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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: B9FV
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 **04/04/2014** (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 **60** (L18)

13.Total Certified Beds **60** (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
	60			
(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):
See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 04/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
MPM
Mark Meath, Enforcement Specialist — 06/02/2014 (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
04/23/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5470

On April 4, 2014, a Post Certification Revisit by review of the facility's plan of correction. Based on the plan of correction, it has been determined that the facility has corrected the deficiencies pursuant to the standard survey completed February 13, 2014, effective March 21, 2014. Refer to the CMS 2567b for both health and life safety code.

Effective March 21, 2014, the facility is certified for 60 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Cerification Number (CCN): 24-5470

June 2, 2014

Ms. Susan Lisell, Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, Minnesota 56751

Dear Ms. Lisell:

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 March 25, 2014 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 4, 2014

Ms. Susan Lisell, Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, Minnesota 56751

RE: Project Number S5470040

Dear Ms. Lisell:

On March 5, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 13, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 4, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 28, 2014 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 February 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 25, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 13, 2014, effective March 25, 2014 and therefore remedies outlined in our letter to you dated March 5, 2014, 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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245470	A. Building B. Wing	4/4/2014

Name of Facility	Street Address, City, State, Zip Code
LIFECARE ROSEAU MANOR	715 DELMORE DRIVE ROSEAU, MN 56751

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0241** Reg. # **483.15(a)** LSC	**02/28/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	**03/07/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	**03/07/2014**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**03/07/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**03/07/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	**03/07/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	**03/07/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	**03/07/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**03/04/2014**
ID Prefix **F0373** Reg. # **483.35(h)** LSC	**03/25/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/LB	04/04/2014	28035	04/04/2014
CMS RO				

Followup to Survey Completed on: 2/13/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245470	CN - ROSEAU C & NC	3/28/2014

Name of Facility	Street Address, City, State, Zip Code
LIFECARE ROSEAU MANOR	715 DELMORE DRIVE ROSEAU, MN 56751

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0038	02/20/2014	ID Prefix Reg. # NFPA 101 LSC K0067	02/13/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	MM/PS	04/04/2014	03006	03/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/12/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: B9FV
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: **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 **02/13/2014** (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 **60** (L18)

13.Total Certified Beds **60** (L17)

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
	60			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jana Bromenshenkel, HFE NEII 03/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/21/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 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
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5470

At the time of the February 13, 2014 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 5, 2014

Ms. Susan Lisell, Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, Minnesota 56751

RE: Project Number S5470037

Dear Ms. Lisell:

On February 13, 2014, 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 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 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:

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - 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;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6**

months after the survey date; and
<u>Informal Dispute Resolution</u> - 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, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
lyla.burkman@state.mn.us.

Telephone: (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 March 25, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 25, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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,

- Include electronic acknowledgement signature of provider and date.

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 May 13, 2014 (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 August 13, 2014 (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
Division of Compliance Monitoring
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 electronic 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File 5470s14.rtf

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 ______	02/13/2014

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 The facility's plan of correction (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 verifcation of compliance. Upon receipt of an acceptable 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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure each resident's dignity was maintained during meals in the main dining room. Staff was observed to scrape off dirty plates when residents were eating which had the potential to affect 6 identified residents (R2, R14, R16, R52, R56 and R61) and had the potential to affect the 22 other residents eating in the dining room during the observation. Findings include: On 2/13/14, at 8:23 a.m. a three tiered cart for busing dishes was observed stationed in the middle of the dining room. The top tier of the busing cart consisted of an uncovered bin for	F 241	"Bus carts" will be kept in a stationary position on the perimeter of dining room and not in the middle of dining room. Nursing and Life Enhancement staff will bring empty plates, utensils, condiment containers to the bus carts. Tables will be cleared after all the residents at that table have finished eating their meal. Cart 1 by door to outside; Cart 2 next to sink; Cart 3 by entrance to dining room. All residents could be impacted and our goal is to enhance the dining experience. Activity, nursing, and dietary staff have	2/28/14

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

Electronically Signed — 03/13/2014

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 ______ B. WING ______	02/13/2014

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F 241	Continued From page 1 "liquid waste" which consisted of a tan mixture of left over liquids; a bucket of table wipes and a bin with two inches of water and soiled silverware. The second tier consisted of two bins ¾'s full of scraped, dirty dishes, glasses, cups and bowls. Two garbage cans were attached to the sides of the busing cart. On 2/13/13, at 8:34 a.m. through 8:46 a.m. the life enhancement supervisor, registered nurse (RN)-E, and the dietician were observed removing dirty dishes from tables, dumping left over coffee, milk, cereal in the uncovered liquid waste bin on the top of the cart, scraping dirty plates into the attached garbage bins and placing the dirty dishes and silverware in the bins. During this time R2, R14, R16, R52, R56, and R61 along with 22 other unidentified residents remained seated at their tables eating their breakfast meal. On 2/13/14, at 8:54 a.m. director of nursing (DON) observed facility staff scraping off dirty dishes and placing them in the busing cart bins while residents remained in the dining room eating their breakfast meal with some residents within three feet of the busing cart. DON confirmed it would be a more dignified dining experience if the busing cart was situated in a less conspicuous location than in the middle of the dining room. On 2/13/14, at 2:12 p.m. RN-D was unable to provide a facility policy regarding clearing tables in the dining room.	F 241	been instructed as to proper placement of "bus carts" and compliance has been achieved. Inservices were held 2/21/14 for staff. Dining room committee met 2/27/14 and 3/04/14 and discussion and further instruction took place. Licensed staff and Life Enhancement staff monitor compliance by observation and dining room audits daily times 30 days and review at dining room committee meeting monthly and will review at next Quality Assurance/Medical Director Meeting. Date of correction: 2/28/14	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities,	F 242		3/7/14

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F 242	Continued From page 2 schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the opportunity to make choices about when to get up in the morning for 1 of 3 (R16) residents reviewed with concerns regarding these choices. Findings include: R16's clinical record indicated diagnoses that included fall, disc degeneration, left 5th metatarsal (foot) fracture, left clavicle (collar bone) fracture, shoulder pain and vertigo. R16's admission Minimum Data Set (MDS) dated 1/2/14 indicated R16 had moderate cognitive impairment and required extensive assist of one for bed mobility, transfers, toilet use and personal hygiene. On 2/11/14, at 9:03 a.m. R16 stated that she is not offered a choice of when to get up in the morning. R16 stated that "they get you up whenever they want you to get up." R16 stated that she preferred to get up about 9 a.m. On 2/12/14, at 7:00 a.m. R16 was observed to be in bed with the lights off. At 7:14 a.m. R16 was observed to be up and nursing assistant (NA)-J was assisting R16 with morning cares.	F 242	Residents are given Resident Bill of Rights pamphlet and Admission checklist upon admission of which accomdation of needs is explained. Staff is encouraged to give residents an option to exercise their choice on matters of waking, bathing, bedtime, activities, clothing, and schedules. MDS, care plan, and care plan guide will reflect resident's choices and communicated via the to-do lists for each CNA on each shift. Inservices for nursing held 2/21/14 to review residents rights. R16 was asked what time she would like to get up and her care plan, care guide, and to-do list updated for nursing assistants to reflect choices. MDS coordinator to complete assessments and ensure resident preferences are noted and communicated via care plan, care plan guide, and to-do lists. Admission checklist to include resident preferences on admission. MDS coordinator to report compliance at quarterly Quality Assurance/Medical Director meeting.	

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F 242	Continued From page 3 R16 was intereviewed on 2/12/14, at 8:55 a.m. and stated that she wasn't ready to get up that morning and would have liked to sleep in until 9 a.m. if she could. R16 stated she had told them previous to that day but "they have so many to get up in the morning that she guessed they couldn't all get up at once." R16's Admission Assessment dated 12/27/13 indicates R16's usual bedtime was 10 p.m. R16 stated that she stays up later in the evening and usually gets up for the day around 9 a.m. R16's hard copy plan of care (POC) dated 1/24/13 and electronic POC dated 2/13/14 directed staff R16 required extensive assist of one for dressing, toileting, grooming/hygiene, transfers and oral hygiene. The POC lacked direction regarding R16's preferences related to time of day to get up. Oak Report dated 12/19/13 did not include any NA interventions or preferences for R16. R16's electronic NA activity of daily living (ADL) interventions, reported on the To Do List Report, directed NA's to provide skin care every shift and barrier cream to buttocks/coccyx after cares and as needed. It lacked direction regarding R16's preference to sleep until 9 a.m. On 2/12/14, at 1:15 p.m. NA-J stated that her usual work routine was to get R16's roommate up first at around 7:00 a.m. R16 often requested the bedpan and NA-J offered to take R16 to the bathroom instead and then got R16 ready for the day. NA-J stated she was not aware of R16's preference to get up later in the morning and that she would be willing and able to accommodate	F 242	Date of correction: 3/07/14	

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F 242	Continued From page 4 that request. On 2/13/13 at 11:25 a.m. registered nurse (RN)-D and RN-E stated that all residents' preferences were assessed upon admission. RN-D confirmed that R16's preference was to get up at 9 a.m. per the Admission Assessment. RN-E indicated R16's preference should have been communicated to the NA's via the care sheet and confirmed that R16's preference was not indicated on the Oak Report. A policy regarding residents' preferences was requested and Your Rights Under the Combined Federal and Minnesota Residents Bill of Rights booklet dated July 2007, prepared and distributed by Aging Services of Minnesota, was provided. The booklet indicated "You have the right to choose activities, schedules, and health care; interact with members of your community; and make choices about aspects of your life in the facility that are significant to you."	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns;	F 272		3/7/14

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F 272	Continued From page 5 Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a comprehensive assessment of a resident's activity of daily living limitations and mood status for 1 of 1 resident (R39) as required. Findings include: On 12/13/14, 8:30 a.m. nursing assistant (NA)-D was observed to assist R39 with morning cares. While NA-D assisted R39 to donne a shirt, R39 was observed to be unable to move the right shoulder above an approximate 60 degree level.	F 272	Comprehensive assessment is completed on admission and quarterly asessment on every resident. Significant change of condition will also generate another assessment. Triggered ares will generate completion of Care Area Assessment by MDS coordinator and also update of plan of care. All residents have a potential to be affected by this practice.	

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F 272	Continued From page 6 On 12/13/14, at 2:15 p.m. NA-D, NA-C, NA-E and registered nurse (RN)-D were observed to ambulate R39 16 feet with a front wheeled walker. R39's Diagnosis Listing indicated R39 was diagnosed with dementia, anxiety, osteoarthrosis and congestive heart failure. R39's annual Minimum Data Set (MDS) dated 12/23/13, indicated R39 had cognitive impairment and required extensive staff assistance with bed mobility, transferring, ambulation in the corridor, dressing, grooming and bathing. The MDS also indicated R39 had upper body functional limitations in range of motion on one side. Section V of the MDS/ Care Area Assessment (CAA) Summary, dated 12/23/13, identified eleven areas (communication, cognition, activities of daily living, urinary incontinence, mood state, behavioral symptoms, falls, nutrition, dehydration, pressure ulcers, falls and psychotropic medications) which required the completion of a comprehensive assessment. However, R39's clinical record lacked a CAA that addressed the identified concern of activities of daily living and mood status. On 2/12/14, at 12:00 p.m. RN-A verified R39 displayed limitations in activities of daily living along with occasional mood concerns. She confirmed the activities of daily living and mood status CAA's had not been completed. RN-A stated they must have been missed. The facility's Resident Assessment policy dated 6/2009, directed staff to complete a compressive assessment of the resident needs on a timely basis. Included in the interpretation and	F 272	MDS coordinator will follow facility policy on Resident Assessment and completion of Care Area Assessment and care plan updates/revision. R39 scheduled significant change MDS scheduled with ARD of 3/11/14 with Care Area Assessments to be completed. Monthly audits completed by MDS coordinator times 12 months to ensure compliance. Report findings to Quality Assurance/Medical Director meeting quarterly. Date of correction: 3/07/14	

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F 272	Continued From page 7 implementation, the staff were to follow the administrative policy that governed the MDS. The Center for Medicare and Medicaid Services (CMS) MDS Version 3.0 Resident Assessment Instrument (RAI) manual, chapter 4 directed facility staff to compete a comprehensive assessment on all areas identified as "triggered" on section V of the MDS. The RAI manual directed providers to further assess the areas causal factors, risk factors, and complications associated with the care area condition. The assessment was then to prompt the development of a plan of care to address the factors with the goal of promoting the resident's highest practicable level of function.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		3/7/14

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F 279	Continued From page 8 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive plan of care (POC) for 1 of 1 resident (R62) to include the monitoring and care of a fistula dialysis access port. Findings include: R62's clinical record indicated diagnoses that included stage IV chronic kidney disease (CKD), edema, and diabetes. R62's admission Minimum Data Set (MDS) dated 11/26/13 indicated R62 had moderate cognitive impairment and received dialysis treatments 3 times per week. The communication between the dialysis unit and the facility regarding R62's care was documented in a two pocket folder that traveled back and forth with R62 from the facility to all dialysis treatments. The folder contained a pocket guide entitled "Your Access Care Pocket Guide". This guide provided the following instructions: no blood pressure in access arm, only hemodialysis needles in access arm, recommended skin care before and after each treatment, universal precautions and also included a contact number for questions. The guide also directed "TLC Your Access Daily". "Touch for pulse, tenderness and temperature. Look at skin color, for swelling and drainage. Care: keep clean, keep protected, no resting on arm, no heavy lifting, no carrying, watch your weight, keep clothes loose and no tight jewelry." R62's hard copy POC dated 1/3/14 and electronic POC dated 2/13/14 directed staff R62 required a	F 279	Care plan updated to reflect post-dialysis care of R62. Dialysis in-service by dialysis nurse on 2/28/14 to nursing staff. Care plan includes monitoring of fistula site by charge nurse including "thrill" twice daily to feel at inner elbow on right arm for a purring, vibration or strong pulse. Monitor for signs of infection including swelling, redness, tenderness, drainage and notify MD of any of the above. Dietician developed plan for fluid restriction for each meal, snack and gave nursing an allotment for number of ml per med pass. Charge nurse to report to oncoming charge nurse at change of shift report intake total and remaining allotment for oncoming shift. Dietician and dialysis unit updated of any concerns related to hydration status. Resident and family have also been educated on this plan of care by dialysis unit staff. Resident care plan completed according to physician orders. Future admits with dialysis or resident who starts dialysis will have site monitored for thrill twice daily, signs and symptoms of infection monitored daily by nursing as well as fluid intake every shift per MD orders. Comprehensive care plan will be implemented to reflect post dialysis care as above.	

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F 279	Continued From page 9 fluid restriction of 2 liters (L) per day. The electronic POC additionally directed staff to document intake and output total every shift for the fluid restriction of 2 liters per day and to administer Aldactone 100 milligrams (mg) orally, daily (a medication for the treatment of fluid retention). Both POC's informed staff R62 attended dialysis every Monday (M), Wednesday (W) and Friday (F) am. Staff were directed to fill out nursing home communication sheet prior to dialysis. Both POC's failed to identify interventions specific to the care of R62's fistula access site, what conditions or complications from dialysis should have been monitored, who was responsible for monitoring the site and how often the access site was to be monitored. R62's nursing assistant's (NA) care sheet indicated R62's 2 liter/day fluid restriction. The care sheet lacked direction to monitor or report fluid intake and lacked direction regarding changes in condition realted to emergencies or complications from dialysis NA's should monitor and report. R62's electronic NA activity of daily living (ADL) interventions, reported on the To Do List Report, failed to indicate R62's fluid restriction and also lacked direction to monitor or report fluid intake. It additionally lacked direction regarding changes in condition related to emergencies or complications from dialysis NA's should monitor and report. Registered nurse (RN)-D was interviewed on 2/13/13, at 10:24 a.m. and stated that the only information pertaining to R62's dialysis care was in the dialysis folder. She confirmed that R62's chart/POC did not contain specific directions	F 279	Charge nurse will monitor for compliance by checking site twice a day and documenting results. Intake totals to be completed every shift and documented by charge nurse. Fluid restriction 2 liters per day. Physician to be notified if there are any complications, i.e. diminished pulse, bleeding, or signs and symptoms of infection at site. Dietician will evaluate hydration on a monthly basis by reviewing fluid intake and weights. This will be reported to Director of Nursing and then to Quality Assurance/Medical Director meeting quarterly. Date of correction: 3/07/14	

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F 279	Continued From page 10 regarding the care and management of his fistula. A policy pertaining to dialysis care was requested but not provided. On 2/13/14, at 11:00 a.m. RN-D stated there was no facility policy for the care of resident's undergoing dialysis.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must 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 provide ambulation services as directed by the resident's individual written plan of care (POC) for 1 of 1 resident (R39) in the sample who required assistance with ambulation. Findings include: R39's POC dated 5/8/13, directed staff to ambulate with R39 three times a day with a front wheeled walker for eight or more minutes per episode. R39's ambulation Progress Notes completed by the nursing assistants revealed the following: - February 1-12, 2014, R39 ambulated nine out of 36 opportunities to ambulate. - January 2014, R39 ambulated 15 out of 93 opportunities to ambulate. - December 2013, R39 ambulated 24 out of 93	F 282	Monthly rehab meeting 3/03/14 R39 program reviewed. Rehab program revised to reflect R39's current level/ability of participation. Range of motion 15 minutes daily to bilateral shoulders and lower extremities added to rehab aide to-do list. Goal added to ambulation program 50 feet three times a day to reflect appropriate distance added to nursing assistant's to-do list. Nursing staff educated regarding changes of plan of care as they occur and instructed to follow care plan. All residents have the potential to be affected. All residents were reviewed on 3/03/14 and all reviewed monthly at rehab meeting to ensure proper rehab program or need of a rehab program. Care plans are audited and updated at rehab meeting and reviewed quarterly by RN that	3/7/14

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F 282	Continued From page 11 opportunities to ambulate. - November 2013, R39 ambulated 34 out of 90 opportunities to ambulate. On 2/12/14, at 8:30 a.m. nursing assistant (NA)-D was observed to assist R39 to transfer from the bed to a wheelchair using a mechanical standing lift. R39 followed NA-D's directions and was able to bear weight as she transferred to the wheelchair. At 8:50 a.m. NA-D was observed to wheel R39 to the dining room for breakfast. NA-D did not attempt to assist or offer R39 to ambulate. At 10:00 a.m. R39 was observed seated in a recliner in the main lobby. R39 had not ambulated. At 2:15 p.m. registered nurse (RN)-B observed as NA-D and NA-C assisted R39 to stand. RN-D was observed to push the wheelchair behind R39 as NA-E walked in front of and faced R39 while encouraging R39 to walk towards the staff. R39's upper body was observed to lean forward onto the wheeled walker as she walked 16 feet with great effort. On 2/13/14, at 9:02 a.m. NA-F and RN-D was observed to assist R39 to stand with a front wheeled walker. NA-L followed with the wheelchair as physical therapy assistant (PTA) encouraged R39 to walk. RN-B observed as R39 ambulated 25 feet, rested for a few moments and then ambulated an additional 15 feet for a total of 40 feet with extensive assistance of two staff. On 2/13/14, at 9:45 a.m. RN-B confirmed R39 had not received ambulation services three times a day as directed by the individual POC. The facility's Care Planning policy dated 6/2009,	F 282	oversees rehab program. Monthly rehab meeting participants include physical therapy staff, rehab aide, RN, and MDS coordinator. Rehab completes section G-0300 A-E and G-0400 A, B on admission and quarterly assessments. Rehab will report any changes to MDS coordinator for follow up orders. MDS coordinator and Physical Therapist/Occupational Therapist will review when changes occur and request Physical Therapy evaluation to establish rehab program or changes in current program. Will review at next Quality Assurance/Medical Director meeting. Date of correction: 3/07/14	

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	245470	A. BUILDING ______ B. WING ______	02/13/2014

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 282	Continued From page 12 directed staff to provide care to the residents as established by the interdisciplinary team to assure that the resident's immediate care needs are met and maintained.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide monitoring for fluid restriction and fistula (direct connection of a vein and an artery allowing access for dialysis) monitoring for 1 of 1 resident (R62) who required dialysis treatments three times per week for renal (kidney) failure. Findings include: R62's clinical record indicated diagnoses that included stage IV chronic kidney disease (CKD) and diabetes. R62's admission Minimum Data Set (MDS) dated 11/26/13 indicated R62 had moderate cognitive impairment and received dialysis treatments 3 times per week. R62's hard copy plan of care (POC) dated 1/3/14 and electronic POC dated 2/13/14 directed staff R62 required a fluid restriction of 2 liters (L) per	F 309	Dialysis in-service by dialysis nurse on 2/28/14 to nursing staff. R62 care plan updated along with care guide and to-do list. Care plan includes monitoring of fistula by charge nurse including "thrill" twice daily to feel at inner elbow on right arm for a purring, vibration or strong pulse. Monitor for signs of infection including swelling, redness, tenderness, drainage and notify MD of any of the above. Dietician developed plan for fluid restriction for each meal, snack and gave nursing an allotment for number of ml per med pass. Charge nurse to report to oncoming charge nurse at change of shift report intake total and remaining allotment for oncoming shift. Resident and family have also been educated in this plan of care by dialysis unit staff. Water pitcher removed from room and staff instructed	3/7/14

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F 309	Continued From page 13	F 309		

day. The electronic POC additionally directed staff to document intake and output total every shift for the fluid restriction of 2 liters per day. Both POC's informed staff R62 attended dialysis every Monday (M), Wednesday (W) and Friday (F) am. Staff were directed to fill out nursing home communication sheet prior to dialysis.

The communication between the dialysis unit and the facility regarding R62's care was documented in a two pocket folder that traveled back and forth with R62 from the facility to all dialysis treatments. The folder contained a pocket guide entitled "Your Access Care Pocket Guide". This guide provided the following instructions: no blood pressure in access arm, only hemodialysis needles in access arm, recommended skin care before and after each treatment, universal precautions and also included a contact number for questions. The guide also directed "TLC Your Access Daily". "Touch for pulse, tenderness and temperature. Look at skin color, for swelling and drainage. Care: keep clean, keep protected, no resting on arm, no heavy lifting, no carrying, watch your weight, keep clothes loose and no tight jewelry."

R62's nursing assistant's (NA) care sheet dated 12/19/13 indicated R62's 2 liter/day fluid restriction. The care sheet lacked direction to monitor or report fluid intake and lacked direction regarding changes in condition realted to emergencies or complications from dialysis NA's should monitor and report

R62's electronic NA activity of daily living (ADL) interventions, reported on the To Do List Report, failed to indicate R62's fluid restriction and also lacked direction to monitor or report fluid intake. It additionally lacked direction regarding changes

that water pitcher will not be in room. Dietician and dialysis unit updated of any concerns related to hydration status.

Future admits with dialysis or resident who starts dialysis will have site monitored for thrill twice daily, signs and symptoms of infection monitored diay by nursing as well as fluid intake every shift per MD orders. Comprehensive care plan will be implemented to reflect post dialysis care as above.

Dialysis care plan and treatment per MD orders.

Charge nurse will monitor compliance by checking site twice a day and documenting results. Intake totals to be completed by charge nurse every shift and documented. Fluid restriction 2 liters per day. Physician to be notified if there are any complications, i.e. diminished pulse, bleeding, or signs and symptoms of infection at site.

Dietician will evaluate hydration on a monthly basis by reviewing fluid intake and weights. This will be reported to Director of Nursing and then to Quality Assurance/Medical Director meeting on a quarterly basis.

Date of correction: 3/07/14

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in condition related to emergencies or complications from dialysis NA's should monitor and report.

On 2/10/2014, at 7:28 p.m. R62's right upper arm was observed with an intact dressing covering his fistula.

On 2/12/14 at 12:45 p.m. R62 was observed in the dining room eating the noon meal. He ate 100% of a potato dumpling, slice of bacon, slice of wheat bread with butter, and 50% of a hash brown patty. Fluids consumed included a 4 ounce glass of juice and 75% of a cup of coffee.

On 2/13/2014, at 10:08 a.m. R62's right upper arm was observed without a dressing to the fistula. Additionally, a water pitcher with approximately 2 ounces of water remaining and an empty coffee cup were observed in R62's room.

On 2/12/14, at 1:16 p.m. NA-J stated R62 attended dialysis on M,W and F at 6:15 a.m. and they needed to be sure he had his folder when he went there. NA-J denied knowlege of any specific care R62 required post dialysis.

On 2/13/14, at 9:50 a.m. NA-M stated they had not tracked intake or output for R62 and she knew he was on a fluid restriction but didn't know how much. She stated R62 should not have a water pitcher in his room. Additionally, NA-M stated she was not sure how you could tell how much fluid R62 drinks in a day.

On 2/13/13, at 10:08 a.m. R62 stated that he had a 2 L/day fluid restriction. When asked if he received water in the water pitcher in his room

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R62 stated "I don't use that. I get colder water out of the tap in the bathroom with my coffee cup." When asked how he is sure he stayed within his fluid restriction R62 stated he didn't and that he didn't track.

Registered dietitian (RD) was interviewed on 02/12/14, at 1:41 p.m. and stated there is no coordination between dietary and nursing regarding R62's fluid restriction. She stated that all fluids are given to R62 by nursing, including those provided at meals. RD indicated the only thing she did is communicated on R62's meal ticket that he had a 2L/day fluid restiction but did not communicate the amount of fluid that was provided by dietary in R62's food.

Registered nurse (RN)-D was interviewed on 2/13/13, at 10:24 a.m. and stated that the nurse assigned to R62 was responsible to track and total his intake every shift. She stated if NA's offered fluids to R62 they should have informed the nurse. RN-D indicated that she hadn't worked with R62 very often and did not know if he should have a water pitcher in his room. RN-D stated that the only information pertaining to R62's dialysis care was in the dialysis folder. She confirmed that R62's chart/POC did not contain specific directions regarding the care and management of his fistula. She futher stated that R62's fistula dressing remained on at all times and was cared for by the nurses at the dialysis unit.
On 2/13/14, at 10:39 a.m. LPN-C confirmed that she did no cares for R62's fistula. She stated the dressing could come off a couple of hours after dialysis but stated she didn't usually take it off. LPN-C confirmed that she did not palpate the fistula for a thrill (a vibration that is felt caused by

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F 309	Continued From page 16 turbulent blood flow) or listen for bruit (the sound of the blood "whooshing" through the fistula). Additionally, LPN-C indicated that she did not know if R62 had a water pitcher in his room but that it wouldn't surprise her. LPN-C stated she was aware that the resident drinks water out of the bathroom tap. When asked how she was able to get an accurate picture of R62's intake to ensure he was within the 2L/day restriction she stated "it is hard". A policy pertaining to dialysis care was requested but not provided. On 2/13/14, at 11:00 a.m. RN-D stated there was no facility policy for the care of resident's undergoing dialysis.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to provide ambulation services to prevent loss of function 1 for 2 of residents (R39) in the sample who required physical assistance with ambulation. R39's decline in ability to ambulate resulted in actual harm. Findings include: R39's The Diagnosis Listing By Resident dated 2/4/13, indicated R39 had dementia, anxiety, osteoarthrosis and congestive heart failure. R39's annual Minimum Data Set dated 12/23/13,	F 311	Monthly rehab meeting 3/03/14 R39 program was reviewed. Rehab program revised to reflect R39's current level/ability of participation. Range of motion 15 minutes daily to bilateral shoulders and lower extremities added to rehab aide to-do list. Goal added to ambulation program 50 feet three times a day to reflect appropriate distance added to nursing assistant's to-do list. Nursing staff educated regarding changes of plan of care as they occur and instructed to follow care plan. Charge nurses are responsible to oversee that nursing assistants are	3/7/14

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F 311	Continued From page 17 indicated R39 had cognitive impairment and required extensive staff assistance with bed mobility, transfers and extensive assistance of two staff to ambulate in the hallway and did not ambulate in the room. The activity of daily living (ADL) Care Area Assessment (CAA) was not completed at the time of the MDS. R39's Plan of Treatment for Outpatient Rehabilitation form dated 3/5/13, indicated R39 was able to ambulate 85 up to 130 feet with a front wheeled walker and moderate assist of one staff. The form indicated at that time R39 was discharged from physical therapy and started on a daily ambulation program. The form and R39's clinical record lacked documentation of formal ambulation goals which were to have been established by the physical therapist. R39's clinical record revealed the physical therapist assistant (PTA) had sent a communication note to R39's physician indicating formal physical therapy had been discontinued and nursing staff were to assist R39 with ambulation three times a day with a front wheeled walker with each episode taking eight minutes or more for a total of greater than 15 minutes daily. R39's plan of care (POC) dated 5/8/13, directed staff to ambulate R39 three times a day with a front wheeled walker for eight or more minutes per episode. R39's Physician Orders dated 1/8/14, indicated R39 was to receive a walking program three times a day with a front wheeled walker with each episode taking eight minutes or more for a total of 15 or more minutes daily. R39's ambulation Progress Notes completed by	F 311	completing rehab per shift according to care plan. All residents have the potential to be affected. All residents were reviewed on 3/03/14 and all reviewed monthly at rehab meeting to ensure proper rehab program or need of a rehab program. Care plans are audited and updated at rehab meeting and reviewed quarterly by RN that oversees rehab program. Monthly rehab meeting participants include physical therapy staff, rehab aide, RN, and MDS coordinator. Rehab completes section G-0300 A-E and G-0400 A, B on admission on quarterly assessments. Rehab will report any changes to MDS coordinator for follow up. MDS coordinator and Physical Therapist/Occupational Therapist will review when changes occur and request Physical Therapy/Occupational Therapy evaluation to establish rehab program or changes in current program. Will review at next Quality Assurance/Medical Director meeting. Date of correction: 3/07/14	

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the nursing assistants revealed the following:

- February 1-12, 2014, R39 ambulated nine out of 36 opportunities to ambulate. R39's ability varied from 5 feet to 60 feet.
- January 2014, R39 ambulated 15 out of 93 opportunities to ambulate. R39's ability varied from 5 feet to 120 feet. The note indicated the last recorded day R39 ambulated over 85 feet was on 1/9/14.
- December 2013, R39 ambulated 24 out of 93 opportunities. R39's ability ranged from 15 to 150 feet.
- November 2013, R39 ambulated 34 out of 90 opportunities. R39's ability ranged from 25 to 200 feet.

R39's quarterly therapy reviews completed by registered nurse (RN)-B in the Progress Notes revealed the following:

-On 12/13/13, R39 was receiving ambulation services three times a day but was refusing ambulation services daily due to behaviors. R39 was ambulating up to 150 feet each opportunity.
- On 9/26/13, R39 was receiving ambulation services, refused services 1-3 times per week but ambulated up to 200 feet.
- On 7/10/13, R39 was receiving ambulation services, refused services 1-3 times per week but was able to ambulate from ten to 225 feet.
- On 4/26/13, R39 was receiving ambulation services, refused services 1-3 times per week but was able to ambulate 30-300 feet.

On 2/12/14, at 8:30 a.m. nursing assistant (NA)-D was observed to assist R39 to transfer from the

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F 311	Continued From page 19 bed to a wheelchair using a mechanical standing lift. R39 was observed to follow NA-D's directions and was able to bear weight as she transferred to the wheelchair. At 8:50 a.m. NA-D was observed to wheel R39 to the dining room for breakfast. NA-D did not attempt to assist or offer R39 to ambulate. At 10:00 a.m. R39 was observed seated in a recliner in the main lobby. R39 had not ambulated. At 12:05 p.m. with extensive assistance, NA-D and licensed practical nurse (LPN)-B was observed to transfer R39 from the recliner to the wheelchair. NA-D was observed to wheel R39 into the dining room for lunch. R39 was not observed to be given the opportunity to ambulate. At 1:05 p.m. restorative aide/NA-L verified R39 did not have a formal ambulation program in place, however, stated R39 was to receive assistance to ambulate by the nursing assistants. At 1:08 p.m. NA-C stated R39's abilities to ambulate varied from being able to stand to walking a few feet. At 2:00 p.m. registered nurse (RN)-B confirmed R39 was to receive assistance to ambulate three times a day. She stated while completing the quarterly therapy reviews, she looked at the documentation completed by the NAs and wrote a summary. RN-B confirmed at no time did she review the therapy notes to determine how far R39 had the ability to ambulate while in therapy and stated she had not identified if R39's ability to ambulate had changed. She stated R39 routinely refused to ambulate but if staff offered at least once a day, R39 would be able to maintain her ability. When questioned what R39's goal range	F 311		

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F 311	Continued From page 20 for ambulation was, RN-B stated she did not know.	F 311		

At 2:15 p.m. RN-B observed as NA-D and NA-C assisted R39 to stand. RN-D was observed to push the wheelchair behind R39 as NA-E walked in front of and faced R39 while encouraging R39 to walk towards the staff. R39's upper body was observed to lean forward onto the walker as she walked 16 feet with great effort.

At 2:20 p.m. RN-B stated R39 was not able to ambulate 85-130 feet as R39 previously had while while receiving ambulation services by physical therapy. RN-B confirmed R39's ability to ambulate had declined.

On 2/13/14, at 9:02 a.m. NA-F and RN-D were observed to assist R39 to stand with a front wheeled walker. NA-L followed with the wheelchair as the physical therapy assistant (PTA) encouraged R39 to walk. RN-B observed as R39 ambulated 25 feet, rested for a few moments and then ambulated an additional 15 feet for a total of 40 feet with extensive assistance of two staff.

At 9:45 a.m. RN-B confirmed R39 did not have the ability to consistently ambulate greater than 85 feet a day. She confirmed R39's ambulation program did not contain an identified goal which would determine how far R39 was to be walking. RN-B verified R39 could not walk over 85 feet as she had in the past and stated this was a decline in R39's ambulation ability.

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F 311	Continued From page 21 The Rehabilitation Services policy dated 7/1999, directed staff to provide a restorative gait program which was to provide the resident with opportunity to reach the highest level of independence in regards to ambulation and assist in the maintenance of maximum potential. The policy directed staff to provide the residents with the opportunities to ambulate according to the established restorative program.	F 311		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary range of motion service in order to maintain upper extremity range of motion abilities for 1 of 2 residents (R39) in the sample who had identified limitations in range of motion. Findings include: R39's Diagnosis Listing indicated R39 was diagnosed with dementia, anxiety, osteoarthrosis, and congestive heart failure. R39's annual Minimum Data Set (MDS) dated 12/23/13, indicated R39 had cognitive impairment and required extensive staff assistance with bed	F 318	Monthly rehab meeting 3/03/14 R39 program reviewed. Rehab program revised to reflect R39's current level/ability of participation. Range of motion to bilateral shoulders and lower extremities 15 minutes daily added to rehab aide to-do list. Goal added to ambulation program 50 feet three times a day to reflect appropriate distance added to nursing assistant's to-do list. Nursing staff educated regarding changes of plan of care as they occur and instructed to follow care plan. Charge nurses are responsible to oversee that nursing assistants are	3/7/14

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F 318	Continued From page 22 mobility, transferring, ambulation in the corridor, dressing, grooming and bathing. The MDS also indicated R39 had upper body functional limitations in range of motion on one side. The activities of daily living care area assessment (CAA) was not completed at the time of the MDS. R39's plan of care (POC) dated 3/12/14, indicated R39 as required staff assistance with dressing, grooming and bathing. The POC did not address a range of motion program for R39. On 2/12/14, at 8:20 a.m. nursing assistant (NA)-D was observed to assist R39 with morning cares. R39 did not participate as NA-D dressed and provided personal care to the lower body. NA-D was observed to transfer R39 from the bed to a wheelchair via a standing lift. R39 was observed to hold onto the handle bars of the standing lift as she was transferred into the chair. At 8:25 a.m. NA-D was observed to wheel R39 into the bathroom. R39 was observed to hold a washcloth with her left hand and wash her face and brush her teeth. At 8:35 a.m. NA-A was observed to assist R39 put on a shirt and a sweater. R39 was observed to be able to move both arms but was not able raise her arms over her head in order to donne the shirt. NA-D was observed to assist R39 to put on the clothing without moving the shoulders. R39's restorative screening for Functional Limitation of Range of Motion dated 2/7/13, indicated the physical therapy assistant (PTA) identified R39 did not display limitations in range of motion. The subsequent screenings dated 4/24/13, and 12/17/13, identified R39 has having functional limitations in range of motion in the right shoulder.	F 318	completing rehab per shift according to care plan. All residents have the potential to be affected. All residents were reviewed on 3/03/14 and all reviewed monthly at rehab meeting to ensure proper rehab program or need of a rehab program. Care plans are audited and updated at rehab meeting and reviewed quarterly by RN that oversees rehab program. Monthly rehab meeting participants include physical therapy, rehab aide, RN, and MDS coordinator. Rehab completes section G-0300 A-E and G-0400 A, B on admission and quarterly assessments. Rehab will report any changes to MDS coordinator for follow up. MDS coordinator and Physical Therapist/Occupational Therapist will review when changes occur and request Physical Therapy/Occupational Therapy evaluation to establish rehab program or changes in current program. Will review at next Quality Assurance/Medical Director meeting. Date of correction: 3/07/14	

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R39's occupational therapy evaluation form completed on 2/5/13, indicated R39 was within functional limits to complete active range of motion. The form indicated R39 had demonstrated a decline in function therefore, R39 began a occupational therapy treatment regime three times a week for functional transfers, activities of daily living, transfers, mobility and general reconditioning.

R39's Plan of Treatment for outpatient Rehabilitation form dated 2/13/13, revealed the occupational therapy services had been discontinued because R39 had experienced a "plateau in progress." A plan for continued rehabilitative services had not been established at that time.

R39's restorative nurse Progress Notes dated 12/13/13, 9.26/13, 7/24/13, and 4/26/13, indicated R39 participated in dressing by lifting extremities and participating in group exercise provided by the activity department. The progress notes did not address R39's right shoulder limitations nor did it identify a range of motion treatment plan.

The restorative nursing "To Do List Report" dated 2/12/14, did not include R39.

On 2/12/14, at 1:05 p.m. NA-L verified R39 did not have a range of motion program and stated she could not recall R39 ever receiving range of motion exercises.

On 2/12/14, at 2:00 p.m. registered nurse (RN)-B stated she completed the quarterly restorative progress reviews. She indicated each quarter she reviewed each resident's ability to participate

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in the facility programs. She stated R39 was not in a formal range of motion program because she was able to assist with dressing, participate in a towel folding program provided by the activity department and also participated in the exercise program provided by activities. When questioned if R39 had any changes after the limitation in the right shoulder had been identified on 4/2013, RN-B stated she was unaware of the change.

On 2/12/14, at 2:50 p.m. the PTA stated when R39's limitations were noted in 4/2013, a range of motion program should have been established at that time.

On 2/13/14, at 9:12 a.m. the PTA was observed to cue R39 to raise her arms and touch the back of her head. R39 was observed to be able to touch her forehead with the right hand and to touch her head just above the left ear with the left hand. R39 was then cued to lift her arms. R39 was observed to lift both arms to approximately a 65-70 degree angle. R39 was then cued to reach her arms out in front of her. R39 was observed to attempt this but was not able to reach full extension. When cued to stretch her arms to the each side of her body, R39 demonstrated inability to complete this task. R39's arms were observed bent at the elbow and extend only a few inches away from her body.

At 9:14 a.m. PTA stated she did not feel R39 had sustained a decline since 2/2013, but confirmed R39 struggled at times to complete the range of motion exercise in her upper body. She stated the difference identified on the range of motion screenings could have been based on different opinions of staff completing the forms. (The PTA had completed all of the forms in the past year.)

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F 318	Continued From page 25 She stated R39 may benefit from a formal range of motion program. On 2/13/14, at 9:42 a.m. RN-B confirmed R39 had not changed in her range of motion abilities since 2/2013. However, verified when occupational therapy had discontinued R39, a range of motion program had not been established by therapy. She stated any resident with identified limitations in range of motion would benefit from a restorative program in order to prevent further decline. The facility's Rehabilitation Services policy revised on 6/2013, directed staff to provide a range of motion program to the resident with the assistance required to maintain and improve joint mobility and promote a greater sense of well-being, thus assisting in the prevention of contractures, pain and edema.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 all family members assisting with meals had received education to prevent or minimize signs/symptoms	F 323	Education provided to family of R61 regarding eating assistance and documentation of completed education signed on 2/21/14. Seating chart and	3/4/14

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F 323	Continued From page 26 of aspiration for 1 of 1 resident (R61) who received family assistance during meals. Findings include: R61's diagnoses included a stroke, dysphagia (difficulty swallowing), hemiplegia (paralysis of the left side), diabetes mellitus and nausea/vomiting. R61's admission Minimum Data Set (MDS) dated 11/19/13, indicated R61 had intact cognition and required extensive assistance of staff with activities of daily living (ADL), including eating. The MDS also indicated R61 had functional limitation in range of motion to upper extremities (shoulder, elbow, wrist, hand) on both sides and lower extremity limitation to one side (left). The MDS did not identify any swallowing disorders and indicated R61 received mechanically altered diet. R61's Activity of Daily Living Care Area Assessment (CAA), dated 11/26/13, indicated R61 was admitted from a hospital following an acute CVA (cardiovascular accident-stroke). The CAA also indicated R61 was able to make his needs known and make own decisions. The CAA indicated R61 had incidents of resisting assistance with activities of daily living and was at risk for cognitive decline, frustration, anxiety, depression and adverse behaviors. R61's nutritional assessment dated 11/14/13, indicated R61 was on a mechanical soft diet with pudding thick liquids. The assessment also indicated R61's liquids were to be administered by spoon only and staff were not to use straws with the liquids. In addition, the assessment indicated R61 required assistance at mealtimes,	F 323	staff responsibilities posted in dining room on 2/27/14. All residents have the potential to be affected. Speech Therapy to evaluate all new admissions requiring feeding assistance and re-admissions with diagnosis of CVA, Parkinson's, MS, MD, COPD, and history of aspiration pneumonia. Speech Therapy will evaluate for proper diet, texture, and fluid consistency, adaptive equipment, and if paid feeding assistants may assist residents. Resident's eating assistance including diet, fluid, adaptive equipment reviewed at quarterly care conference meetings with resident/responsible party/family. Direct nursing and Life Enhancement staff present in the dining room to notify charge nurse immediately if changes noted with eating ability including swallowing problems or coughing/choking and charge nurse to assess clinical situation immediately and document. Charge nurse to remove resident's name from Paid Feeding Assistant (PFA) list and educate PFA and nursing staff of change, then notify MDS coordinator to request assessment by speech therapist. MDS coordinator to review at weekly multidisciplinary meeting. Director of Nursing and dietician will oversee compliance with regard to education of residents' responsible party/family as to assistance needed for	

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F 323	Continued From page 27 his wife had assisted him with eating and R61 denied having any chewing or swallowing issues on his current diet. A nutritional reassessment dated 2/11/14, indicated R61 remained on a mechanical soft diet with nectar thick liquids and continued to need assistance at meals. R61's clinical record revealed R61 was seen by speech therapy twice weekly for dysphagia treatment sessions. A swallow study was completed 1/9/2014, and revealed R61 had oropharyngeal dysphagia with evidence of oral phase deficits which included poor oral containment, poor tongue base retraction and there was evidence of pharyngeal phase deficits which included: aspiration and penetration of thin liquid trials by straw, poor hyolaryngeal excursion and poor airway protection. The plan was for R61 to receive a nectar-thick liquid and dental soft, ground meats with extra gravies/sauces diet and to follow swallowing precautions. R61's plan of care (POC) revised on 1/3/14, indicated R61 required staff assistance with eating and directed staff to monitor for chewing/swallowing problems and for coughing and or choking. On 2/10/14, at 6:54 p.m. R61 was observed in his room. An empty meal tray was observed on the bedside table. R61 reported he had no problems swallowing but he had problems chewing his food as he was missing several teeth. R61 indicated he had no problems swallowing "thin liquids" and occasionally had problems swallowing pudding. R61 confirmed he needed assistance with meals as his left arm/hand was affected by "the stroke" and his right hand/arm was injured in a logging injury several years ago. R61's right hand was	F 323	feeding and/or for further training. Will review at next Quality Assurance/Medical Director meeting. Date of correction: 3/04/14	

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F 323	Continued From page 28 observed to be in a fixed curved position and R61 was unable to extend his fingers. R61 also stated his left hand/arm was flaccid as result of the stroke. On 2/12/14 at 9:30 a.m., R61 was observed in the dining room being fed by a nursing assistant. R61 was observe to drink nectar thickened liquids and was served oatmeal and toast. R61 was observed to tolerate the foods/liquids with no observed episodes of coughing or choking. On 2/12/14 at 2:14 p.m., R61 stated his elderly father had fed him the noon meal. R61 stated his father periodically visited him at the facility and would feed him his meal when he came. R61 also stated when his daughter visited, she also fed him his meal. Additionally, R61 stated his wife visited almost daily and would feed him during those visits. On 2/12/14, at 2:49 p.m. nursing assistants (NA)-N, NA-I and NA-C verified R61's father had visited R61 over the noon meal and had fed him his meal in the dining room. They also confirmed R61's father and daughter occasionally visited R61 and would feed him during those visits. They also verified R61 was identified as a choking risk. On 2/12/14, at 2:54 p.m. registered nurse (RN)-A confirmed R61 was at risk for choking and stated she was unaware R61's father and daughter were feeding him. RN-A stated she was aware of his wife feeding him but indicated his wife had been very involved in his care and had attended a session with speech therapy with R61. The facility's policy titled Eating Assistance and Training of Family Members/Paid feeding	F 323		

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F 323	Continued From page 29 assistants to assist residents, revised 6/12, indicated a resident may be assisted with eating by a family member who had been designated and who had received training to assist the resident. The POC was to reflect review by nursing staff regarding the family assisting the resident and family were to be trained in helping resident's consume oral food and fluids. After the training, the family was to sign documentation of this training and education. RN-A verified on 2/12/14, at 3:22 p.m. R61's family had not received any education or training on signs/symptoms of aspiration/chocking. She also verified the POC's should reflect when a family member of a resident at risk for choking was able to feed the resident. She verified R61's POC did not address family feeding the resident.	F 323		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant	F 373		3/25/14

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feeds only residents who have no complicated feeding problems.

Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.

NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160:
o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following:
Feeding techniques.
Assistance with feeding and hydration.
Communication and interpersonal skills.
Appropriate responses to resident behavior.
Safety and emergency procedures, including the Heimlich maneuver.
Infection control.
Resident rights.
Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.

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F 373	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 1 of 2 resident (R20) identified at high risk for nutrition and eating in order to determine the safe and appropriate assistance with eating by a paid feeding assistant. Findings include: R20's Diagnoses included dementia, organic brain syndrome and anxiety. R20's annual Minimum Data Set (MDS) indicated R20 had cognitive impairment and required extensive staff assistance for eating. The MDS also indicated R20 received a mechanically altered diet and had no chewing or swallowing problems. R20's quarterly MDS dated 8/6/13, indicated she received a mechanically altered diet and had no swallowing disorders. R20's Nutritional Assessment form dated 1/13/14, indicated R20 received a dental soft with pureed fruits and vegetables diet due to having problems eating fruit and vegetables and tolerated the diet without difficulties. The form also indicated R20 continued to be monitored while eating ground hamburger to staff were to assess if R20 spit it out and indicated recommended pureed hamburger if R20 continued to spit the meat out. The form directed staff to offer 20 one bite of food at a time to improve intake. R20's Nurses Notes dated 1/14/14, indicated R20 received a soft diet with pureed fruits and vegetables.	F 373	List of appropriate residents for paid feeding assistants to be reviewed by Speech Therapist and nursing staff. R20 was removed from paid feeding assistant list per Speech Therapist's recommendation. All residents have the potential to be affected. Speech Therapist to evaluate all new admissions/readmissions with diagnosis of CVA, Parkinson's, MS, MD, COPD, and history of aspiration pneumonia. Speech Therapist will evaluate for proper diet, texture, and fluid consistency, adaptive equipment and if paid feeding assistants may assist resident. Residents eating assistance reviewed at quarterly care conference meetings. Resident Care Coordinator admission and readmission checklists updated to obtain order for Speech Therapy evaluation for diet consistency, eating instructions, and whether paid feeding assistant is appropriate to assist with meals if resident has any one of the following diagnoses: CVA, Parkinson's disease, Muscular Dystrophy, Multiple Sclerosis, COPD, history of aspiration pneumonia. Direct nursing and Life Enhancement staff present in the dining room to notify charge nurse immediately if changes noted with eating ability including swallowing	

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R20's quarterly review Progress Note dated 1/20/14, indicated a new order was received to change R20's diet to pureed on 11/15/13.

R20's plan of care (POC) dated 2/10/14, indicated R20 was a nutritional / feeding "High Risk" due to advanced dementia, supervision required at meals, number of medications prescribed and decreased albumin. The POC indicated at times R20 was able to feed self food and fluids after meal set and supervision by staff. The POC also indicated three or more times per week R20 required extensive staff assistance to eat and directed staff to feed her. The POC indicated R20 could be resistive at times to staff assistance. In addition, the POC directed staff to monitor for chewing and swallowing problems and coughing and choking. The POC further indicated R20 may be assisted to eat by family or a PFA.

The informally titled "who feeding assitants cannot help" dated 2/1014, was observed taped to a cupboard in the office between the main dinin room and acitivy room. The form identified five residents residing in the facility in which PFA's could not assist to eat.

R20's Care Guide dated 2/11/14, indicated R20 received a pureed diet and required extensive staff assistance for eating and at times was resistive to staff assistance. The guide directed staff to cut R20's food into bite size pieces, hand her finger foods, utilize cupped glasses's, provide cues to eat and drink and to monitor for coughing or choking. In addition, the guide indicated R20 may be assisted to eat by family and paid feeding assistants.

problems or coughing/choking and charge nurse to assess clinical situation immediately and document. Charge nurse to remove resident's name from Paid Feeding Assistant (PFA) list and educate PFA and nursing staff of change, then notify MDS coordinator to request assessment by speech therapist. MDS coordinator to review at weekly multidisciplinary meeting.

Nursing staff, life enhancement staff, and paid feeding assistants educated that the paid feeding assistants can only assist residents who have been determined by speech therapy to be appropriate.

Speech Therapist will perform screen on in-house residents with diagnosis of CVA, Parkinson's, MS, MD, COPD, and history of aspiration pneumonia to establish baseline and make recommendations regarding paid feeding assistant participation. After baseline established of in-house residents, evaluation of all admissions and readmissions with certain diagnosis as listed above and difficulty swallowing will take place by Speech Therapy. Review will take place at least quarterly at care conference meeting.

Will review at next Quality Assurance/Medical Director meeting.

Date of correction: 3/25/14

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F 373	Continued From page 33 On 2/10/14, during the evening meal observation, in the activity dining room, six female residents were observed dining. Nursing assistant (NA)-O and Paid feeding assistant (PFA)-B were observed to assist the residents with eating. PFA-B was observed to feed R20 her meal which consisted of pureed spaghetti and meat sauce. The observation further revealed:: - 6:23 p.m. R20 talking to PFA-B. R20's voice was moist and raspy. PFA-B was observed to to give R20 a bite of pudding. -6:25 p.m. R20 was observed coughing with food in her mouth followed by R20 independently taking another bite of food. -6:27 p.m. R20 was observed coughing and attempted to take a drink of milk via a straw. PFA-B assisted R20 in taking a drink. -6:28 p.m. PFA-B observed giving R20 bites of her food and a drink. -6:30 p.m. R20 was observed coughing with loose unproductive secretions, -6:32 p.m. PFA-B was observed to give R20 another bite of food and a drink. -6:35 a.m. R20 stated she was done eating. -6:36 p.m. R20 was observed to cough with loose unproductive secretions. On 2/10/14, at 6:40 p.m. PFA-B verified she worked at the facility five days per pay period and stated she fed all the residents that needed assistance with eating. In addition, PFA-B stated all residents eating abilities changed throughout the course of a day. PFA-B verified the facility utilized PFA's daily, during all three meals. PFA-B stated there were only three residents in the facility she was not to assist with eating. PFA-B stated R20 coughed "all the time" even when not	F 373		

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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 373	Continued From page 34 eating. PFA-B stated she could assist any resident that was not identified on the list of who not to feed. At 6:49 p.m. NA-O verified R20 coughed during every meal. At 6:54 p.m. NA-O stated she was unaware of which residents the PFA's were not to feed as it did not pertain to her. At approximately 7:00 p.m. until 7:05 p.m. R20 was observed in another residents room removing items from an over bed table. R20 was not observed to cough. At 7:30 p.m. R20 was observed seated in her wheelchair. R20 was not observed to cough. At 7:23 p.m. NA-G verified she routinely worked with R20 and stated R20 had good days and bad days with eating. NAG confirmed R20 was assigned to be assisted to eat by a PFA. At 7:37 p.m. registered nurse (RN)-B confirmed R20 received a pureed diet, staff were directed to feed her one bite at a time and was assisted to eat by PFA's. In addition, RN-B stated she did not think R20 coughed while eating, however, stated she did not feed her. At approximately 7:41 p.m. RN-A stated she did not think R20 coughed while eating, however, stated she did not feed her. RN-A verified R20 was not assessed to determine eligibility to be fed safely by a PFA. RN-A stated nursing judgement only was used to determine if a resident was safe to be fed by a PFA. RN-A stated there was no documentation / assessment related to the determination criteria indicating R20 was able to be safely fed by a PFA.	F 373		

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 ________	02/13/2014

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 373	Continued From page 35	F 373		

At 8:35 p.m. both RN-A and RN-B stated the facility had utilized PFA's the past year and a half and determined by nursing judgment only if a resident was eligible to be fed by PFA's. RN-A stated there were residents currently residing in the facility that silently aspirated while eating therefore, were unable to be fed by PFA's. In addition, RN-A stated residents being assisted to eat by PFA's were not "necessarily" assessed by a speech therapist.

On 2/11/14, during the morning meal observation, in the main dining room, the following was observed:

-7:20 a.m. R20 was served a cup of coffee with no straw.
-7:49 a.m. R20 was observed to cough after independently taking a drink of coffee.
-7:54 a.m. R20 was served a regular pancake, poached egg and toast with grape juice with a straw. A nursing assistant was observed to sit next to R20 and begin to feed her. The NA was observed to give R20 a bite of food followed by R20 coughing. R20 independently took a drink of fluid, was given another bite of food by the NA and coughed again. R20 took another sip of fluid and coughed while sipping.
-7:59 a.m. R20 was observed to cough with loose unproductive secretions. The NA asked R20 if she was ok.
-8:01 a.m. the NA was observed to give R20 a bite of the egg followed by R20 taking a drink. R20 was observed to cough after the drink.
-8:03 a.m. R20 was observed to have a moist cough.
-8:04 a.m. R20 was observed to cough softly while drinking.

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	245470	A. BUILDING ______ B. WING ______	02/13/2014

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 373	Continued From page 36	F 373		

-8:07 a.m. R20 was observed to cough with loose unproductive secretions followed by a drink of juice.
-8:09 a.m. the NA asked R20 if she desired more to eat. R20 stated "not necessarily" and cleared her throat.
-8:12 a.m. R20 was observed to have a loose, unproductive cough following an independent drink of coffee.
-8:17 a.m. R20 continued to drink the juice with intermittent loose unproductive coughing.
-8:23 a.m. R20 was observed to cough after taking drink of fluid.
-8:40 a.m. R20 was assisted out of the dining room.

At 8:49 a.m. NA-F stated R20 coughed occasionally when eating, at least once per meal. NA-F confirmed R20 was routinely fed by PFA's.

At 11:09 a.m. the speech therapist stated nursing assessed residents for swallowing problems and she relied "heavily" on nursing observations to alert her of any resident having swallowing problems and / or coughing. She stated she verbally communicated with staff any resident concerns with chewing, swallowing, choking and / or coughing. She added, for any resident coughing during meals she would have a screen evaluation request sent to speech therapy. She stated it was her expectation of staff to notify the nurse to alert her when a resident was coughing during meals so that a screen could be requested. She stated she was not aware of R20 coughing while eating.

At 11:33 a.m. the director of nursing (DON)

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	245470	A. BUILDING ______ B. WING ______	02/13/2014

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 373	Continued From page 37 verified the facility had hired five to six PFA's within the past year. She also confirmed all PFA's had received the required PFA training. In addition, the DON stated the PFA's should only feed low risk residents that require supervision type assistance related to cognitive impairment. The DON stated a resident that coughs while eating or drinking should not be assisted to eat by a PFA nor should they feed a resident that was high risk for aspiration or had a history of aspiration. The DON also stated if R20's coughing was out of her norm it should have been reported to the nurse, however, stated a resident coughing while eating was a concern. The DON stated in some residents it would take longer to determine if they were silently aspirating. Lastly, the DON stated she did not know who determined which residents could be fed by a PFA. At 12:14 p.m. The DON stated R20's coughing should have been reported to a nurse. At 3:58 p.m. PFA-C verified she had received the required PFA training course. She confirmed she fed R20 and stated R20 did not cough while eating. PFA-C stated she could feed any resident in the facility that was not identified on the list. The facility policy Eating Assistance and Training of Family Members / Paid Feeding Assistant to Assist resident revised 6/13, indicated trained PFA's may assist residents to consume food / fluids. The policy further stated the resident will have been assessed by nursing or appropriate discipline and a plan of care will reflect the assistance if appropriate. In addition, the policy indicated nursing oversight by a registered nurse or licensed practical nurse will occur and	F 373		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE ROSEAU MANOR	**715 DELMORE DRIVE ROSEAU, MN 56751**

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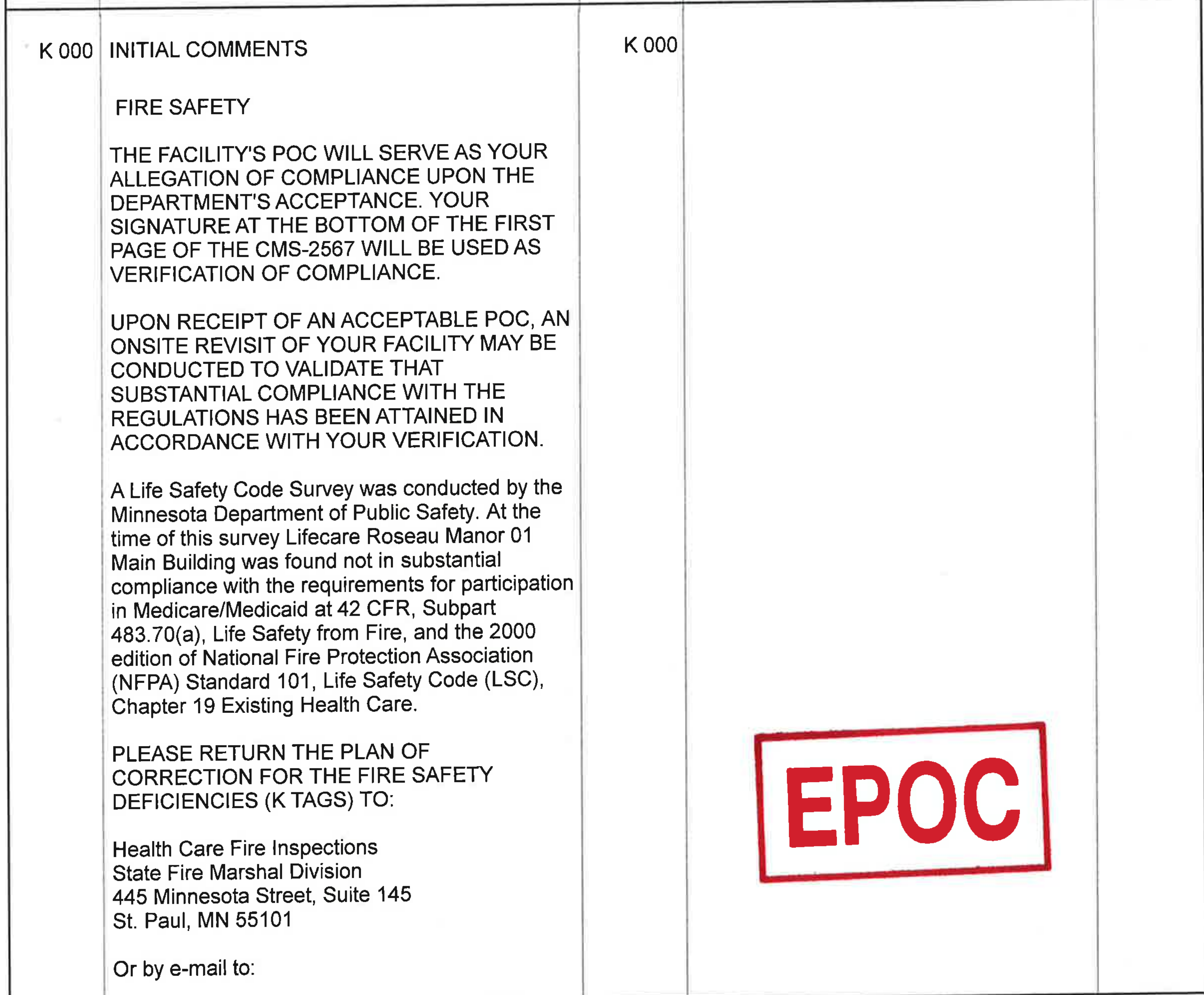
F 373	Continued From page 38 managed by the director of nursing.	F 373		

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

F5470037

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245470	A. BUILDING **CN - ROSEAU C & NC** B. WING	**02/12/2014**

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 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 in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 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 Or by e-mail to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/13/2014

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	K 000		

Marian.Whitney@state.mn.us

Fax Number 651-215-0525

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 in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). 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" 1999 edition. All sleeping rooms have smoke detectors and all hazardous areas have automatic fire

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	245470	A. BUILDING **CN - ROSEAU C & NC** B. WING ______	**02/12/2014**

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K 000	Continued From page 2 detectors in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 52 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observations and an interview with staff, it was determined that the facility exits is not in accordance with National Fire Protection Association 101 "The Life Safety Code" 2000 edition (LSC) section 7.2.1.6 and Centers for Medicaid/ Medicare Services (CMS) guidelines. This deficient practice could negatively affect all 60 of the residents of the facility, all staff and any visitors of the facility by causing confusion in an emergency. Findings include: During the facility tour on February 12, 2014, between 12:00 pm and 2:00 pm, by surveyor 03006, revealed that three of the five exits doors	K 038	Posted reverse code signs on the doors that were missing the signs. Completed by Chancy Otto, Facilities Management. Completion date: 2/20/14	2/20/14

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K 038	Continued From page 3 that are locked against egress in accordance with CMS guidelines and the Minnesota State Fire Code, the Cherrywood, Pinewood, and Maple Grove wings' stairway exit doors, no longer have the door release code posted near the door release device as required. The Director of Maintenance was surprised that the codes were missing. This finding was verified by the Director of Maintenance during the facility tour and at the exit conference.	K 038		
K 067 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and a staff interview, it was determined that the facility's general ventilating and air conditioning system (HVAC) was not maintained in accordance with the National Fire Protection Association 101 "The Life Safety Code" 2000 edition (LSC), Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 60 of the residents, all staff and any visitors of the facility by failing to contain a fire allowing the by products of combustion to travel far from the room of fire of origin. Findings include:	K 067	Received documentation from C.L. Linfoot Company. Completed by Brian Grafstrom, Director of Facilities Management. Date of completion: 2-13-14	2/13/14

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K 067	Continued From page 4 During the facility tour on February 12, 2014, between 12:00 pm and 2:00 pm, a review of the fire damper testing report for Lifecare Medical Center, by surveyor 03006, and an interview with the Director of Maintenance, revealed that the fire damper testing was done on May 14, 2013 but documentation about the testing results was not available for review. This finding was verified by the Director of Maintenance during the facility tour and at the exit conference.	K 067		

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
March 5, 2014

Ms. Susan Lisell, Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, Minnesota 56751

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5470040

Dear Ms. Lisell:

The above facility was surveyed on February 10, 2014 through February 13, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule 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.

When all orders are corrected, the order form should be signed and electronically submitted 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 Lyla Burkman at (218) 308-2104 or email at: lyla.burkman@state.mn.us.

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.

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Original - Facility
Licensing and Certification File

5470r14lic.rtf