DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 3, 2026

Administrator
Lifecare Roseau Manor
715 DELMORE DRIVE
ROSEAU, MN 56751

RE: CCN:245470
Cycle Start Date: February 19, 2026

Dear Administrator:

On February 19, 2026, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 May 19, 2026 (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 August 19, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us

Web: www.sfm.dps.mn.gov

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245470	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lifecare Roseau Manor	**715 DELMORE DRIVE , ROSEAU, Minnesota, 56751**

(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
E0000	Initial Comments On 2/17/26 through 2/19/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		03/12/2026
F0000	INITIAL COMMENTS On 2/17/26 through 2/19/26. a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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. 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.	F0000		03/12/2026
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as	F0585	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident identified in the citation was on end of life care during survey window and expired on 2/21/26. When concerns were brought to DON on 2/19/26, follow up with care coordinator was completed. Per care coordinator and MDS supervisor who had a conversation	03/20/2026

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 reverse for further 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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F0585 SS = D	Continued from page 1 that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;	F0585	Continued from page 1 with R2's family about concerns, the medication found was from weeks prior to when concern was brought forward. On 2/19/26 DON instructed nurse to check all the medications in the memory care unit cart. Pill resembled metformin that 3 residents in memory care have orders for. R2 did not have an order for this medication. Blood sugar monitoring reviewed for last month for all 3 residents. No concerns noted. Medication administration reviewed for all 3 residents for Jan 2026 and Feb 2026 with no missed doses noted. LSW interviewed 10 residents throughout the facility that are able to express concerns. LSW asked 10 residents if there are any complaints or issues we did not resolve? All 10, plus one resident representative stated no. She asked if they will let us know of any complaints? All ten responded yes. She asked if there were any complaints right now. 9 stated no. One stated that they did not like there mattress. Air mattress added to bed. LSW reached out to residents' daughter about purchasing a foam overlay if resident agreed. "Complaint/Formal Grievance in LTC" policy created and staff education. How the facility will identify other residents having the potential to be affected by the same deficient practice. Complaint spreadsheet added to Shared IDT folder. Complaint discussion added to IDT agenda. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not recur. "Complaint/Formal Grievance in LTC" policy created to include processes for both complaints and grievances. Education staff on new policy/process. How the facility will monitor its corrective actions to	

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F0585 SS = D	Continued from page 2 (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to follow through on a grievance regarding medication found in recliner for 1 of 1 resident (R2) reviewed for grievances. Findings include: R2's quarterly Minimum Data Set (MDS) dated 2/5/26, identified R2 had severe cognitive impairment and diagnoses included dementia, anxiety, and depression. R2's care plan revised 2/10/26, identified R2 preferred medications crushed in vanilla pudding. An e-mail dated 2/12/26 at 5:31 p.m., identified family member (FM)-B reported to registered nurse (RN)-B that FM-B reported to the charge nurse two whole pills were found on R2's chair (one with an imprint "C") and R2's Wanderguard (device to monitor exiting) was found on	F0585	Continued from page 2 ensure that the deficient practice is being corrected and will not recur. Audits to be completed by director of nursing or designee of complaint/grievances weekly for 12 weeks and report to QAPI, to ensure that all staff are following new policy and that they are resolved timely. The date that each deficiency will be corrected. 3/20/26	

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F0585 SS = D	Continued from page 3 R2's bed footboard. FM-B identified R2's medications were crushed, and the family was unsure if the pills found were missing doses or dropped pills. The e-mail included three photos. The first photo was a broken pill with an imprinted c and light orange in color. The second photo was a pill broken in half, orange in color and partially dissolved. The third photo was a Wanderguard wrapped around the footboard. During a telephone interview on 2/17/26 at 5:45 p.m., FM-A stated on 2/12/26 FM-A and FM-B were at the facility to visit R2. FM-A and FM-B found a "pill" in R2's chair in R2's room, then found another on the floor even though R2 took her medications crushed. When FM-A and FM-B brought the pill to nursing, they were told the facility could not determine what the medication was nor where it came from. FM-A stated it made her feel "awful" that R2 was cared for this way. FM-A brought other concerns to the director of nursing (DON), however, FM-A stated she was just told it shouldn't be that way, but the facility didn't really do anything about it. During an interview on 2/18/26 at 5:00 p.m., FM-B stated it was "crazy". On 1/12/26, after visiting R2, FM-B and FM-A found a pill in R2's chair. FM-B took a photo of the pill and brought the pill to the charge nurse. R2's wandguard was also at the foot of R2's bed. The following day, FM-B sent an e-mail to the care coordinator. FM-B stated it was half a pill that had been scored with another small portion next to it. FM-B stated she was told it was "weird" because R2's medications were crushed before administration. FM-B stated she was told the care coordinator spoke with staff who didn't know what the pill was. During an interview on 2/19/26 at 8:36 a.m., registered nurse (RN)-A stated she was the care coordinator for R2. When a family member reports a concern, RN-A makes a "note of it." RN-A or the social worker would interview the resident. If the resident cannot be interviewed, RN-A would figure out what she could and would report back to the family what was found. This should be documented in the resident's chart in a family communication note. However, RN-A stated there was no way to run a report for these concerns in order for the facility to track the different concerns to determine if there was a pattern. RN-A sated she was aware of FM-B's concern regarding an unknown medication found in R2's room. However, RN-A stated no formal grievance was documented and no formal grievance was completed. RN-A stated FM-B's email didn't provide how long the medication was there, where the chair came from because the chairs were not static to resident	F0585		

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F0585 SS = D	Continued from page 4 rooms, and there wasn't enough information for RN-A to investigate further. RN-A did not call and speak with FM-A to obtain clarifying information. RN-A took the photo from the e-mail and looked at R2's medication cassettes from the medication car and didn't find a match. RN-A did not review other resident medication cassettes to determine if there was a possible match. RN-A then e-mailed FM-A to let her know she couldn't determine what the medication was nor where it came from. No further investigation was completed. During an interview with the director of nursing (DON) and licensed social worker (SS)-A on 2/19/26 at 9:52 a.m., SS-A stated most complaints come to her. Then, SS-A would talk to the DON and together they would determine a solution. The DON stated there was a formal grievance process, however, if they were able solve the problem the formal process wasn't followed. During an interview on 2/19/26 at 1:45 p.m., the administrator stated staff were expected to report complaints to the charge nurse who reported concerns to the administration. Staff were able to use e-mail or phone after hours and administration would follow up. An investigation and resolution should be documented. The Patient Complaint of Grievance Policy revised 10/11/24, identified the facility informed patients of their rights, including the right to resolution of grievance. Complaints and grievances related to patient care and services at the facility were addressed according to the following guidelines. Patients and/or their representatives voicing a complaint or making a grievance would not jeopardize the quality of care or access to future health care services. Procedure: A. Grievances submitted to facility personnel in writing, verbally, via e-mail, or over the telephone are forwarded to the Director of Quality & Risk Management or the Director of Clinic Operations, who are considered the patient advocate/patient representatives. In the event the Director of Quality & Risk Management or the Director of Clinic Operations is not available, this role will be assumed by the Chief Nursing Officer or other administrative personnel. B. The facility's staff in receipt of a grievance will communicate with the patient or their representative regarding the plan to investigate and follow-up the grievance. C. The investigation of the grievance shall be	F0585		

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F0585 SS = D	Continued from page 5 conducted by the Director of Quality & Risk Management or Director of Clinic Operations, who will collaborate with the areas involved. The medical staff peer review process will be used to investigate a grievance concerning the quality of medical care as needed. D. All grievances will have a prompt written or verbal response, within 7 days if possible depending upon the nature of the grievance. For more complicated grievances requiring extensive investigation and analysis, the Director of Quality & Risk Management will contact the patient or their representative stating that the hospital is still working on the response, which they should expect within 30 days if possible. Exception: Grievances regarding situations that endanger the patient shall be addressed immediately. E. All grievances are followed-up in writing. The final written response shall include the name of the facility, a contact person at the facility, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. All grievance response letters will be mailed to the patient's home address unless the patient or representative has asked otherwise. F. Tracking of complaints/grievances and identifying trends is an important part of the quality improvement process. Grievance information is aggregated, tracked, trended and communicated by the Director of Quality and Risk Management or designee to leadership on an as-needed basis.	F0585		
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive assessment following resident to resident incidents to maintain safety of the residents for 1 of 5 residents (R2) reviewed for dementia care. Findings include:	F0744	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident identified in the citation was on end of life care during survey window and expired on 2/21/26. Psychoactive drug assessments completed on all residents in memory care unit. Behavior monitoring and intervention were reviewed for each resident in memory care unit. Based on charting and assessments, care plan reviews were conducted with DON, MDS coordinator, LSW and care coordinator for each individual in the memory care unit. There are no current like residents residing in memory care unit. How the facility will identify other residents having	03/20/2026

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F0744 SS = D	Continued from page 6 R2's quarterly Minimum Data Set (MDS) dated 2/5/26, identified R2 had severe cognitive impairment and diagnoses included dementia, anxiety, and depression. R2 exhibited physical behaviors directed towards others (for example: hitting, kicking, pushing, grabbing) 4-6 days, verbal behavioral symptoms directed towards others 4-6 days, other behavioral symptoms not directed towards others such as hitting/scratching self 1-3 days, rejection of care 4-6 days, and wandering 4-6 days. R2 required setting up or clean up assistance with eating, substantial/maximal assistance for toileting and was dependent on staff for all other care areas. R2 used antipsychotic, antianxiety, antidepressant, diuretic, and medications. R2's Delirium Care Area Assessment (CAA) dated 11/18/25, identified inattention, disorganized thinking, and altered level of consciousness had been R2's baseline since her initial admission more than nine months ago which led to her requiring 24-hour supervision and activities of daily living (ADL) assistance. This was not new or worsening. This had been R2's baseline for more than a year per R2's family. R2's Behavioral Symptoms CAA dated 11/18/25, identified R2's goal was to continue to attempt to express self and avoid complication such as social isolation and avoidance behaviors. Staff were to provide simple step by step instructions, allow time to process and respond, don't offer too many choices, repeat and rephrase as needed, provide verbal and nonverbal prompts and cues, approach in a calm and unhurried manner, offer smiles, list potential needs one at a time and observe for indication/acknowledgement that was what she wants/needs, provide reassurance, leave alone in safe situation and return later when unable to console or deescalate agitation, administer medications as ordered for anxiety, depression, agitation and observe for adverse effects and notify R2's physician of concerns, document target behaviors for physician to review with ongoing visits/consults. R2 was at risk for miscommunication, frustration, agitation, worsening symptoms of anxiety and depression, falls with injury, adverse effects of medications, social isolation, escalating adverse behaviors, unmanaged pain, and unmet needs. Medications were monitored per policy with behavioral health consultations. R2's Cognitive Loss/Dementia CAA dated 11/18/25, identified R2's goal was to continue to make her needs known, minimize risks, and avoid complications. Staff were to assist with communication with verbal and nonverbal prompts and cues, allow time to process and	F0744	Continued from page 6 the potential to be affected by the same deficient practice. Nurse coordinator, MDS nurse, DON, and LSW will meet weekly to review care plans. Review changes with resident daily Monday-Friday at IDT and MDS coordinator will update care plan as needed with changes. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not recur. Nurse coordinator, MDS nurse, DON, and LSW will meet weekly to review care plans. Review changes with resident daily Monday-Friday at IDT and MDS coordinator will update care plan as needed with changes. Review and revise quality of care/quality of life policy. Review and revise care planning policy- add dementia care planning. Educate all staff on revisions to policies. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits to be completed by director of nursing or designee of care plan reviews and that care plans are updated to reflect current behaviors/trigger and interventions weekly for 12 weeks and report audit findings to QAPI, specific to resident with dementia diagnosis. The date that each deficiency will be corrected. 3/20/26	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lifecare Roseau Manor	**715 DELMORE DRIVE , ROSEAU, Minnesota, 56751**

(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
F0744 SS = D	Continued from page 7 respond, offer reassurance, and allow to vent frustrations. R2 was at risk for miscommunication, frustration, anxiety, depression, adverse behaviors, and unmet needs. R2's Psychotropic Drug Use CAA dated 11/18/25, identified R2's goal was to continue to attempt to express self and avoid complications such as social isolation and avoidance behaviors. Staff were to provide simple step by step instructions, allow time to process and respond, don't offer too many choices, repeat and rephrase as needed, provide verbal and nonverbal prompts and cues, approach in a calm and unhurried manner, offer smiles, list potential needs one at a time and observe for indication/acknowledgement that is what she wants/needs, provide reassurance, leave alone in safe situation and return later when unable to console or deescalate agitation, administer medications as ordered for anxiety, depression, agitation and observe for adverse effects and notify R2's physician of concerns, document target behaviors for R2's physician to review with ongoing visits/consults. R2 was at risk for miscommunication, frustration, agitation, worsening symptoms of anxiety and depression, falls with injury, adverse effects of medications, social isolation, escalating adverse behaviors, unmanaged pain, and unmet needs. Medications are monitored per policy with behavioral health consultations. R2's care plan revised 2/10/26, identified R2's target behaviors included wandering, poor safety awareness, verbal aggression, physical aggression, crying out that was disruptive to others, unable to understand boundaries, elopement risk, and grabs on to other walkers/items. The care plan identified nonpharmacological interventions to try, such as calm, hurried approach; approach with 1 or 2 staff; leave alone and return later when safe to do so; and distract with snacks. R2's Physical Aggression Initiated dated 12/3/25 at 3:30 p.m., identified R2 was attempting to enter another resident's room. When the other resident said, "go to your own room", R2 stated "shut up you bitch" and then swung her hand toward the other resident's face. The other resident raised her arm and stopped the blow with her forearm. Staff stepped between the residents and R2 swung a second time. R2's hand connected with the other resident's forehead before staff was able to completely stop R2. Staff reported the hit as "weak". Immediate action taken was the residents were separated and redirected. However, the document failed to identify potential triggers for R2's	F0744		

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F0744 SS = D	Continued from page 8 behavior or potential interventions to prevent further incidents. R2's Physical Aggression Initiated dated 12/5/25 at 12:15 p.m., identified staff reported R2 hit another resident on the right shoulder four times as staff was attempting to get R2 to let go of the other resident's walker. Staff stated it was possible R2 was attempting to hit staff and not the other resident. R2 was unable to provide a description of the incident. The immediate action taken was staff intervened and redirected R2 with another activity. However, the document failed to identify potential triggers for R2's behavior or potential interventions to prevent further incidents. R2's nursing progress note dated 12/9/25 at 11:30 a.m., identified R2 had a behavioral health video appointment regarding management of psychotropic medications related to dementia with aggressive behaviors and anxiety. R2's provider was informed R2 had an increase in verbal and physical aggression toward staff and other residents. The incidents appeared to be triggered by R2 not getting her way (for example, being told she could not have something another resident already had) or when ADLs were being attempted. The noted further identified a review of R2's psychotropic medications were completed, but no nonpharmacological interventions were discussed. R2's Physical Aggression Initiated dated 12/18/25 at 6:00 p.m., R2 was attempted to squeeze between the wall and another resident's wheelchair in the dining room. Staff tried to tell R2 to stop because there was not enough room to safely pass. R2 became aggressive swinging out and hitting staff several times, pulling hair, pinching skin. The other resident also told her to stop, and R2 hit him once on the back of the neck. The other resident was not injured. A few minutes later R2 tried taking silverware from another resident. This resident asked her to stop, and R2 swung out at him, but he raised his arm and blocked R2's punch. The immediate action taken was R2 was redirected, staff took R2 for a walk down the hall and R2 eventually sat down in a chair. However, the document failed to identify potential triggers for R2's behavior or potential interventions to prevent further incidents. R2's nursing progress note dated 1/6/26 at 8:39 a.m., identified R2 had a behavioral health video appointment regarding management of psychotropic medications related to dementia with aggressive behaviors and anxiety. A review of staff notes was completed to evaluate whether the last medication change was effective. Based on documentation, R2 had been	F0744		

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F0744 SS = D	Continued from page 9 sleepier, has not been aggressive toward other residents but has been physically and verbally aggressive with staff at times when cares are attempted. The note further identified that a review of R2's psychotropic medications was completed, but no nonpharmacological interventions were discussed. During a telephone interview on 2/17/26 at 5:45 p.m., family member (FM)-A stated she and FM-B had visited R2 on 2/12/26. R2 had been up all night and hadn't had cares and eaten. FM-A stated the staff let R2 lie in bed all day and then R2 was up all night. FM-A stated they had discussed R2's behaviors with the facility many times and they were told the facility would provide more training to the staff on how to care for a resident with dementia. During an interview on 2/18/26 at 4:50 p.m., nursing assistant (NA)-A stated R2 had a lot of behaviors and could get combative with staff and other residents. "You don't see it coming." NA-A stated she didn't trust R2 around the other residents and immediately stepped between them whether R2 was agitated or not because R2 could hit hard. During an interview on 2/18/26 at 5:00 p.m., FM-B stated there were times when family visited R2 didn't have her glasses, dinner will just sit there, and staff did not offer to assist R2. A lot of the time, R2 just remained in her bed or room in the dark with alarms blaring. FM-B stated it wasn't fair to R2, "she's just existing". During an interview on 2/19/26 at 7:52 a.m., NA-B stated R2 was "difficult" resident and had a lot of behaviors. R2 was unpredictable and, in the previous weeks, R2's behavior had gotten a lot worse. R2 was very clingy and would "hang" on you. Staff tried their best to keep R2 away from other residents. For example, if a resident was sitting in a chair and R2 wanted to sit there or was trying to move the chair and staff tried to redirect R2, R2 would become angry and start hitting the staff and R2 could hit the other resident too. That's why staff tried to keep R2 away. R2 would cling to one person so staff would have to ask for help and the help had to do whatever was needed because R2 wouldn't let the staff go. Also, if the staff did get away from R2, that would make R2's behaviors worse. Staff just had to do their best to keep R2 away from the other residents. Some days, R2 would sleep all day. Some days, R2 was up all day. Staff never knew. Staff were just told that if R2 was sleeping to not ask if R2 wanted to get up. Staff were to be encouraging to R2 to get up for the day.	F0744		

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F0744 SS = D	Continued from page 10 During an interview on 2/19/26 at 8:09 a.m., trained medication aide (TMA)-A stated R2 was very combative. Any time staff had to “touch” R2 it made R2 more combative. R2 was unable to understand every small, direct communication and nothing calmed R2 except R2’s family. R2 could be vulgar too. TMA-A stated she had never witnessed or been told R2 was combative with other residents. During an interview on 2/19/26 at 8:36 a.m., registered nurse (RN)-A stated staff were expected to report all resident-to-resident incidents immediately. First, staff were directed to ensure all residents were safe, separated and without injury. Then, the charge nurse would report the incident to the administrator and social worker. Then, an investigation of the incident would occur, and family was notified. All incidents were then discussed during the interdisciplinary team (IDT) meeting. For R2’s resident-to-resident incidents, staff were just to monitor. The facility used the communication page of the electronic medical record system, however, RN-A stated she could not determine if a communication had been entered regarding R2’s behaviors and/or possible interventions to prevent resident-to-resident incidents. R2's medical record lacked evidence a comprehensive assessment was completed following each incident to identify potential new interventions to keep R2 and others safe. During an interview with the director of nursing (DON) and licensed social worker (SS)-A on 2/19/26 at 9:52 a.m., the DON stated staff had been working with R2’s behavioral health provider to adjust R2’s medications but R2’s family was hesitant to follow recommendations. R2 was difficult because there wasn’t really any sign of aggression. R2 could be happy or R2 could be tired and could be fine. There wasn’t any way to determine the trigger of R2’s behaviors. However, the DON stated a lot of behaviors did occur when R2 was told no or during cares. During the facility’s psychotropic meeting, staff review the behavior charting and see if there was anything the nursing assistants were seeing/charting but not reporting up. Then the care plan was reviewed and updated if needed. This was done quarterly. The DON stated she did not know what could have been care planned to help prevent R2’s resident-to-resident incidents. During an interview on 2/19/26 at 1:45 p.m., the administrator stated staff were expected to recognize potential signs of aggressive behaviors, identify root	F0744		

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F0744 SS = D	Continued from page 11 causes, to create potential interventions to prevent incidents and to care according to what had been decided on as a team. Also, staff were expected to reassess and change the care plan as needed. The facility Care Planning policy revised 6/09, identified a care plan would be developed and maintained on each resident according to the RAI guidelines to provide mandated and essential information in an organized manner to develop and maintain a plan of care for each resident. A facility policy regarding dementia care was requested but not received.	F0744		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a schedule 2 narcotic (a medication with a high potential for abuse) was stored in a manner to prevent diversion for 1 of 3 units (Maple Unit); and failed to monitor temperature on a	F0761	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Thermometers added to the fridge and freezer in Memory care medication room fridge on 2/19/26. Education provided on 2/19/26 to the TMA working on 2/19/26 in memory care about locking the medication cabinet in medication room if there are controlled drugs in storage. How the facility will identify other residents having the potential to be affected by the same deficient practice. Memory Care fridge/freezer added to charge nurse nightly fridge temp log. Education provided to the nursing staff that all medication fridges need to be checked daily. Re-education to be provided to all nursing staff (RNs, LPNs, and TMAs) about controlled substance storage policy. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not recur. Memory Care fridge/freezer added to charge nurse	03/20/2026

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F0761 SS = D	Continued from page 12 medication refrigerator temperatures of 1 of 2 medication fridges (Maple Unit) reviewed for medication storage. Findings include: During observation on 2/19/26 at 8:25 a.m., the director of nursing (DON) did a tour of the medication room on the Maple unit (memory care unit). Upon entering the locked medication room on the unit, it was observed there were keys in a lock on one of the cupboards. The DON reached up and pulled the cupboard door open as it was not locked. In the cupboard there was a 30-milliliter (ml) unopened bottle of liquid morphine (a scheduled 2 narcotic). The medication refrigerator did not have a thermometer inside of it nor was there evidence the temperatures were monitored. The refrigerator contained two vials of injectable lorazepam 2 milligrams (mg)/ml. for R22. The refrigerator had cool air coming out upon opening and the freezer had some frost buildup. During an interview on 2/19/26 at 8:40 a.m., the DON stated the liquid morphine needed to be double locked and it wasn't. When staff were done in the medication room, they should have locked all locks and taken the keys with them to ensure resident safety. The refrigerator temperature should be monitored daily and there should be a thermometer in the refrigerator to ensure the efficacy of the residents' medications were maintained. There was no evidence there was missing morphine, or the fridge temperature was out of range. During an interview on 2/23/26 at 9:35 a.m., the consulting pharmacist (CP) returned a call from 2/18/26. The CP stated that schedule 2 narcotics are to be double locked for safety and refrigerator needed the temperature to be monitored to ensure medication stability. The facility's Labeling and Storing of Medication policy dated May 2009, identified schedule 2 medications were to be locked with double locks. The policy did not address the monitoring of medication refrigerators.	F0761	Continued from page 12 nightly fridge temp log. Education provided to the nursing staff that all medication fridges need to be checked daily. Re-education to be provided to all nursing staff (RNs, LPNs, and TMAs) about controlled substance storage policy and temp log policy. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits to be completed by director of nursing or designee of medication rooms weekly for 12 weeks and report to QAPI to ensure controlled medications are stored properly and fridge temps are being monitored daily. The date that each deficiency will be corrected. 3/20/26	

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/17/2026. At the time of this survey, Lifecare Roseau Manor was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:	K0000		03/12/2026

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 reverse for further 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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K0000	Continued from page 1 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Lifecare Roseau Manor was built at two different times. The first building was an addition to the hospital and was built in 1972. It is 1-story with a basement and was determined to be Type II(111) construction with a 2- hour fire barrier between the hospital and the care manor. In 1993 an addition was built to the north of the original structure, is 1-story with a basement and determined to be Type II (000) construction. The facility is divided into 7 smoke zones, two on the basement level, by 30 minute and 2-hour fire barriers. The facility is completely sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system which includes corridor smoke detection throughout and in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code". All sleeping rooms have smoke detectors and all hazardous areas have automatic fire detectors. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 39 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and	K0345	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Sensitivity testing scheduled to be completed on 4-15-26 by Johnson Control. How the facility will identify other residents having the potential to be affected by the same deficient	04/15/2026

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K0345 SS = F	Continued from page 2 NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 14.2.1.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/17/2026 at 2:02pm, it was revealed by a review of available documentation that the annual fire alarm inspection report produced by Johnson Control dated 04/14/2025 that the facility could not provide documentation that a sensitivity testing had been conducted. . An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0345	Continued from page 2 practice. Facility will ensure sensitivity report is completed with annual fire alarm inspections. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not recur. Will put on annual preventative maintenance checklist to ensure the report is completed along with the annual fire alarm inspections. How the facility will monitor it's corrective actions to ensure that the deficient practice is being corrected and will not recur. Will put on annual preventative maintenance checklist to ensure the report is completed along with the annual fire alarm inspections. The date that each deficiency will be corrected. 4-15-26	
K0353 SS = E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K0353	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Removed improper stored items by LifeCare staff on 3-4-26. How the facility will identify other residents having the potential to be affected by the same deficient practice. Removed improper stored items by LifeCare staff on 3-4-26. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not recur. Provide education to staff about storing items over 18 inches from sprinkler heads. Will complete random audits of sprinkler head obstructions weekly X 12 weeks. Will report findings to QAPI committee. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.	03/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245470	(X2) MULTIPLE CONSTRUCTION A. BUILDING **CN - ROSEAU C & NC** B. WING	(X3) DATE SURVEY COMPLETED **02/17/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lifecare Roseau Manor	**715 DELMORE DRIVE , ROSEAU, Minnesota, 56751**

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K0353 SS = E	Continued from page 3 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 02/17/2026 at the following times, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in the following areas: 1) at 2:29pm, high piles storage in the pine wing clean utility room 2) at 2:32pm, high piled storage in the pine wing central storage 3) at 3:09pm, high piled storage in the volunteer services storage room An interview with the Director of Maintenance verified these deficient findings at the time of discovery	K0353	Continued from page 3 Will complete random audits of sprinkler head obstructions weekly X 12 weeks. Will report findings to QAPI committee. The date that each deficiency will be corrected. 3-20-26	
K0372 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)	K0372	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Penetrations on memory wing and therapy housekeeping closet were sealed by LifeCare Maintenance staff on 3-5-26. How the facility will identify other residents having the potential to be affected by the same deficient practice. Penetrations on memory wing and therapy housekeeping closet were sealed by LifeCare Maintenance staff on 3-5-26. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not	03/05/2026

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K0372 SS = F	Continued from page 4 Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/17/2026 at the following times, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors in the following areas. 1) at 2:54pm, penetration in fire wall on memory wing 2) at 2:58pm, penetration in fire wall in therapy house keeping closet An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0372	Continued from page 4 recur. Will complete random audits weekly X 12 weeks to identify for potential penetrations. Results will report results to QAPI committee. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Will complete random audits weekly X 12 weeks to identify for potential penetrations. Results will report results to QAPI committee. The date that each deficiency will be corrected. 3-5-26	
K0374 SS = E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1,	K0374	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Penetrations on memory wing and therapy housekeeping closet were sealed by LifeCare Maintenance staff on 3-5-26. How the facility will identify other residents having the potential to be affected by the same deficient practice. Penetrations on memory wing and therapy housekeeping closet were sealed by LifeCare Maintenance staff on 3-5-26. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not recur. Will complete random audits weekly X 12 weeks to identify for potential penetrations. Results will report results to QAPI committee. How the facility will monitor it’s corrective actions to ensure that the deficient practice is being	03/05/2026

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K0374 SS = E	Continued from page 5 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/17/2026 at the following times, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors in the following areas. 1) at 2:54pm, penetration in fire wall on memory wing 2) at 2:58pm, penetration in fire wall in therapy house keeping closet An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0374	Continued from page 5 corrected and will not recur. Will complete random audits weekly X 12 weeks to identify for potential penetrations. Results will report results to QAPI committee. The date that each deficiency will be corrected. 3-5-26	
K0521 SS = F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/17/2026, at 1:18pm, it was revealed by a review of available documentation that the facility could not provide a fire damper inspection report. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0521	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? Damper inspection will be completed by CL Linfoot on 3-31-26. Facility will obtain inspection report at that time. How the facility will identify other residents having the potential to be affected by the same deficient practice. Damper inspection will be completed by CL Linfoot on 3-31-26. Facility will obtain inspection report at that time. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not recur. Placed on a preventative maintenance checklist to ensure inspections are completed every 4 years. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Placed on a preventative maintenance checklist to ensure inspections are completed every 4 years. The date that each deficiency will be corrected. 3-31-26	03/31/2026
K0901 SS = D	Fundamentals - Building System Categories	K0901	How corrective action will be accomplished for those residents found to have been affected by the deficient	03/10/2026

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K0901 SS = D Bldg. CN	Continued from page 6 CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/17/2026 at 2:08pm, it was revealed during documentation review and an interview with the Environmental Services that a complete utility risk assessment document could not be provided at the time of the survey. The document provided was missing date of completion and any reference on review time frames. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0901	Continued from page 6 practice? Utilities risk assessment was completed on 3-10-26 by maintenance staff. How the facility will identify other residents having the potential to be affected by the same deficient practice. Utilities risk assessment was completed on 3-10-26 by maintenance staff. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not recur. Utilities risk assessment will be reviewed annually and updated as needed. This will be placed on preventative maintenance checklist. How the facility will monitor it’s corrective actions to ensure that the deficient practice is being corrected and will not recur. Utilities risk assessment will be reviewed annually and updated as needed. This will be placed on preventative maintenance checklist. The date that each deficiency will be corrected. 3-10-26	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 18, 2026

Administrator
Lifecare Roseau Manor
715 DELMORE DRIVE
ROSEAU, MN 56751

RE: CCN: 245470
Cycle Start Date: February 19, 2026

Dear Administrator:

On March 3, 2026, we notified you a remedy was imposed. On April 17, 2026 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 15, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 19, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 31, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 19, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 15, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Ritke-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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E0000	Initial Comments On 2/17/26 through 2/19/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		03/12/2026
F0000	INITIAL COMMENTS On 2/17/26 through 2/19/26. a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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. 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.	F0000		03/12/2026
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as	F0585	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident identified in the citation was on end of life care during survey window and expired on 2/21/26. When concerns were brought to DON on 2/19/26, follow up with care coordinator was completed. Per care coordinator and MDS supervisor who had a conversation	03/20/2026

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 reverse for further 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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F0585 SS = D	Continued from page 1 that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;	F0585	Continued from page 1 with R2's family about concerns, the medication found was from weeks prior to when concern was brought forward. On 2/19/26 DON instructed nurse to check all the medications in the memory care unit cart. Pill resembled metformin that 3 residents in memory care have orders for. R2 did not have an order for this medication. Blood sugar monitoring reviewed for last month for all 3 residents. No concerns noted. Medication administration reviewed for all 3 residents for Jan 2026 and Feb 2026 with no missed doses noted. LSW interviewed 10 residents throughout the facility that are able to express concerns. LSW asked 10 residents if there are any complaints or issues we did not resolve? All 10, plus one resident representative stated no. She asked if they will let us know of any complaints? All ten responded yes. She asked if there were any complaints right now. 9 stated no. One stated that they did not like there mattress. Air mattress added to bed. LSW reached out to residents' daughter about purchasing a foam overlay if resident agreed. "Complaint/Formal Grievance in LTC" policy created and staff education. How the facility will identify other residents having the potential to be affected by the same deficient practice. Complaint spreadsheet added to Shared IDT folder. Complaint discussion added to IDT agenda. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not recur. "Complaint/Formal Grievance in LTC" policy created to include processes for both complaints and grievances. Education staff on new policy/process. How the facility will monitor its corrective actions to	

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F0585 SS = D	Continued from page 2 (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to follow through on a grievance regarding medication found in recliner for 1 of 1 resident (R2) reviewed for grievances. Findings include: R2's quarterly Minimum Data Set (MDS) dated 2/5/26, identified R2 had severe cognitive impairment and diagnoses included dementia, anxiety, and depression. R2's care plan revised 2/10/26, identified R2 preferred medications crushed in vanilla pudding. An e-mail dated 2/12/26 at 5:31 p.m., identified family member (FM)-B reported to registered nurse (RN)-B that FM-B reported to the charge nurse two whole pills were found on R2's chair (one with an imprint "C") and R2's Wanderguard (device to monitor exiting) was found on	F0585	Continued from page 2 ensure that the deficient practice is being corrected and will not recur. Audits to be completed by director of nursing or designee of complaint/grievances weekly for 12 weeks and report to QAPI, to ensure that all staff are following new policy and that they are resolved timely. The date that each deficiency will be corrected. 3/20/26	

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F0585 SS = D	Continued from page 3 R2's bed footboard. FM-B identified R2's medications were crushed, and the family was unsure if the pills found were missing doses or dropped pills. The e-mail included three photos. The first photo was a broken pill with an imprinted c and light orange in color. The second photo was a pill broken in half, orange in color and partially dissolved. The third photo was a Wanderguard wrapped around the footboard. During a telephone interview on 2/17/26 at 5:45 p.m., FM-A stated on 2/12/26 FM-A and FM-B were at the facility to visit R2. FM-A and FM-B found a "pill" in R2's chair in R2's room, then found another on the floor even though R2 took her medications crushed. When FM-A and FM-B brought the pill to nursing, they were told the facility could not determine what the medication was nor where it came from. FM-A stated it made her feel "awful" that R2 was cared for this way. FM-A brought other concerns to the director of nursing (DON), however, FM-A stated she was just told it shouldn't be that way, but the facility didn't really do anything about it. During an interview on 2/18/26 at 5:00 p.m., FM-B stated it was "crazy". On 1/12/26, after visiting R2, FM-B and FM-A found a pill in R2's chair. FM-B took a photo of the pill and brought the pill to the charge nurse. R2's wandguard was also at the foot of R2's bed. The following day, FM-B sent an e-mail to the care coordinator. FM-B stated it was half a pill that had been scored with another small portion next to it. FM-B stated she was told it was "weird" because R2's medications were crushed before administration. FM-B stated she was told the care coordinator spoke with staff who didn't know what the pill was. During an interview on 2/19/26 at 8:36 a.m., registered nurse (RN)-A stated she was the care coordinator for R2. When a family member reports a concern, RN-A makes a "note of it." RN-A or the social worker would interview the resident. If the resident cannot be interviewed, RN-A would figure out what she could and would report back to the family what was found. This should be documented in the resident's chart in a family communication note. However, RN-A stated there was no way to run a report for these concerns in order for the facility to track the different concerns to determine if there was a pattern. RN-A sated she was aware of FM-B's concern regarding an unknown medication found in R2's room. However, RN-A stated no formal grievance was documented and no formal grievance was completed. RN-A stated FM-B's email didn't provide how long the medication was there, where the chair came from because the chairs were not static to resident	F0585		

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F0585 SS = D	Continued from page 4 rooms, and there wasn't enough information for RN-A to investigate further. RN-A did not call and speak with FM-A to obtain clarifying information. RN-A took the photo from the e-mail and looked at R2's medication cassettes from the medication car and didn't find a match. RN-A did not review other resident medication cassettes to determine if there was a possible match. RN-A then e-mailed FM-A to let her know she couldn't determine what the medication was nor where it came from. No further investigation was completed. During an interview with the director of nursing (DON) and licensed social worker (SS)-A on 2/19/26 at 9:52 a.m., SS-A stated most complaints come to her. Then, SS-A would talk to the DON and together they would determine a solution. The DON stated there was a formal grievance process, however, if they were able solve the problem the formal process wasn't followed. During an interview on 2/19/26 at 1:45 p.m., the administrator stated staff were expected to report complaints to the charge nurse who reported concerns to the administration. Staff were able to use e-mail or phone after hours and administration would follow up. An investigation and resolution should be documented. The Patient Complaint of Grievance Policy revised 10/11/24, identified the facility informed patients of their rights, including the right to resolution of grievance. Complaints and grievances related to patient care and services at the facility were addressed according to the following guidelines. Patients and/or their representatives voicing a complaint or making a grievance would not jeopardize the quality of care or access to future health care services. Procedure: A. Grievances submitted to facility personnel in writing, verbally, via e-mail, or over the telephone are forwarded to the Director of Quality & Risk Management or the Director of Clinic Operations, who are considered the patient advocate/patient representatives. In the event the Director of Quality & Risk Management or the Director of Clinic Operations is not available, this role will be assumed by the Chief Nursing Officer or other administrative personnel. B. The facility's staff in receipt of a grievance will communicate with the patient or their representative regarding the plan to investigate and follow-up the grievance. C. The investigation of the grievance shall be	F0585		

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F0585 SS = D	Continued from page 5 conducted by the Director of Quality & Risk Management or Director of Clinic Operations, who will collaborate with the areas involved. The medical staff peer review process will be used to investigate a grievance concerning the quality of medical care as needed. D. All grievances will have a prompt written or verbal response, within 7 days if possible depending upon the nature of the grievance. For more complicated grievances requiring extensive investigation and analysis, the Director of Quality & Risk Management will contact the patient or their representative stating that the hospital is still working on the response, which they should expect within 30 days if possible. Exception: Grievances regarding situations that endanger the patient shall be addressed immediately. E. All grievances are followed-up in writing. The final written response shall include the name of the facility, a contact person at the facility, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. All grievance response letters will be mailed to the patient's home address unless the patient or representative has asked otherwise. F. Tracking of complaints/grievances and identifying trends is an important part of the quality improvement process. Grievance information is aggregated, tracked, trended and communicated by the Director of Quality and Risk Management or designee to leadership on an as-needed basis.	F0585		
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive assessment following resident to resident incidents to maintain safety of the residents for 1 of 5 residents (R2) reviewed for dementia care. Findings include:	F0744	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident identified in the citation was on end of life care during survey window and expired on 2/21/26. Psychoactive drug assessments completed on all residents in memory care unit. Behavior monitoring and intervention were reviewed for each resident in memory care unit. Based on charting and assessments, care plan reviews were conducted with DON, MDS coordinator, LSW and care coordinator for each individual in the memory care unit. There are no current like residents residing in memory care unit. How the facility will identify other residents having	03/20/2026

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F0744 SS = D	Continued from page 6 R2's quarterly Minimum Data Set (MDS) dated 2/5/26, identified R2 had severe cognitive impairment and diagnoses included dementia, anxiety, and depression. R2 exhibited physical behaviors directed towards others (for example: hitting, kicking, pushing, grabbing) 4-6 days, verbal behavioral symptoms directed towards others 4-6 days, other behavioral symptoms not directed towards others such as hitting/scratching self 1-3 days, rejection of care 4-6 days, and wandering 4-6 days. R2 required setting up or clean up assistance with eating, substantial/maximal assistance for toileting and was dependent on staff for all other care areas. R2 used antipsychotic, antianxiety, antidepressant, diuretic, and medications. R2's Delirium Care Area Assessment (CAA) dated 11/18/25, identified inattention, disorganized thinking, and altered level of consciousness had been R2's baseline since her initial admission more than nine months ago which led to her requiring 24-hour supervision and activities of daily living (ADL) assistance. This was not new or worsening. This had been R2's baseline for more than a year per R2's family. R2's Behavioral Symptoms CAA dated 11/18/25, identified R2's goal was to continue to attempt to express self and avoid complication such as social isolation and avoidance behaviors. Staff were to provide simple step by step instructions, allow time to process and respond, don't offer too many choices, repeat and rephrase as needed, provide verbal and nonverbal prompts and cues, approach in a calm and unhurried manner, offer smiles, list potential needs one at a time and observe for indication/acknowledgement that was what she wants/needs, provide reassurance, leave alone in safe situation and return later when unable to console or deescalate agitation, administer medications as ordered for anxiety, depression, agitation and observe for adverse effects and notify R2's physician of concerns, document target behaviors for physician to review with ongoing visits/consults. R2 was at risk for miscommunication, frustration, agitation, worsening symptoms of anxiety and depression, falls with injury, adverse effects of medications, social isolation, escalating adverse behaviors, unmanaged pain, and unmet needs. Medications were monitored per policy with behavioral health consultations. R2's Cognitive Loss/Dementia CAA dated 11/18/25, identified R2's goal was to continue to make her needs known, minimize risks, and avoid complications. Staff were to assist with communication with verbal and nonverbal prompts and cues, allow time to process and	F0744	Continued from page 6 the potential to be affected by the same deficient practice. Nurse coordinator, MDS nurse, DON, and LSW will meet weekly to review care plans. Review changes with resident daily Monday-Friday at IDT and MDS coordinator will update care plan as needed with changes. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not recur. Nurse coordinator, MDS nurse, DON, and LSW will meet weekly to review care plans. Review changes with resident daily Monday-Friday at IDT and MDS coordinator will update care plan as needed with changes. Review and revise quality of care/quality of life policy. Review and revise care planning policy- add dementia care planning. Educate all staff on revisions to policies. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits to be completed by director of nursing or designee of care plan reviews and that care plans are updated to reflect current behaviors/trigger and interventions weekly for 12 weeks and report audit findings to QAPI, specific to resident with dementia diagnosis. The date that each deficiency will be corrected. 3/20/26	

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F0744 SS = D	Continued from page 7 respond, offer reassurance, and allow to vent frustrations. R2 was at risk for miscommunication, frustration, anxiety, depression, adverse behaviors, and unmet needs. R2's Psychotropic Drug Use CAA dated 11/18/25, identified R2's goal was to continue to attempt to express self and avoid complications such as social isolation and avoidance behaviors. Staff were to provide simple step by step instructions, allow time to process and respond, don't offer too many choices, repeat and rephrase as needed, provide verbal and nonverbal prompts and cues, approach in a calm and unhurried manner, offer smiles, list potential needs one at a time and observe for indication/acknowledgement that is what she wants/needs, provide reassurance, leave alone in safe situation and return later when unable to console or deescalate agitation, administer medications as ordered for anxiety, depression, agitation and observe for adverse effects and notify R2's physician of concerns, document target behaviors for R2's physician to review with ongoing visits/consults. R2 was at risk for miscommunication, frustration, agitation, worsening symptoms of anxiety and depression, falls with injury, adverse effects of medications, social isolation, escalating adverse behaviors, unmanaged pain, and unmet needs. Medications are monitored per policy with behavioral health consultations. R2's care plan revised 2/10/26, identified R2's target behaviors included wandering, poor safety awareness, verbal aggression, physical aggression, crying out that was disruptive to others, unable to understand boundaries, elopement risk, and grabs on to other walkers/items. The care plan identified nonpharmacological interventions to try, such as calm, hurried approach; approach with 1 or 2 staff; leave alone and return later when safe to do so; and distract with snacks. R2's Physical Aggression Initiated dated 12/3/25 at 3:30 p.m., identified R2 was attempting to enter another resident's room. When the other resident said, "go to your own room", R2 stated "shut up you bitch" and then swung her hand toward the other resident's face. The other resident raised her arm and stopped the blow with her forearm. Staff stepped between the residents and R2 swung a second time. R2's hand connected with the other resident's forehead before staff was able to completely stop R2. Staff reported the hit as "weak". Immediate action taken was the residents were separated and redirected. However, the document failed to identify potential triggers for R2's	F0744		

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F0744 SS = D	Continued from page 8 behavior or potential interventions to prevent further incidents. R2's Physical Aggression Initiated dated 12/5/25 at 12:15 p.m., identified staff reported R2 hit another resident on the right shoulder four times as staff was attempting to get R2 to let go of the other resident's walker. Staff stated it was possible R2 was attempting to hit staff and not the other resident. R2 was unable to provide a description of the incident. The immediate action taken was staff intervened and redirected R2 with another activity. However, the document failed to identify potential triggers for R2's behavior or potential interventions to prevent further incidents. R2's nursing progress note dated 12/9/25 at 11:30 a.m., identified R2 had a behavioral health video appointment regarding management of psychotropic medications related to dementia with aggressive behaviors and anxiety. R2's provider was informed R2 had an increase in verbal and physical aggression toward staff and other residents. The incidents appeared to be triggered by R2 not getting her way (for example, being told she could not have something another resident already had) or when ADLs were being attempted. The noted further identified a review of R2's psychotropic medications were completed, but no nonpharmacological interventions were discussed. R2's Physical Aggression Initiated dated 12/18/25 at 6:00 p.m., R2 was attempted to squeeze between the wall and another resident's wheelchair in the dining room. Staff tried to tell R2 to stop because there was not enough room to safely pass. R2 became aggressive swinging out and hitting staff several times, pulling hair, pinching skin. The other resident also told her to stop, and R2 hit him once on the back of the neck. The other resident was not injured. A few minutes later R2 tried taking silverware from another resident. This resident asked her to stop, and R2 swung out at him, but he raised his arm and blocked R2's punch. The immediate action taken was R2 was redirected, staff took R2 for a walk down the hall and R2 eventually sat down in a chair. However, the document failed to identify potential triggers for R2's behavior or potential interventions to prevent further incidents. R2's nursing progress note dated 1/6/26 at 8:39 a.m., identified R2 had a behavioral health video appointment regarding management of psychotropic medications related to dementia with aggressive behaviors and anxiety. A review of staff notes was completed to evaluate whether the last medication change was effective. Based on documentation, R2 had been	F0744		

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F0744 SS = D	Continued from page 9 sleepier, has not been aggressive toward other residents but has been physically and verbally aggressive with staff at times when cares are attempted. The note further identified that a review of R2's psychotropic medications was completed, but no nonpharmacological interventions were discussed. During a telephone interview on 2/17/26 at 5:45 p.m., family member (FM)-A stated she and FM-B had visited R2 on 2/12/26. R2 had been up all night and hadn't had cares and eaten. FM-A stated the staff let R2 lie in bed all day and then R2 was up all night. FM-A stated they had discussed R2's behaviors with the facility many times and they were told the facility would provide more training to the staff on how to care for a resident with dementia. During an interview on 2/18/26 at 4:50 p.m., nursing assistant (NA)-A stated R2 had a lot of behaviors and could get combative with staff and other residents. "You don't see it coming." NA-A stated she didn't trust R2 around the other residents and immediately stepped between them whether R2 was agitated or not because R2 could hit hard. During an interview on 2/18/26 at 5:00 p.m., FM-B stated there were times when family visited R2 didn't have her glasses, dinner will just sit there, and staff did not offer to assist R2. A lot of the time, R2 just remained in her bed or room in the dark with alarms blaring. FM-B stated it wasn't fair to R2, "she's just existing". During an interview on 2/19/26 at 7:52 a.m., NA-B stated R2 was "difficult" resident and had a lot of behaviors. R2 was unpredictable and, in the previous weeks, R2's behavior had gotten a lot worse. R2 was very clingy and would "hang" on you. Staff tried their best to keep R2 away from other residents. For example, if a resident was sitting in a chair and R2 wanted to sit there or was trying to move the chair and staff tried to redirect R2, R2 would become angry and start hitting the staff and R2 could hit the other resident too. That's why staff tried to keep R2 away. R2 would cling to one person so staff would have to ask for help and the help had to do whatever was needed because R2 wouldn't let the staff go. Also, if the staff did get away from R2, that would make R2's behaviors worse. Staff just had to do their best to keep R2 away from the other residents. Some days, R2 would sleep all day. Some days, R2 was up all day. Staff never knew. Staff were just told that if R2 was sleeping to not ask if R2 wanted to get up. Staff were to be encouraging to R2 to get up for the day.	F0744		

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F0744 SS = D	Continued from page 10 During an interview on 2/19/26 at 8:09 a.m., trained medication aide (TMA)-A stated R2 was very combative. Any time staff had to “touch” R2 it made R2 more combative. R2 was unable to understand every small, direct communication and nothing calmed R2 except R2’s family. R2 could be vulgar too. TMA-A stated she had never witnessed or been told R2 was combative with other residents. During an interview on 2/19/26 at 8:36 a.m., registered nurse (RN)-A stated staff were expected to report all resident-to-resident incidents immediately. First, staff were directed to ensure all residents were safe, separated and without injury. Then, the charge nurse would report the incident to the administrator and social worker. Then, an investigation of the incident would occur, and family was notified. All incidents were then discussed during the interdisciplinary team (IDT) meeting. For R2’s resident-to-resident incidents, staff were just to monitor. The facility used the communication page of the electronic medical record system, however, RN-A stated she could not determine if a communication had been entered regarding R2’s behaviors and/or possible interventions to prevent resident-to-resident incidents. R2's medical record lacked evidence a comprehensive assessment was completed following each incident to identify potential new interventions to keep R2 and others safe. During an interview with the director of nursing (DON) and licensed social worker (SS)-A on 2/19/26 at 9:52 a.m., the DON stated staff had been working with R2’s behavioral health provider to adjust R2’s medications but R2’s family was hesitant to follow recommendations. R2 was difficult because there wasn’t really any sign of aggression. R2 could be happy or R2 could be tired and could be fine. There wasn’t any way to determine the trigger of R2’s behaviors. However, the DON stated a lot of behaviors did occur when R2 was told no or during cares. During the facility’s psychotropic meeting, staff review the behavior charting and see if there was anything the nursing assistants were seeing/charting but not reporting up. Then the care plan was reviewed and updated if needed. This was done quarterly. The DON stated she did not know what could have been care planned to help prevent R2’s resident-to-resident incidents. During an interview on 2/19/26 at 1:45 p.m., the administrator stated staff were expected to recognize potential signs of aggressive behaviors, identify root	F0744		

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F0744 SS = D	Continued from page 11 causes, to create potential interventions to prevent incidents and to care according to what had been decided on as a team. Also, staff were expected to reassess and change the care plan as needed. The facility Care Planning policy revised 6/09, identified a care plan would be developed and maintained on each resident according to the RAI guidelines to provide mandated and essential information in an organized manner to develop and maintain a plan of care for each resident. A facility policy regarding dementia care was requested but not received.	F0744		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a schedule 2 narcotic (a medication with a high potential for abuse) was stored in a manner to prevent diversion for 1 of 3 units (Maple Unit); and failed to monitor temperature on a	F0761	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Thermometers added to the fridge and freezer in Memory care medication room fridge on 2/19/26. Education provided on 2/19/26 to the TMA working on 2/19/26 in memory care about locking the medication cabinet in medication room if there are controlled drugs in storage. How the facility will identify other residents having the potential to be affected by the same deficient practice. Memory Care fridge/freezer added to charge nurse nightly fridge temp log. Education provided to the nursing staff that all medication fridges need to be checked daily. Re-education to be provided to all nursing staff (RNs, LPNs, and TMAs) about controlled substance storage policy. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not recur. Memory Care fridge/freezer added to charge nurse	03/20/2026

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Lifecare Roseau Manor	**715 DELMORE DRIVE , ROSEAU, Minnesota, 56751**

(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
F0761 SS = D	Continued from page 12 medication refrigerator temperatures of 1 of 2 medication fridges (Maple Unit) reviewed for medication storage. Findings include: During observation on 2/19/26 at 8:25 a.m., the director of nursing (DON) did a tour of the medication room on the Maple unit (memory care unit). Upon entering the locked medication room on the unit, it was observed there were keys in a lock on one of the cupboards. The DON reached up and pulled the cupboard door open as it was not locked. In the cupboard there was a 30-milliliter (ml) unopened bottle of liquid morphine (a scheduled 2 narcotic). The medication refrigerator did not have a thermometer inside of it nor was there evidence the temperatures were monitored. The refrigerator contained two vials of injectable lorazepam 2 milligrams (mg)/ml. for R22. The refrigerator had cool air coming out upon opening and the freezer had some frost buildup. During an interview on 2/19/26 at 8:40 a.m., the DON stated the liquid morphine needed to be double locked and it wasn't. When staff were done in the medication room, they should have locked all locks and taken the keys with them to ensure resident safety. The refrigerator temperature should be monitored daily and there should be a thermometer in the refrigerator to ensure the efficacy of the residents' medications were maintained. There was no evidence there was missing morphine, or the fridge temperature was out of range. During an interview on 2/23/26 at 9:35 a.m., the consulting pharmacist (CP) returned a call from 2/18/26. The CP stated that schedule 2 narcotics are to be double locked for safety and refrigerator needed the temperature to be monitored to ensure medication stability. The facility's Labeling and Storing of Medication policy dated May 2009, identified schedule 2 medications were to be locked with double locks. The policy did not address the monitoring of medication refrigerators.	F0761	Continued from page 12 nightly fridge temp log. Education provided to the nursing staff that all medication fridges need to be checked daily. Re-education to be provided to all nursing staff (RNs, LPNs, and TMAs) about controlled substance storage policy and temp log policy. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits to be completed by director of nursing or designee of medication rooms weekly for 12 weeks and report to QAPI to ensure controlled medications are stored properly and fridge temps are being monitored daily. The date that each deficiency will be corrected. 3/20/26	