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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 9DN1

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 **09/14/2021** (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:
X 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 :
Jennifer Bahr, Unit Supervisor 09/22/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/22/2021 (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
09/15/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 22, 2021

CMS Certification Number (CCN): 245470

Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, MN 56751

Dear Administrator:

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 September 14, 2021 the above facility is certified 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 22, 2021

Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, MN 56751

RE: CCN: 245470
Cycle Start Date: July 22, 2021

Dear Administrator:

On August 12, 2021, we notified you a remedy was imposed. On September 14, 2021 the Minnesota Department(s) 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 September 14, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 26, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 12, 2021, 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 September 26, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 14, 2021, 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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9DN1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00579

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(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: **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 **07/22/2021** (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

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From (a) :
To (b) :

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___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 :
Jamie Boser, HFE - NE II 09/03/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/15/2021 (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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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
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 12, 2021

Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, MN 56751

RE: CCN: 245470
Cycle Start Date: July 22, 2021

Dear Administrator:

On July 22, 2021, 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 26, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 26, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 26, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 26, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lifecare Roseau Manor will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 26, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 January 22, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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 _____	C 07/22/2021

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
E 000	Initial Comments On 7/19/21 through 7/22/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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.	E 000		
F 000	INITIAL COMMENTS On 7/19/21 through 7/22/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The complaint H5470016C (MN74510) was SUBSTANTIATED: Deficiencies were cited at F880 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 that substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/01/2021

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 _____	C 07/22/2021

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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure each fall was comprehensively assessed and appropriate interventions were assessed for and/or implemented in an effort to reduce falls for 1 of 4 residents (R9) reviewed for falls. Findings include: R9's care area assessment (CAA) dated 8/18/20, identified a risk for falls, history of falls, decreased mobility and altered mental status. The CAA indicated R9 had a bed alarm, routine toileting and chair alarm to help prevent falls. R9's falls most often occurred related to toileting needs, urgency/frequency, or confusion with bladder infections. R9's quarterly Minimum Data Set (MDS) dated 5/6/21, indicated R9 had severe cognitive impairment and required extensive assistance from two staff for bed mobility, transfers and toileting. R9 had lower extremity impairment on both sides, was continent of bowel and frequently incontinent of bladder. Further, R9 had sustained two or more falls without injury and two or more falls with injury since the previous assessment.	F 689	- Careplan updated to include to count each episode that resident is found on boom mat to be counted as a fall. - Facility reviewed all residents fall risk scores, interventions, and identified patterns and corrected on 8/30/21. Falls risks will be reviewed with each fall, significant change and/or quarterly and changes made as needed. - Facility will complete review of other residents at risk for falls to ensure appropriate interventions are in place. - Complete chart reviews weekly to ensure resident has been assessed and a new intervention is imitated/trialed after each fall. - IDT (interdisciplinary team) will review using root cause analysis and make changes to plan of care each morning M-F with any falls happening since the prior business day. These changes will be communicated to staff using Point Click Care communications board.	8/31/21

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 _____	C 07/22/2021

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 689	Continued From page 2 R9's care plan dated 5/10/21, identified a risk for falls and a history of repeated falls. Care planned interventions included: bed alarm, routine toileting and chair alarm to help prevent falls as well as pain medication, anti-anxiety medication and non pharmacological interventions for behaviors, pain and risk for falls. The care plan directed staff to check R9 on rounds every two hours and encourage bathroom on a routine basis. The interventions updated on 4/26/21, indicated R9 had demonstrated to staff how she put herself on the floor mat intentionally. When R9 was found on the mat, staff were to ask if she intentionally put herself there and if R9 said yes, staff did not need to count the incident as a fall. R9's incident reports identified the following falls: - 3/23/21, at 8:45 p.m. R9 was found kneeling on the floor mat with her arms on the bed, bed alarm sounding. R9 stated she did not want to be in bed anymore and wanted to get up. A Falls Worksheet dated 3/24/21, indicated interventions included: mats on both sides of bed, call light was within reach, bed alarm was sounding. R9 awakened easily to noise in hallway so sometimes the door was closed. There was no evidence a comprehensive fall assessment was completed including evidence new interventions were assessed for and/or why new interventions were not necessary. - 3/26/21, at 11:20 p.m. R9's alarm was sounding and staff heard her calling for help. R9 was found on hands and knees resting against the bed on the floor mat. She was yelling for help. Reported she had company coming and was trying to get up. There was no evidence a comprehensive fall	F 689	- Care coordinator will make a post fall summary note to include current and new interventions and attempting to identify patterns. - Simplify the fall documentation. - DON or designee will complete chart and care plan reviews on residents who have had recent falls weekly X 3 months. - Audit results will be reported to the QAPI team for review and input. - Provide staff education on preventing falls including interventions, improving documentation at time of falls, and post fall.	

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	245470	A. BUILDING _____ B. WING _____	C 07/22/2021

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assessment was completed including evidence new interventions were assessed for and/or why new interventions were not necessary.

- 3/28/21, at 4:00 p.m. staff heard R9 yelling from her room. Staff responded to find R9 lying on her left side on the floor mat next to the bed. R9 was sitting and stated she needed to get out of there and was having delusions. No mat was in place and alarm did not sound. R9 reported mild hip pain. Staff were reminded the importance of having the mat in place. The alarm was found to have a broken cord and was replaced. A Falls Worksheet dated 3/28/21, indicated mats were not in place at time of the fall. Mats need to be placed as care planned and staff were reminded. The bed alarm was in place but was not working. The call light was in reach and R9 was reminded the importance of pushing her call light, even though R9 had severe cognitive impairment. There was no evidence a comprehensive fall assessment was completed including evidence new interventions were assessed for and/or why new interventions were not necessary.

- 4/3/21, at 9:10 p.m. R9 was found kneeling over her bed, unsure what she wanted to do. A Falls Worksheet dated 4/3/21, indicated R9 did not know what she was doing at the time of the fall. There was no evidence a comprehensive fall assessment was completed including evidence new interventions were assessed for and/or why new interventions were not necessary.

- 4/19/21, at 8:45 p.m. R9 found sitting on her butt on the floor mat next to her bed. R9 was talking about her children and wondering if they were awake. A Fall Worksheet dated 4/19/21, indicated alarm had been sounding and R9 was assisted to

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the recliner. There was no evidence a comprehensive fall assessment was completed including evidence new interventions were assessed for and/or why new interventions were not necessary.

- 4/25/21, at 2:35 a.m. R9 was found with her knees on the mat and her upper body on the bed. R9 stated she was trying to get to the bathroom. A Falls Worksheet dated 4/25/21, included a section for recommendations/interventions. The section was left blank. There was no evidence a comprehensive fall assessment was completed including evidence new interventions were assessed for and/or why new interventions were not necessary.

- 4/25/21, at 9:13 a.m. R9 was found sitting on the floor mat next to her bed. R9 stated she tried to get up and check on the kids. A Falls Worksheet dated 4/26/21, indicated R9 was trying to get up and check on the kids. Intervention identified as R9 was brought to the common area. The Falls Worksheet further identified R9 had five falls in the last 30 days and 12 falls in the last 31-180 days.

- 5/8/21, at 10:35 p.m. R9 was found on her knees on the mat with her upper body on the bed, holding on to the side rail. R9 stated she fell out of bed. A Falls Worksheet dated 5/8/21, indicated R9 stated she fell out of bed and thought she was cold and that's why she fell. Intervention indicated she was put back to bed and covered up; however, did not identify interventions to prevent further falls or an assessment to identify why new interventions were not warranted.

- 5/30/21, at 5:00 a.m. R9's alarm sounded. Staff

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entered the room and found R9 on the floor next to her bed. The report indicated the interdisciplinary team (IDT) reviewed the fall, R9 had been incontinent at the time of the fall likely putting her at increased risk for fall. R9 had been checked on continence rounds one hour before and as a result, no change to care plan was recommended. The intervention included "Will have pharmacist look at medications."

R9's nursing Progress Notes identified the following:

6/12/21, at 6:40 a.m. staff responded to R9's alarm and found her kneeling on her floor mat. R9 stated she was getting up for the day.

7/16/21, at 11:45 P.M. R9 was found seated on the floor mat next to her bed. R9 stated she was going to get up and said "I sat here."

7/17/21, at 12:57 a.m. R9 was found rolling out of bed with her knees on the floor mat. R9 was incontinent of urine.

7/17/21 at 1:29 p.m. R9 found sitting on the floor mat at the edge of the bed. R9 stated she was getting up.

7/18/21, at 4:28 a.m. R9 found on the floor mat next to the bed. R1 was experiencing hallucinations.

7/21/21, at 11:09 a.m. R9 was found lying on the floor next to her bed. R9 stated she needed a cup of coffee and had rolled too fast. A Falls Worksheet dated 7/21/21, indicated R9 reported she wanted coffee and rolled too fast. A request for medication changes was identified as an

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intervention.

During observation on 7/21/21, at 5:26 a.m. R9 was lying in bed asleep. At 5:54 a.m. nursing assistant (NA)-B entered R9's room, woke her up and asked her if she wanted to get up. R9 stated she wanted to stay in bed. At 5:56 a.m. NA-D and NA-F entered R9's room, turned on the lights, raised the bed and got R9 up and dressed for the day. While NA-D and NA-F were putting R9's pants on, R9's legs were observed to be contracted and R9 complained of pain when her legs were straightened. R9 was assisted out of bed and into her recliner with a mechanical lift. At 6:06 a.m. licensed practical nurse (LPN)-A gave R9 pain medication and asked her if her knees hurt. R9 replied yes.

During interview on 7/21/21, at 6:12 a.m. NA-D stated R9 would crawl out of bed because she was unable to stand. NA-D stated usually it was because R9 "had a mess in her pants." NA-D said R9's fall interventions included fall mats, bed alarms and gripper socks but stated R9 didn't walk. NA-D said there was nothing they could do to prevent R9 from falling and said R9 had never had a horrible fall.

On 7/22/21, at 9:00 a.m. NA-C stated R9 had fallen the previous day and had checked on her around 9:45 a.m. , after she returned from her break the other staff had found R9 on the floor. NA-C stated R9 was not reliable to use her call light and often woke up after having bad dreams. If R9 rolled over she would fall. NA-C stated some nights R9 was up all night and would sleep in her chair or bed all day and sometimes she was awake all day.

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At 10:15 a.m. registered nurse (RN)-A stated R9's care plan indicated she had demonstrated she had been attempting to get out of bed intentionally and was not having falls. RN-A said R9 was able to slide herself to the edge of the bed, put her feet down and roll out of bed intentionally. RN-A stated R9 was not able to stand and needed assistance from staff. RN-A stated the bed alarm was used to alert staff if R9 was moving around in bed or wheel chair and said R9 did not remember to use her call light. RN-A said a falls assessment was conducted quarterly with the MDS and R9 was a high risk for falls. RN-A stated no patterns had been identified.

At 11:52 a.m. the director of nursing (DON) stated after a fall the interdisciplinary team looked at data prior to the fall such as what was happening at the time of the fall to try to determine the cause. The DON stated the team would then try to come up with ideas to prevent further falls. The DON stated R9 had a lot of behaviors and R9 had demonstrated how she crawled out of bed but said if R9 did not say she crawled out of bed they counted it as a fall. The DON stated R9 often got restless in the early morning and a lot of times the night shift got her up. The DON stated a comprehensive assessment of R9's falls had not been completed.

A facility policy Fall Risk Assessment/Re-Assessment dated 5/15, indicated the facility was to identify residents at risk for falls and develop fall precautions with an overall goal to reduce the incidence of falls. The policy directed the IDT to review falls on business days or within 72 hours and monitor interventions and modify as needed. The policy indicated falls would be reviewed quarterly and at quality

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F 689	Continued From page 8 assurance meetings.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		9/21/21

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F 880	Continued From page 9 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure hand hygiene, to prevent cross contamination, was performed after incontinence cares for 2 of 5 residents (R3, R6) who were observed during toileting assistance. Findings include:	F 880	- Staff education including Relias Course of Basics of Hand Hygiene - Update policy to include cleaning hands before and after assisting residents with toileting and perineal cares - Placing hand sanitizers in each resident□s bathroom and easily accessible glove placement	

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F 880	Continued From page 10 R3's quarterly MDS dated 4/8/21 indicated R3 had little to no cognitive impairment or behavior issues. R3's MDS indicated she was independent with Activities of Daily Living (ADLs). R3's MDS indicated she was continent of bowel and bladder. R3's daily care sheet dated 7/19/21 indicated R3 required assistance with toileting and transferring. During observations on 7/21/21, at 7:27 a.m. nursing assistant (NA)-A entered R3's room and sanitized their hands and put on clean gloves. NA-A assisted R3 into her wheelchair and brought R3 to the bathroom. NA-A assisted R3 to stand, pulled down R3's pants with gloved hands and removed a urine soiled brief. With contaminated gloves NA-A opened R3's lip balm, used a contaminated gloved finger to place lip balm on R3's lips. With the contaminated gloves NA-A then put on clean pants and a clean brief on R3's legs. While wearing the contaminated gloves NA-A washed R3's face and upper body, and assisted R3 to dry off. NA-A assisted R3 to stand and using the contaminated gloves NA-A cleaned and dried R3's bottom; pulled up R3's brief and pants; transferred R3 to her wheelchair; and brought her to the over bed table. NA-A removed the contaminated gloves and sanitized his hands as NA-A left the room. During interview on 7/21/21, at 7:43 a.m. NA-A stated the same gloves were wore throughout assisting R3 with her cares. NA-A usually wore the same gloves from start to finish with morning cares, unless a resident had a brief soiled with fecal mater. Further, the staff should change their gloves and wash their hands when ever going	F 880	- Frequent audits to ensure there is not cross-contamination during incontinent cares, toileting, and peri cares and coaching - Staff education including Relias Course of Basics of Hand Hygiene - Update policy to include cleaning hands before and after assisting residents with toileting and perineal cares - Placing hand sanitizers in each resident□s bathroom and easily accessible glove placement - Frequent audits to ensure there is not cross-contamination during incontinent cares, toileting, and peri cares and coaching - Placing hand sanitizer stations in each residents bathrooms - Frequent audits to ensure there is not cross-contamination during incontinent cares, toileting, and peri cares and coaching - Complete daily audits X 1 week. Decrease frequency once goal of >90% of compliance is reached - Report audit results to the QAPI committee for recommendations and review Directed Plan of Correction COMPLETED and documents attached.	

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F 880	Continued From page 11	F 880		

from dirty to clean, like after removing a brief.

R6's quarterly MDS dated 4/22/21, indicated R6 had mild cognitive impairment and weakness. The MDS also indicated R6 required supervision with activities of daily living (ADL's) including toileting, transferring and personal hygiene. R6's Bowel and Bladder assessment dated 7/18/21, indicated R6 was incontinent of stool 1-3 days per week.

During observation on 7/21/21, at 6:17 a.m. NA-D was in the bathroom next to R6 while R6 was standing near the toilet and holding onto the grab bar on the wall. NA-D was wearing gloves and wiping stool from R6's buttocks. With the same dirty gloves, NA-D proceeded to dress R6 with a clean brief and pajama bottoms. NA-D failed to doff dirty gloves or complete hand hygiene after performing perineal care and prior to touching R6's clean clothing.

During interview on 7/21/21, at 6:30 a.m. NA-D stated when providing cares for a resident she would change her gloves when they were soiled or dirty with stool. NA-D did not remove the dirty gloves or use hand sanitizer after performing perineal cares and prior to dressing R6.

During interview on 7/22/21 at 1:27 p.m. the director of nursing (DON) stated staff should change gloves and perform hand hygiene whenever they go from dirty to clean. After incontinent cares were completed, staff should remove and throw away the dirty gloves, perform hand hygiene, and put on new gloves prior to touching anything else. Staff should not continue to wear dirty gloves when performing clean duties including putting on a clean brief and/or clean

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F 880	Continued From page 12 clothing. The facility's Infection Control Practices policy revised date 2/10 directed staff to wash their hands after direct resident contact, including toileting, to prevent infections of any nature. The facility's undated Hand Hygiene/Handwashing policy directed staff to practice proper hand hygiene to prevent the spread of infection by using soap and water or alcohol-based hand rub. The policy further directed staff to perform hand hygiene after completing activities including contact with body fluids or excretions and removing gloves.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 12, 2021

Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, MN 56751

Re: State Nursing Home Licensing Orders
Event ID: 9DN111

Dear Administrator:

The above facility was surveyed on July 19, 2021 through July 22, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/19/21 through 7/22/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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	00579	A. BUILDING: _____ B. WING _____	C 07/22/2021

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The complaint H5470016C (MN74510) was SUBSTANTIATED: A licensing order was issued at MN RULE 4658.0800 Subpt 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure each fall was comprehensively assessed and appropriate interventions were assessed for and/or implemented in an effort to reduce falls for 1 of 4 residents (R9) reviewed for falls. Findings include: R9's care area assessment (CAA) dated 8/18/20,	2 830	CORRECTED	8/31/21

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2 830	Continued From page 3	2 830		

identified a risk for falls, history of falls, decreased mobility and altered mental status. The CAA indicated R9 had a bed alarm, routine toileting and chair alarm to help prevent falls. R9's falls most often occurred related to toileting needs, urgency/frequency, or confusion with bladder infections.

R9's quarterly Minimum Data Set (MDS) dated 5/6/21, indicated R9 had severe cognitive impairment and required extensive assistance from two staff for bed mobility, transfers and toileting. R9 had lower extremity impairment on both sides, was continent of bowel and frequently incontinent of bladder. Further, R9 had sustained two or more falls without injury and two or more falls with injury since the previous assessment.

R9's care plan dated 5/10/21, identified a risk for falls and a history of repeated falls. Care planned interventions included: bed alarm, routine toileting and chair alarm to help prevent falls as well as pain medication, anti-anxiety medication and non pharmacological interventions for behaviors, pain and risk for falls. The care plan directed staff to check R9 on rounds every two hours and encourage bathroom on a routine basis. The interventions updated on 4/26/21, indicated R9 had demonstrated to staff how she put herself on the floor mat intentionally. When R9 was found on the mat, staff were to ask if she intentionally put herself there and if R9 said yes, staff did not need to count the incident as a fall.

R9's incident reports identified the following falls:

- 3/23/21, at 8:45 p.m. R9 was found kneeling on the floor mat with her arms on the bed, bed alarm sounding. R9 stated she did not want to be in bed anymore and wanted to get up. A Falls

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2 830	Continued From page 4 Worksheet dated 3/24/21, indicated interventions included: mats on both sides of bed, call light was within reach, bed alarm was sounding. R9 awakened easily to noise in hallway so sometimes the door was closed. There was no evidence a comprehensive fall assessment was completed including evidence new interventions were assessed for and/or why new interventions were not necessary. - 3/26/21, at 11:20 p.m. R9's alarm was sounding and staff heard her calling for help. R9 was found on hands and knees resting against the bed on the floor mat. She was yelling for help. Reported she had company coming and was trying to get up. There was no evidence a comprehensive fall assessment was completed including evidence new interventions were assessed for and/or why new interventions were not necessary. - 3/28/21, at 4:00 p.m. staff heard R9 yelling from her room. Staff responded to find R9 lying on her left side on the floor mat next to the bed. R9 was sitting and stated she needed to get out of there and was having delusions. No mat was in place and alarm did not sound. R9 reported mild hip pain. Staff were reminded the importance of having the mat in place. The alarm was found to have a broken cord and was replaced. A Falls Worksheet dated 3/28/21, indicated mats were not in place at time of the fall. Mats need to be placed as care planned and staff were reminded. The bed alarm was in place but was not working. The call light was in reach and R9 was reminded the importance of pushing her call light, even though R9 had severe cognitive impairment. There was no evidence a comprehensive fall assessment was completed including evidence new interventions were assessed for and/or why new interventions were not necessary.	2 830		

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2 830	Continued From page 5 - 4/3/21, at 9:10 p.m. R9 was found kneeling over her bed, unsure what she wanted to do. A Falls Worksheet dated 4/3/21, indicated R9 did not know what she was doing at the time of the fall. There was no evidence a comprehensive fall assessment was completed including evidence new interventions were assessed for and/or why new interventions were not necessary. - 4/19/21, at 8:45 p.m. R9 found sitting on her butt on the floor mat next to her bed. R9 was talking about her children and wondering if they were awake. A Fall Worksheet dated 4/19/21, indicated alarm had been sounding and R9 was assisted to the recliner. There was no evidence a comprehensive fall assessment was completed including evidence new interventions were assessed for and/or why new interventions were not necessary. - 4/25/21, at 2:35 a.m. R9 was found with her knees on the mat and her upper body on the bed. R9 stated she was trying to get to the bathroom. A Falls Worksheet dated 4/25/21, included a section for recommendations/interventions. The section was left blank. There was no evidence a comprehensive fall assessment was completed including evidence new interventions were assessed for and/or why new interventions were not necessary. - 4/25/21, at 9:13 a.m. R9 was found sitting on the floor mat next to her bed. R9 stated she tried to get up and check on the kids. A Falls Worksheet dated 4/26/21, indicated R9 was trying to get up and check on the kids. Intervention identified as R9 was brought to the common area. The Falls Worksheet further identified R9 had five falls in the last 30 days and 12 falls in the	2 830		

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2 830	Continued From page 6 last 31-180 days. - 5/8/21, at 10:35 p.m. R9 was found on her knees on the mat with her upper body on the bed, holding on to the side rail. R9 stated she fell out of bed. A Falls Worksheet dated 5/8/21, indicated R9 stated she fell out of bed and thought she was cold and that's why she fell. Intervention indicated she was put back to bed and covered up; however, did not identify interventions to prevent further falls or an assessment to identify why new interventions were not warranted. - 5/30/21, at 5:00 a.m. R9's alarm sounded. Staff entered the room and found R9 on the floor next to her bed. The report indicated the interdisciplinary team (IDT) reviewed the fall, R9 had been incontinent at the time of the fall likely putting her at increased risk for fall. R9 had been checked on continence rounds one hour before and as a result, no change to care plan was recommended. The intervention included "Will have pharmacist look at medications." R9's nursing Progress Notes identified the following: 6/12/21, at 6:40 a.m. staff responded to R9's alarm and found her kneeling on her floor mat. R9 stated she was getting up for the day. 7/16/21, at 11:45 P.M. R9 was found seated on the floor mat next to her bed. R9 stated she was going to get up and said "I sat here." 7/17/21, at 12:57 a.m. R9 was found rolling out of bed with her knees on the floor mat. R9 was incontinent of urine. 7/17/21 at 1:29 p.m. R9 found sitting on the floor	2 830		

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2 830	Continued From page 7 mat at the edge of the bed. R9 stated she was getting up. 7/18/21, at 4:28 a.m. R9 found on the floor mat next to the bed. R1 was experiencing hallucinations. 7/21/21, at 11:09 a.m. R9 was found lying on the floor next to her bed. R9 stated she needed a cup of coffee and had rolled too fast. A Falls Worksheet dated 7/21/21, indicated R9 reported she wanted coffee and rolled too fast. A request for medication changes was identified as an intervention. During observation on 7/21/21, at 5:26 a.m. R9 was lying in bed asleep. At 5:54 a.m. nursing assistant (NA)-B entered R9's room, woke her up and asked her if she wanted to get up. R9 stated she wanted to stay in bed. At 5:56 a.m. NA-D and NA-F entered R9's room, turned on the lights, raised the bed and got R9 up and dressed for the day. While NA-D and NA-F were putting R9's pants on, R9's legs were observed to be contracted and R9 complained of pain when her legs were straightened. R9 was assisted out of bed and into her recliner with a mechanical lift. At 6:06 a.m. licensed practical nurse (LPN)-A gave R9 pain medication and asked her if her knees hurt. R9 replied yes. During interview on 7/21/21, at 6:12 a.m. NA-D stated R9 would crawl out of bed because she was unable to stand. NA-D stated usually it was because R9 "had a mess in her pants." NA-D said R9's fall interventions included fall mats, bed alarms and gripper socks but stated R9 didn't walk. NA-D said there was nothing they could do to prevent R9 from falling and said R9 had never had a horrible fall.	2 830		

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2 830	Continued From page 8 On 7/22/21, at 9:00 a.m. NA-C stated R9 had fallen the previous day and had checked on her around 9:45 a.m. , after she returned from her break the other staff had found R9 on the floor. NA-C stated R9 was not reliable to use her call light and often woke up after having bad dreams. If R9 rolled over she would fall. NA-C stated some nights R9 was up all night and would sleep in her chair or bed all day and sometimes she was awake all day. At 10:15 a.m. registered nurse (RN)-A stated R9's care plan indicated she had demonstrated she had been attempting to get out of bed intentionally and was not having falls. RN-A said R9 was able to slide herself to the edge of the bed, put her feet down and roll out of bed intentionally. RN-A stated R9 was not able to stand and needed assistance from staff. RN-A stated the bed alarm was used to alert staff if R9 was moving around in bed or wheel chair and said R9 did not remember to use her call light. RN-A said a falls assessment was conducted quarterly with the MDS and R9 was a high risk for falls. RN-A stated no patterns had been identified. At 11:52 a.m. the director of nursing (DON) stated after a fall the interdisciplinary team looked at data prior to the fall such as what was happening at the time of the fall to try to determine the cause. The DON stated the team would then try to come up with ideas to prevent further falls. The DON stated R9 had a lot of behaviors and R9 had demonstrated how she crawled out of bed but said if R9 did not say she crawled out of bed they counted it as a fall. The DON stated R9 often got restless in the early morning and a lot of times the night shift got her up. The DON stated a comprehensive assessment of R9's falls had not	2 830		

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2 830	Continued From page 9 been completed. A facility policy Fall Risk Assessment/Re-Assessment dated 5/15, indicated the facility was to identify residents at risk for falls and develop fall precautions with an overall goal to reduce the incidence of falls. The policy directed the IDT to review falls on business days or within 72 hours and monitor interventions and modify as needed. The policy indicated falls would be reviewed quarterly and at quality assurance meetings. SUGGESTED METHOD OF CORRECTION: The DON or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by:	21375		8/31/21

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21375	Continued From page 10 Based on observation, interview and document review the facility failed to ensure hand hygiene, to prevent cross contamination, was performed after incontinence cares for 2 of 5 residents (R3, R6) who were observed during toileting assistance. Findings include: R3's quarterly MDS dated 4/8/21 indicated R3 had little to no cognitive impairment or behavior issues. R3's MDS indicated she was independent with Activities of Daily Living (ADLs). R3's MDS indicated she was continent of bowel and bladder. R3's daily care sheet dated 7/19/21 indicated R3 required assistance with toileting and transferring. During observations on 7/21/21, at 7:27 a.m. nursing assistant (NA)-A entered R3's room and sanitized their hands and put on clean gloves. NA-A assisted R3 into her wheelchair and brought R3 to the bathroom. NA-A assisted R3 to stand, pulled down R3's pants with gloved hands and removed a urine soiled brief. With contaminated gloves NA-A opened R3's lip balm, used a contaminated gloved finger to place lip balm on R3's lips. With the contaminated gloves NA-A then put on clean pants and a clean brief on R3's legs. While wearing the contaminated gloves NA-A washed R3's face and upper body, and assisted R3 to dry off. NA-A assisted R3 to stand and using the contaminated gloves NA-A cleaned and dried R3's bottom; pulled up R3's brief and pants; transferred R3 to her wheelchair; and brought her to the over bed table. NA-A removed the contaminated gloves and sanitized his hands as NA-A left the room.	21375	CORRECTED	

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During interview on 7/21/21, at 7:43 a.m. NA-A stated the same gloves were wore throughout assisting R3 with her cares. NA-A usually wore the same gloves from start to finish with morning cares, unless a resident had a brief soiled with fecal mater. Further, the staff should change their gloves and wash their hands when ever going from dirty to clean, like after removing a brief.

R6's quarterly MDS dated 4/22/21, indicated R6 had mild cognitive impairment and weakness. The MDS also indicated R6 required supervision with activities of daily living (ADL's) including toileting, transferring and personal hygiene. R6's Bowel and Bladder assessment dated 7/18/21, indicated R6 was incontinent of stool 1-3 days per week.

During observation on 7/21/21, at 6:17 a.m. NA-D was in the bathroom next to R6 while R6 was standing near the toilet and holding onto the grab bar on the wall. NA-D was wearing gloves and wiping stool from R6's buttocks. With the same dirty gloves, NA-D proceeded to dress R6 with a clean brief and pajama bottoms. NA-D failed to doff dirty gloves or complete hand hygiene after performing perineal care and prior to touching R6's clean clothing.

During interview on 7/21/21, at 6:30 a.m. NA-D stated when providing cares for a resident she would change her gloves when they were soiled or dirty with stool. NA-D did not remove the dirty gloves or use hand sanitizer after performing perineal cares and prior to dressing R6.

During interview on 7/22/21 at 1:27 p.m. the director of nursing (DON) stated staff should change gloves and perform hand hygiene whenever they go from dirty to clean. After

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incontinent cares were completed, staff should remove and throw away the dirty gloves, perform hand hygiene, and put on new gloves prior to touching anything else. Staff should not continue to wear dirty gloves when performing clean duties including putting on a clean brief and/or clean clothing.

The facility's Infection Control Practices policy revised date 2/10 directed staff to wash their hands after direct resident contact, including toileting, to prevent infections of any nature.

The facility's undated Hand Hygiene/Handwashing policy directed staff to practice proper hand hygiene to prevent the spread of infection by using soap and water or alcohol-based hand rub. The policy further directed staff to perform hand hygiene after completing activities including contact with body fluids or excretions and removing gloves.

SUGGESTED METHOD FOR CORRECTION: The DON and/or designee could review and/or develop policies and provide education for staff regarding hand hygiene and glove use. The DON/ designee could audit staff to ensure proper hand hygiene and glove use was provided during toileting cares. The audits could be brought to the QAPI committee for further review and recommendations on continued auditing or changes in the plan.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, LifeCare Roseau 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code (NFPA 99). THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/24/2021

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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	245470	A. BUILDING **CN - ROSEAU C & NC** B. WING _____	**07/20/2021**

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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 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	K 000		

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K 000	Continued From page 2 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 30 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission	K 341		7/29/21

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K 341	Continued From page 3 paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2012 NFPA 101, "The Life Safety Code" Sections 19.3.4.1 and 9.6, as well as 2010 NFPA 72, "National Fire Alarm and Signaling Code" section 17.7.4.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 07/20/2021 at 12:13 PM, observation revealed, that the smoke detector located in the wheelchair washing room was installed within 36 inches of a HVAC vent diffuser. This deficient condition was confirmed by a Maintenance Supervisor.	K 341	- LifeCare Medical Staff installed deflector shield on the diffuser. - Monitoring will be done semi-annual and/or with changes and construction projects as needed. - Monitoring will be done semi-annual and/or with changes and construction projects as needed. - Monitoring will be completed by the Director of Facilities Management	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection	K 351		8/31/21

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K 351	Continued From page 4 measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to install and maintain the fire sprinkler system in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.7.1.1, and NFPA 13 - 2010 edition, Sections 6.2.9.1, 8.5.4, and 8.5.4.1.4. This deficient condition could have a patterned impact on the residents within the facility. Findings include: 1. On 07/20/2021 at 11:57 AM, observation revealed that the ceiling tile located on the min entry side of the oak wing smoke barrier doors has a 2 inch by 2 inch triangular piece missing. 2. On 07/20/2021 at 12:27 PM, observation revealed that there are 3 spare sprinkler heads that are not secured and protected within the fire sprinkler spare head box located by the main sprinkler riser. These deficient condition was verified by the Maintenance Supervisor.	K 351	- Ceiling tile replaced by LifeCare Medical Center staff. - Ordered a spare head storage box to be installed to hold spare sprinkler heads. - Monitoring of ceiling tiles condition will be done monthly by Roseau Manor IDT safety rounds. - Facilities Management staff will also complete spot checks along with semi-annual monitoring. - Monitoring of ceiling tiles condition will be done monthly by Roseau Manor IDT safety rounds. - Facilities Management staff will also complete spot checks along with semi-annual monitoring. - Director of Facilities Management - Tile replaced 7/21/21 - Spare head storage box 8/31/21	

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K 901	Continued From page 5	K 901		
K 901 SS=F	Fundamentals - Building System Categories 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 REQUIREMENT is not met as evidenced by: Based on staff interview and a review of all available documentation, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/20/2021, at 11:40 AM, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not cover patient care equipment as detailed in NFPA 99 "Health Care Facilities Code" 2012 edition Chapter 10 - Electrical Equipment, and Chapter 11 - Gas Equipment.	K 901	- The utility risk assessment for patient care equipment was completed on 8/11/21. - Will be reviewed and updated at least annually by Facilities Maintenance - Will be reviewed and updated at least annually by Facilities Maintenance - Director of Facilities Management	8/11/21

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K 901	Continued From page 6 This deficient condition was verified by the Maintenance Supervisor.	K 901		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure	K 923		8/31/21

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K 923	Continued From page 7 considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that oxygen cylinders are not being stored in accordance with NFPA 99 Standards for Health Care Facilities 2012 sections 11.3.4.1, 11.3.4.2. and 11.6.2.3 (11). This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 07/20/2021 at 12:41 PM, during the facility tour, observations revealed that there were 6 loose oxygen cylinder located in the oxygen storage room in the Maple Grove wing that were not secured in tip resistant holder. 2. On 07/20/2021 at 12:55 PM, during the facility tour, observations revealed that there were 8 loose oxygen cylinder located in the main medication room that were not secured in tip resistant holder. 3. On 07/20/2021 at 12:35 PM, during the facility tour, observations revealed that the room labeled as a soiled linen room located in the Maple Grove wing was being used for oxygen storage and did not have the proper precaution sign and labeling for an oxygen storage room. 4. On 07/20/2021 at 12:50 PM, during the facility tour, observations revealed that the room labeled as a soiled linen room located in the Oak wing was being used for oxygen storage and did not	K 923	- Oxygen tanks were placed in secure holders on 7/20/21 - In progress of turning a dirty utility room into an oxygen room. - Proper signage will be placed on the oxygen room and medication room door as recommended. - Will be monitored and audited by the Director of Nursing and Director of Facilities Management 2x/week for 12 weeks - Audit results will be shared with QAPI committee - Will provide staff education on proper storage of oxygen - Random audits will be conducted and reported back to the QAPI committee for recommendations based on audit results - Director of Nursing - Director of Facilities Management - Placed oxygen tanks in secure holders on 7/20/21 - Renovation for Oxygen room will be completed by 8/31/21 - Education to staff will be provided by 8/31/21	

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K 923	Continued From page 8 have the proper precaution sign and labeling for an oxygen storage room. These deficient condition was verified by the Maintenance Supervisor.	K 923		