DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5NZI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00579

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245470**

2.STATE VENDOR OR MEDICAID NO.
(L2) **842724100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LIFECARE ROSEAU MANOR**
(L4) **715 DELMORE DRIVE**
(L5) **ROSEAU, MN** (L6) **56751**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/28/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 08/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Peterson, Enforcement Specialist — 08/22/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/03/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245470 August 3, 2017

Ms. Emily Straw, Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, MN 56751

Dear Ms. Straw:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 20, 2017 the above facility is recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 3, 2017

Ms. Emily Straw, Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, MN 56751

RE: Project Number S5470043

Dear Ms. Straw:

On June 20, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 7, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 28, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 6, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 7, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 20, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 7, 2017, effective July 20, 2017 and therefore remedies outlined in our letter to you dated June 20, 2017, will not be imposed.

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

Feel free to contact me if you have questions related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5NZI

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Facility ID: 00579

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(L1) **245470**
2.STATE VENDOR OR MEDICAID NO.
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3. NAME AND ADDRESS OF FACILITY
(L3) **LIFECARE ROSEAU MANOR**
(L4) **715 DELMORE DRIVE**
(L5) **ROSEAU, MN** (L6) **56751**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/07/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

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10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE NE II 07/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/03/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 20, 2017

Ms. Emily Straw, Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, MN 56751

RE: Project Number S5470043

Dear Ms. Straw:

On June 7, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 17, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 September 7, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 7, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

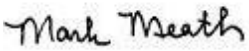
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245470	A. BUILDING _____ B. WING _____	06/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE ROSEAU MANOR	715 DELMORE DRIVE ROSEAU, MN 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
F 000	INITIAL COMMENTS On June 5, 2017 through June 7, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.	F 248		7/20/17

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

Electronically Signed | 06/29/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245470	A. BUILDING _____ B. WING _____	06/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE ROSEAU MANOR	715 DELMORE DRIVE ROSEAU, MN 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
F 248	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide resident assessed activities for 1 of 3 residents (R21) who had cognitive impairment and observed not to be provided with activities per the care plan. Findings included R21's Face Sheet dated 6/7/17, included diagnoses of dementia with behavioral disturbance, aphasia (difficulty expressing language and comprehension) major depressive disorder, and glaucoma. R21's annual Minimum Data Set (MDS) dated 9/6/16, indicated R21's participation in religious services and practices was very important and areas that were not very important to R21 included have reading material, listen to music, current events, going outside, doing favorite activities, and doing things with a group of people. R21's quarterly MDS dated 2/28/17, indicated R21 had severe cognitive impairment with signs and symptoms of delirium, and had behaviors. The MDS also indicated R21 was dependent on staff for transfers and locomotion on and off the unit. R21's psychosocial well-being Care Area Assessment (CAA) dated 9/13/16, indicated R21 had little interest or pleasure in doing things and favorite activities were not very important. The activities CAA dated 9/14/16, indicated activity preferences prior to admission to the facility were passive, active, outside of home, and inside of home. R21 had indicators of depression and anxiety, had functional mobility problems,	F 248	1. R21 deceased on 6/20/2017. 2. All residents who depend on staff to assist with getting to activities will have their care plans and participation records reviewed for appropriateness by 6/30/2017. 3. A life enhancement policy was created and nursing and life enhancement staff will be trained on the new policy requirements no later than 7/14/17. The policy identifies components for activity programming and care planning. 4. Life enhancement supervisor or designee will complete documentation audits on three randomly selected residents per week for activity attendance for three months. The Quality assurance and performance improvement committee will review audit findings for compliance and make necessary follow up or recommendations. 5. Three observational audits of resident's attending activities will be completed by the life enhancement supervisor weekly for 3 months.The Quality assurance and performance improvement committee will review audit findings for compliance and make necessary follow up or recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245470	A. BUILDING _____ B. WING _____	06/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE ROSEAU MANOR	715 DELMORE DRIVE ROSEAU, MN 56751

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F 248	Continued From page 2	F 248		

cognitive deficits, unstable health problems, chronic health problems, socially inappropriate behavior, and performed tasks slowly related to reduced energy. The CAA's analysis indicated attended meals and activities in the dining room, near daily visits from family, and interacted with staff appropriately. She is at risk for anxiety, depression, frustration, adverse behaviors, unmet needs. No referrals, has additional one to one visits weekly.

R21's activity care plan dated 12/8/16, indicated R21 would attend 2-4 activities per week and scheduled one to one visits and directed staff to provide encouragement to attend activities and to verbally inform R21 daily of recreation activities an to invite R21 to all large home events and outings, supervise and provide prompts to encourage participation, provide weekly activity schedule, and to escort to and from activities. The care plan indicated R21's activity preferences were enjoys group fitness, sing alongs, Jehovah witness bible studies, manicures, and music.

R21's May and June 2017, activity participation records indicated the last time R21 attended a group activity was 5/18/17. May's record indicated one on one visits were on 5/11/17, and 5/27/17. R21's record lacked evidence of documentation R21 was offered and/or refused activities.

The facility activity calendar for May and June 2017, revealed several activities that were outlined on R21's care plan that included:
-coffee socials nearly every day at 2:30 p.m.
-group fitness scheduled on 5/19, 5/24, 5/31, and 6/2.
-sing along on 5/25 and 6/1

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The activity calendar for May and June 2017, did reflect Jehovah Witness religion services and documentation for May and June did not reflect religious services were arranged or provided to R21.

On 6/5/17, at 2:45 p.m. R21 was not observed to be at the scheduled birthday party on 6/6/17 at 2:30 p.m. and was not observed to be at the scheduled coffee social.

On 6/7/17, at 11:03 a.m. R21 was observed in bed, sleeping. The facility activity calendar indicated bible study was at 10:30 a.m. The calendar did not indicate which religion the bible study was associated with. R21 was not in attendance at the scheduled birthday party at 2:30 p.m.

-At 12:41 p.m. activity director (AD) stated the bible study was not for Jehovah witnesses and would have conflicted with R21's wishes. The AD stated one on one visits were scheduled on a weekly basis and provided by one of the feeding assistants. The AD reviewed R21's activity attendance record and verified R21 had not been to an activity since 5/18/17, and confirmed not all weekly one to one visits had been conducted. The AD stated R21 could only be up for a certain amounts of time and sometimes if R21 was woken up, she displayed behaviors. The AD stated if residents were sleeping, they were not woken up and the activity staff were instructed to leave the attendance calendar blank in such cases and if the resident refused to attend, the refusal would be indicated on the attendance calendar. The AD indicated activity staff would re-approach a resident who refused one to one visits however, scheduled group activities were

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F 248	Continued From page 4 only offered once. -At 4:15 p.m. feeding assistant (FA)-A indicated if R21 was sleeping, she would not be woken up for activities. FA-A stated the FAs did not document anything if they did not ask the residents if they wanted to attend activities. FA-A stated group activities were announced a half hour before and posters were hung up to let people know of activities scheduled. FA-A stated R21 could not be up for long periods and staff did not typically ask residents in the morning if they wanted to attend any afternoon activities. A facility policy was requested and not received.	F 248		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the	F 279		7/20/17

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F 279	Continued From page 5	F 279		

comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

(iv)In consultation with the resident and the resident’s representative (s)-

(A) The resident’s goals for admission and desired outcomes.

(B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

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F 279	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop an insomnia care plan which included individual goals for sleep management related to the use of sleep medication for 1 of 5 residents (R61) whose medication regimens were reviewed. Findings included: R61's facility face sheet dated 6/7/17 included diagnosis of insomnia (difficulty sleeping) R61's quarterly Minimum Data Set (MDS) dated 5/1/17, indicated R61 was cognitively intact and did not have any difficulty with falling asleep or staying asleep. R61's physicians orders dated 6/7/17, included an order for Amitriptyline 25 milligrams (mg) (antidepressant medication sometimes used to treat insomnia) every night at bedtime for insomnia. R61's care plan dated 6/7/17, had diagnoses which included insomnia, however, the care plan lacked identification of individualized goals for sleep management, lacked non-pharmacological interventions for sleep, and lacked interventions for monitoring for potential adverse effects of the medication. On 6/7/17, at 11:12 a.m. registered nurse (RN)-B confirmed R61's care plan lacked a plan of care for sleep management and should have been identified. Facility policy was requested and not received.	F 279	1. R61 was seen by his Primary care provider to review his medication on 6/14/17. A medication review was conducted by consulting pharmacist on 6/21/2017. Individualized goals for sleep management, non pharmalogical interventions for sleep and interventions for monitoring potential adverse effects of the medications were identified and implemented on 6/29/17. 2. All residents who have a diagnosis of insomnia will have their care plans, goals and interventions reviewed for appropriateness of goals, non pharmalogical interventions and interventions for monitoring potential adverse effects of the medication by 6/30/17. 3. Revisions of the current sleep monitoring tool and assessment have been made. Sleep assessments will be completed on all newly admitted residents, quarterly, with significant changes, and as needed with medication changes. Sleep hygiene care plans will be reviewed monthly. Licensed staff will be educated no later than 7/14/17 on changes to the process for completing the sleep assessment. 4. Director of Nursing or designee will complete three randomly selected monthly documentation audits of resident care plans for resident□s with a diagnosis of insomnia for three months. The Quality	

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F 279	Continued From page 7	F 279	assurance and performance improvement committee will review audit findings for compliance and make necessary follow up or recommendations.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative.	F 280		7/14/17

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F 280	Continued From page 8 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 280		

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F 280	Continued From page 9 or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan to include additional fall prevention interventions following fall incidents for 1 of 3 residents (R33) reviewed for accidents. Findings included R33's Face Sheet [undated], indicated R33's diagnoses included chronic pain, hypertension, hearing loss, urinary retention, unsteadiness on feet, and abnormalities of gait and mobility. R33 sustained four falls between 5/21/17, through 5/30/17. After the falls, the additional assessed interventions were not included in the care plan. R33's care plan (current) printed on 6/7/17, identified problem area of risk for falls with injury due to history of falls. Fall interventions listed included call light within reach and change bed pad alarm every three months. R33's nursing assistant daily Care Guide did not reflect fall interventions. R33's progress note dated 5/30/17, indicated the interdisciplinary team (IDT) reviewed R33's falls that occurred on 5/21/17, and 5/27/17, and determined the following interventions should be attempted: urinal at bed side and chair alarm.	F 280	1. R33 fall interventions are in place and effective. All staff have been educated on R33□s interventions to prevent falls effective 6/9/17. 2. Residents with multiple falls occurring in the last three months will be reviewed for appropriateness of interventions effective 6/30/2017. 3. Written communication 24 hour report sheets were implemented for use effective 6/23/17. Changes to care plans and new interventions will be documented on the new 24 hour report sheet available for shift change and as needed and were educated on 6/22/17 regarding the use of the new form. All life enhancement and nursing care staff will be educated on how to access the resident care plans electronically no later than 7/14/2017. 4. Director of Nursing or designee will complete documentation audits and staff interviews one time per week for three months to ensure interventions are appropriate, timely and communicated appropriately. The Quality assurance and performance improvement committee will review audit findings for compliance and make necessary follow up or	

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R33's fall Incident report dated 5/30/17, indicated the use of a fall mat as an intervention.

R33's progress note dated 5/31/17, indicated the fall intervention for R33's bed to be in the lowest position.

On 6/5/17, at 5:34 p.m. R33 was observed seated on his bed with gripper socks on. The bed was in the lowest position with a fall mat next it. R33's bed and wheelchair were equipped with a safety alarm. A urinal was not observed at bedside.

On 6/7/17, at 7:01 a.m. R33 was observed awake in bed, with gripper socks on. The bed was in the lowest position, floor mat next to bed, safety alarms on wheelchair and bed, and a urinal was not observed at bedside.

-At 7:26 a.m. nursing assistant (NA)-A stated R33's fall interventions included a fall mat, low bed, check on every two hours, and R33 was moved to a room closer to the nurses station on 6/4/17. In a subsequent interview at 8:17 a.m. NA-A indicated the fall interventions could be located on the care plan, however was not aware if it was accessible to the nursing assistants. NA-A stated staff were made aware of the new interventions and changes primarily through verbal report given prior to the start of shift, and staff relied totally on obtaining new information from verbal shift reports.

-At 7:39 a.m., licensed practical nurse (LPN)-A stated R33's fall interventions included a room closer to the nurses station, low bed, fall mat, alarms, and gripper socks.

-At 8:31 a.m. NA-B stated R33's fall risk recommendations.

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F 280	Continued From page 11 interventions included a bed alarm, call light within reach, fall mats, low bed, offer bathroom every two hours, and hourly checks. NA-B indicated R33's fall risk interventions could be found on the care guide that hung in his closet, NA-B reviewed the care guide and confirmed the care guide was dated 4/25/17, and indicated the bed alarm was the only intervention identified. -At 9:05 a.m. registered nurse (RN)-A stated the care guides in the resident rooms were supposed to be updated as changes occurred. RN-A reviewed and confirmed the fall care plan lacked revision to include the additional fall interventions. RN-A stated the care plan should have been revised. A facility policy was requested and not received.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure activities were provided as directed by the care plan for 1 of 3 residents (R21) reviewed for activities. Findings included:	F 282	1. R21 deceased 6/20/2017. 2. All residents who depend on staff to assist with getting to activities will have their care plans and participation records reviewed for appropriateness by 6/30/2017.	7/14/17

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F 282	Continued From page 12 R21's activities care plan dated 12/8/16, indicated R21 would attend 2-4 activities per week and scheduled one to one visits. The care plan directed staff to provide R21 encouragement to attend activities and to verbally inform R21 daily of recreation activities, invite to all large home events and outings, supervise and provide prompts to encourage participation, provide weekly activity schedule, and to escort to and from activities. The care plan identified R21's activity preferences as enjoys group fitness, sing alongs, Jehovah witness bible studies, manicures, and music. R21's May and June 2017, activity participation records indicated the last time R21 attended a group activity was 5/18/17. May's record indicated one on one visits dates of 5/11/17 and 5/27/17. R21's record lacked evidence of documentation R21 was offered and/or refused activities. The facility activity calendar for May and June 2017, was reviewed and revealed several activities that were outlined on R21's care plan that included: -coffee socials nearly every day at 2:30 p.m. -group fitness scheduled on 5/19, 5/24, 5/31, and 6/2. -sing along on 5/25 and 6/1 On 6/5/17, at 2:45 p.m., R21 was not observed to be at the scheduled birthday party and on 6/6/17, at 2:30 p.m. R21 was not observed to be at the scheduled coffee social. On 6/7/17, at 11:03 a.m. R21 was observed in bed, sleeping. The facility activity calendar indicated bible study was at 10:30 a.m. however, the calendar did not indicate which religion the	F 282	3. A life enhancement policy was created and nursing and life enhancement staff will be trained on the new policy requirements no later than 7/20/17. The policy identifies components for activity programming and care planning. 4. Life enhancement supervisor or designee will complete documentation audits on three randomly selected residents per week for activity attendance for three months. Life enhancement supervisor or designee will complete observational audits on 3 residents per week for three months. The Quality assurance and performance improvement committee will review audit findings for compliance and make necessary follow up or recommendations.	

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bible study was associated with. R21 was not in attendance at the scheduled birthday party at 2:30 p.m.

-At 12:41 p.m. activity director (AD) stated the bible study was not for Jehovah witnesses and would have conflicted with R21's wishes. The AD stated one on one visits were scheduled on a weekly basis and provided by one of the feeding assistants. The AD reviewed R21's activity attendance record and verified R21 had not been to an activity since 5/18/17, and confirmed one, and not all weekly one to one visits were conducted. The AD stated R21 could only be up for a certain amounts of time and sometimes if R21 was woken up, she displayed behaviors. The AD stated if residents were sleeping, they were not to be woken up. The AD stated activity staff were instructed to leave the attendance calendar blank in such cases and if the resident refused to attend, the refusal would be indicated on the attendance calendar. The AD indicated activity staff would re-approach a resident who refused one to one visits however, scheduled group activities were only offered once.

-At 4:15 p.m. feeding assistant (FA)-A stated R21 was not woken up for activities and FAs did not document anything if they did not ask residents if they wanted to attend activities. FA-A stated group activities were announced a half hour before the activity started and posters were hung up to let people know. FA-A stated R21 could not be up for long periods and staff did not typically ask residents in the morning if they wanted to attend any afternoon activities.

A facility policy was requested and not received.

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F 456	Continued From page 14	F 456		
F 456 SS=D	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure side rail padding maintained a cleanable surface for 1 of 1 resident (R135) observed who utilized side rail padding with exposed, uncleanable foam padding. Findings include: During an environmental tour on 6/7/17, at 11:45 a.m. with the Director of Maintenance (DM), the foam padding on R135's side rails was observed torn and peeling exposing uncleanable foam padding. The DM verified the finding and stated housekeeping staff was to send maintenance staff a work order which identified any areas that needed repair or need to be addressed by maintenance. A policy related to cleanable surfaces, exposed foam was not provided.	F 456	1. Room 135 side rail foam padding was replaced on 6/27/17. 2. All residents with foam padded protected side rails will be audited for wear by 6/30/17. Repairs or replacements will be made as necessary and will be completed by 7/14/17. 3. Foam padded protected side rails will be added to safety round observational auditing completed by interdisciplinary team monthly. If replacement is needed, work order requests will be send to maintenance as they are identified. 4. The Quality assurance and performance improvement committee will review safety rounding observational audit findings for compliance and make necessary follow up or recommendations.	7/14/17
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		7/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245470	A. BUILDING _____ B. WING _____	06/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE ROSEAU MANOR	715 DELMORE DRIVE ROSEAU, MN 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
F 465	Continued From page 15 (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain doors, walls and closet doors in a clean, sanitary and a home like manner for 9 of 35 resident rooms (112, 158, 163, 165, 170, 174, 175, 176, 177, 178) observed in need or repair. Findings include: During an environmental tour on 6/7/17, at 11:45 a.m., the Director of Maintenance (DM) verified the following findings: -rooms 112, 163, 165, 170, 174, 175, 177, 178's closet doors and walls had scraped paint and the walls had gouges in the sheet rock -room 158 had floor tile chipped and missing -room 174's floor by bed had black scuff marks/discoloration -room 112's bathroom walls had scraped paint and an area down to the sheet rock: -room 176 had stained ceiling tile Following the tour, the DM stated the facility did not have a policy on room repairs but had a preventative maintenance (PM) schedule which	F 465	1. Rooms 112, 163, 165, 170, 174, 175, 177, 178 closet doors scraped paint will be repainted and sheetrock gouges will be repaired. Room 158 tile floor chip will be replaced. Repairs will be made to room 174 floor marks/discoloration. Room 112 bathroom wall scrapes will be repainted. Room 176 stained ceiling tile will be replaced. These repairs will be completed by 7/14/17. 2. Maintenance staff will complete monthly observational audits on all resident rooms to check the condition of all areas listed above for three months. After three months, director of facilities or designee will do environmental rounding every six months on all resident rooms. Revisions were made to the environmental rounding checklist to include all issues identified on 6/27/17. Staff will be provided additional education on current submission system for reporting electronic requests for repairs on 7/11/17 and 7/13/17.	

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F 465	Continued From page 16 directs staff to review each room annually for needed repairs. A review of the PM schedule annual procedure revealed staff were directed to conduct checks of cabinet doors and drawers and to check ceiling and wall conditions.	F 465	3. The Quality assurance and performance improvement committee will review environmental audit findings for compliance and make necessary follow up or recommendations.	

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	245470	A. BUILDING **CN - ROSEAU C & NC** B. WING _____	**06/06/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE ROSEAU MANOR	**715 DELMORE DRIVE ROSEAU, MN 56751**

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Lifecare Roseau Manor 01 Main Building was found not 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/29/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 and has a fire alarm system which includes corridor smoke detection throughout and in all common areas. All sleeping rooms have smoke detectors and all hazardous areas have automatic fire detectors in accordance with the Minnesota State	K 000		

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	245470	A. BUILDING **CN - ROSEAU C & NC** B. WING _____	**06/06/2017**

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K 000	Continued From page 2 Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 46 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 291 SS=D	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain emergency lighting in accordance with 7.9. The deficient practice could affect 46 out of 46 residents. Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 FINDINGS INCLUDE: On facility tour between 8:30 AM and 12:30 PM on 06/06/2017, documentation could not be located to show that the annual 90 minute test was conducted on the Battery Back-up Emergency Lights. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	1. 90 minute annual testing has been completed. 2. Date completed was 6/7/17. 3. Annual testing has been added into annual preventative maintenance schedule. Director of facilities maintenance will monitor to prevent reoccurrence of deficiency.	6/7/17