report dated 7/22/25, identified total assist with all ADLs. R31's Kardex dated 7/29/25, identified cares but lacked information that addressed grooming or shaving facial hair.During an observation on 7/28/25 at 5:01 p.m., R31 had several white chin hairs, approximately 1/4 inch long and a full white mustache. During an observation on 7/29/25 at 11:50 p.m., R31's chin hairs were still present after a bath.During an interview on 7/29/25 at 12:33 p.m., licensed practical nurse (LPN)-A stated R31 had a bath this morning and it was always on Tuesday mornings. During an interview on 7/29/25 at 12:37 p.m., nursing assistant (NA)-B stated R31's bath was given that morning and they would shave her chin hair, if asked. NA-B stated they believed residents had to bring in their own shaver and R31 did not have her own, so they wouldn't do it. NA-B confirmed R31 had chin hair and a mustache but did not have a shaver. During an interview on 7/29/25 at 12:40 p.m., nursing assistant (NA)-A stated residents needed to supply their own razors, and NA-A was aware of one female resident with a razor and wanted to be shaved. NA-A indicated most residents who refused to be shaved had documentation on the care plan. NAs document baths in the tub book binder located in each tub room and if residents were shaved, NAs document the shaver was cleaned.During an interview on 7/29/25 at 12:44 p.m., NA-B reviewed the tub book and verified R31 received a bath on 7/15/25. The column with clean shaver was marked with a straight line indicating the task was not completed. NA-B verified a bath was completed today, 7/29/25, but not charted in the tub book, but would be before the end of the shift. NA-B verified that R31 was not shaved during their baths. During an interview on 7/29/25 at 12:45 p.m., R31 was unable to state if facial hair bothered her. During an interview on 7/29/25 at 1:25 p.m., family member (FM)-A stated R31 would be bothered by having facial hair and used to tweeze chin hairs. R31 has been confused but they would expect the facility to take care of facial hair during baths.During an interview on 7/30/25 at 7:27 a.m., registered nurse (RN)-A stated the expectation was female facial hairs were plucked or shaved during their bath. Usually the assessment identified resident preferences, but if it was not documented that a resident refused it was expected to be done during their bath. The resident must supply a razor. During an interview on 7/30/25 at 9:01 a.m., nursing assistant (NA)-C verified R31 had hair above her lip (mustache) and several white chin hairs approximately 1/4 inch long. NA-C verified there was not a razor in R31's room but stated R31 would not refuse shaving if it was offered. During an interview on 7/31/25 at 10:42 a.m., the ADON stated the facility had personal care items available upon admission, but the family would need to supply specialty items. Bath aides should be offering shaving for female residents, and if a resident wanted to be shaved, the family was asked to bring in an electric razor. If a resident did not have family, they could work with the clinical coordinators for donations but wouldn't leave a resident unshaved unless it was their preference. The ADON

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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** Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 2 residents (R3) reviewed for infection control related to the management of a tube feeding.Findings include:R53's quarterly Minimum Data Set (MDS) dated [DATE], indicated R53 was cognitively intact, and had no behaviors or hallucinations. MDS also indicated R53 had difficulty swallowing and received enteral feeding via a tube.R53's Clinical Diagnosis Report dated 7/31/25, indicated dysphagia following cerebral infarction, pharyngeal dysphagia, diverticulum of esophagus, gastrostomy, anxiety and gastro esophageal reflux.R53's Clinical Orders Report indicated R53 had orders for enteral feeding, medications via tube feeding, and nothing per mouth. Orders Report also indicated special instructions for EBP.R53's care plan printed on 7/31/25, titled feeding tube, directed staff to use infection control precautions and related techniques following the manufacture recommendations when stopping, starting, flushing, and giving medications through the feeding tube.During observation on 7/28/25 at 3:28 p.m., a sign posted on R53's door indicated R53 was under EBP and identified staff must wear gloves and a gown for high contact resident care activities including cares or use of the feeding tube. During observation on 7/28/25 at 3:33 p.m. , registered nurse (RN)-E entered R53's room, washed her hands, put on gloves, but did not put on a gown. RN-E explained to R53 she was scheduled to received Tylenol, a water flush, and it was time to start her tube feeding. RN-E did not wear a gown throughout these procedures.During interview on 7/28/25 at 4:11 p. m., RN-E stated I was supposed to wear a gown, and I did not. I just forgot. RN-E stated R53 was on EBP precaution because she had a tube feeding and was at risk for infections.During interview on 7/31/25 at 9:40 a.m., nursing assistant (NA)-E stated staff did yearly training online, and throughout the year they did specific training for different infections. NA-E added, we just had additional training last week about standard precautions. There are signs posted in the residents' doors instructing staff to wear protective equipment like gowns, gloves, and sometimes masks. We need to read the signs before we enter the rooms to make sure we don't spread infections. We must wear the equipment to prevent giving something to the patients that are already compromised and to protect ourselves.During interview on 7/31/25 at 9:47 a.m., licensed practical nurse (LPN)-E, stated when a resident received medications through a tube feeding, he or she would be on enhanced barrier precautions. We will need to wash our hands, wear gloves and gown to prevent the spread of infections. We receive infection control education at least a couple times a year and at every nurses monthly meeting we talk about it.During interview on 7/31/25 at 9:54 a.m., assistant director of nursing/infection control nurse (ADON) stated, RN-E was supposed to wear a gown while caring for R53 because R53 had a tube feeding and the nurse administered a medication, flushed the tube with water and started R53's tube feeding. ADON stated the EBP was in place to protect R53 from infection or bacteria, and to protect the staff, as it was an infection control concern for the resident.Facility policy titled Enhanced Barrier Precautions dated 8/20/2024 indicated facility will apply EBP to prevent the spread of multidrug-resistant organisms (MDROs). Policy indicated EBPs shall be used when providing high contact care to residents who are colonized or are infected with an MDRO when contact or other precautions do not apply. EBP should also be used for residents with chronic wound and/or indwelling medical devices (e.g., urinary catheters, feedings tubes, central lines, tracheostomy).