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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DPEI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00579

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245470**
2.STATE VENDOR OR MEDICAID NO.
(L2) **842724100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/08/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, HFE NEII 05/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/11/2015 (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
Posted 06/02/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/20/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245470

May 11, 2015

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 April 21, 2015 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

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

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
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 11, 2015

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

RE: Project Number S5470041

Dear Ms. Lisell:

On March 26, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 12, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On May 8, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 12, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 21, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 12, 2015, effective April 21, 2015 and therefore remedies outlined in our letter to you dated March 26, 2015, 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 letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245470	A. Building B. Wing	5/8/2015

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **04/21/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/21/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/21/2015**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **04/21/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **04/21/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/21/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/21/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **04/21/2015**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **04/21/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	05/11/2015	28035	05/08/2015
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
3/12/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DPEI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00579

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(L1) **245470**

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

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

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/12/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE NEII 04/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/20/2015 (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
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3. Both of the Above :
_____

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/20/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 26, 2015

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

RE: Project Number S5470041

Dear Ms. Lisell:

On March 12, 2015, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 21, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 12, 2015 (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 September 12, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

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
Health Regulation Division
Email: mark.meath@state.mn.us

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

5470s15

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 _____	03/12/2015

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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess for safe self-administration of nebulizer medications for 1 of 1 resident (R2) who was observed to self administer a nebulizer treatment. Findings include: R2's significant change Minimum Data Set (MDS) dated 2/24/15, indicated R2 was diagnosed with chronic obstructive disease (COPD), congestive	F 176	It is the policy of Roseau Manor to administer medications ordered by the provider in a safe, efficient, and organized process. Resident #2 was assessed for safe self administration of nebulizer medications 3/11/15 and his care plan was updated. All other residents with nebulizer medication orders were assessed for safe self administration of nebulizer medications and care plans reviewed and	4/21/15

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

Electronically Signed | 04/03/2015

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 _____	03/12/2015

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 176	Continued From page 1 heart failure (CHF) and had moderately impaired cognition. R2's current physician's orders included nebulizer duo neb three times a day and as needed (PRN). No further documentation or assessment related to the self administration of medications was found in R2's medical record. On 3/11/15, at 7:35 a.m. licensed practical nurse (LPN)-A was observed to apply a nebulizer administration face mask on R2, turn the nebulizer machine on, inform R2 she would return in about 10 minutes to remove the mask and then exited the room. At 7:55 a.m. LPN-A returned to R2's room, removed the mask from R2's face and turned the machine off. On 3/11/15, at 12:00 p.m. register nurse (RN)-B verified a self medication administration assessment was not completed for R2 and should have been. The facility policy, Medication-Self Administration dated 5/09, indicated on admission and there after if the resident asked to self administer medication the staff would complete an assessment to determine the safe ability of the resident to self administer medication.	F 176	updated. For all residents: Inservice training will be provided at staff meetings scheduled for April 8, 9, 14, 15, 2015. The meeting agenda will include the process for self administration of medication assessment to be completed on admission and the need for these assessments to be reviewed quarterly and with any significant change by the MDS RN Coordinator. DON or designee will monitor for compliance by completing audits on admission assessments every 2 weeks x 4 weeks or until compliance is ensured. Audit results will be reported to the QAPI committee.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		4/21/15

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	245470	A. BUILDING _____ B. WING _____	03/12/2015

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F 279	Continued From page 2 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 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the care plan identified medication monitoring and therapeutic goals and interventions for 2 of 5 residents (R53, R24) who were receiving anticoagulant medication. Findings include: R53's care plan lacked interventions for the monitoring of adverse effects of anticoagulant medication (Coumadin).	F 279	It is the policy of Roseau Manor to administer medications ordered by the provider in a safe, efficient, and organized process. The care plans for resident #24 and #53 were updated to include medication monitoring, therapeutic goals, and interventions for anticoagulant medications. Also the Warfarin monitoring tool is now utilized for #24 and #53. The care plans for all residents receiving	

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F 279	Continued From page 3 R53's Diagnosis List, dated 3/11/15, indicated R53 had diagnoses that included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hypertension and a stroke. R53's quarterly Minimum Data Set (MDS) dated 2/10/15, indicted R53 was cognitively intact and received anticoagulant medication daily. R53's Physician Orders dated 3/11/15, indicated R53 received Coumadin 6 milligrams (mg) by mouth daily for atrial fibrillation. R53's care plan dated 3/11/15, identified R53's cardiovascular diagnoses and the daily administration of Coumadin (anticoagulant) 6 mg daily, however, it did not address monitoring for potential adverse effects of the medication. On 03/12/2015 8:44 a.m. R53 was observed lying in bed. R53's skin was observed to be intact without bruising noted to his face, arms or legs. On 3/12/15, at 8:07 a.m. registered nurse (RN)-A confirmed there was no formal monitoring performed for the adverse effects of Coumadin for R53. RN-A also confirmed R53's care plan lacked interventions to address the monitoring for adverse effects of Coumadin. On 3/12/15, at 1:35 p.m. the director of nursing (DON) confirmed side effect monitoring for Coumadin use should have been included on R53's care plan. R24's care plan lacked interventions for the	F 279	anticoagulant medications were reviewed and updated to include medication monitoring, therapeutic goals, and interventions. Education was provided for all staff at staff meetings April 8, 9, 14, 15, 2015 regarding need for medication monitoring for therapeutic goals and interventions for residents receiving anticoagulant medications. DON or designee will audit care plans including newly admitted resident care plans weekly x 4 weeks or until compliance is ensured. Results of audits will be reported at QAPI committee.	

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F 279	Continued From page 4 monitoring of adverse effects of anticoagulant medication (Coumadin). R24's Diagnosis Listing by Resident dated 3/13/15, indicated R24 had diagnoses of atrial fibrillation, angina, hypertension and CHF. R24's quarterly MDS dated 2/24/15, indicted R24 was cognitively intact and received anticoagulant medication daily. R24's Physician Orders dated 2/25/15, identified R24 received Coumadin 2.5 mg by mouth daily for atrial fibrillation. R24's care plan dated 3/12/15, indicated R24 had a diagnoses of hypertension, angina, atrial fibrillation, congestive heart failure and had a cardiac pacemaker. The care plan also identified R24 received Coumadin daily, however, did not address the monitoring for potential adverse effects of the medication. On 3/12/15, at 11:39 a.m. RN-A confirmed R24's care plan lacked interventions to address monitoring for adverse effects of Coumadin. On 3/12/15, at 2:01 p.m. the DON confirmed side effect monitoring for Coumadin use should have been included on R24's care plan. The Care Planning policy dated 6/09, indicated a comprehensive care plan that included measurable objectives and timetables to meet the	F 279		

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F 279	Continued From page 5 resident's medical, nursing, mental and psychological needs would be developed for each resident and would be designed to incorporate risk factors associated with identified problems and would reflect treatment goals and objectives in measurable outcomes.	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, timely positioning and incontinence care as directed by the written care plan for 1 of 1 resident (R12) who required staff assistance for ambulation, positioning and incontinence care and for 1 of 1 resident (R25) who required repositioning and incontinence care. Findings include: R12 was not ambulated as directed by the care plan. R12's quarterly Minimum Data Set (MDS) dated 1/27/15, indicated R12 was diagnosed with dementia, hearing loss and edema. The MDS also indicated R12 had impaired cognition and	F 282	The policy of repositioning, toileting, and incontinence care has been updated. For resident #12, therapy re-screened and care plan was updated and currently utilized. For resident #25, the care plan was reviewed regarding repositioning and incontinence care. The current care plan is being followed. For all residents, staff was provided education on 3/26/15, 3/27/15, and 4/01/15 at staff meetings regarding policy and need for care plans and care guidelines to be utilized each shift to ensure policy is followed regarding repositioning toileting, and incontinence care. DON or designee will do random	4/21/15

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F 282	Continued From page 6 required extensive assist with bed mobility, transfers and ambulated with a walker and staff supervision. R12's care plan dated 3/11/15, indicated R12 was on a walking program and directed staff to assist R12 with ambulation to and from all meals and day/evening activities and to ensure R12 ambulated 300 feet per walking episode, every shift. R12's nurse progress note dated 2/27/15, to 3/11/15, indicated R12 ambulated as follows: -3/1/15, ambulated 150 feet. -3/2/15, ambulated from bed to bathroom and back to bed. -3/3/15, ambulated 30 feet in room. -3/4/15, ambulated 250 feet to and from dining room. -3/6/15, ambulated 240 feet. -3/6/15, ambulated 675 feet. -3/7/15, ambulated 1,025 feet. -3/8/15, ambulated to and from dining room two times. -3/10/15, ambulated 875 feet and 240 feet. -3/11/15, ambulated 160 feet. On 3/10/15, at 8:00 a.m. R12 was observed at the dining room table, seated in her wheelchair. On 3/11/15, at 7:55 a.m. R12 was observed seated in her wheelchair at the dining room table, independently eating.	F 282	observation audits 3 x weekly x 4 weeks to ensure policy is being followed. Results will be reported to QAPI committee.	

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F 282	Continued From page 7 On 3/12/15, at 8:20 a.m. nursing assistant (NA)-A confirmed R12 had not ambulated as directed. On 3/12/15, at 8:25 a.m. registered nurse (RN)-B verified R12's care plan for ambulation was not followed. On 3/12/15, at 12:30 p.m. R12 was observed to walk from the dining room to her room with staff assist. R25 did not receive positioning and incontinence care as directed by the care plan. R25's quarterly MDS dated 1/22/15, indicated R25 was diagnosed with hemiplegia, organic brain syndrome and urinary retention. The MDS also indicated R25 had impaired cognition, required extensive assist with bed mobility, toilet use and was non-ambulatory. The MDS also indicated R25 was frequently incontinent of bowel and had an indwelling urinary catheter. R25's care plan dated 1/22/15, directed staff to turn and reposition R25 every 2 hours and as needed and to check/change incontinent product as needed and provide peri-care as needed with each incontinent episode. On 3/10/15, at 7:05 a.m. R25 was observed seated in the wheelchair next to the dining room	F 282		

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F 282	Continued From page 8 table. -At 8:00 a.m. R25 was observed being assisted to eat breakfast by staff. -At 9:10 a.m., 9:30 a.m., 9:45 a.m. and 10:00 a.m. R25 was observed to remain seated in the wheelchair, at the dining room table, sleeping. On 3/10/15, at 10:15 a.m. NA-A and NA-B were observed to transfer R25 into bed with a mechanical lift. R25's coccyx was observed bright red with creases. R25's incontinent brief was observed to have bowel movement (BM) in it. NA-A and NA-B provided peri care followed with application of Avilone skin barrier cream. On 3/10/15, at 10:25 a.m. NA-A verified R25 was assisted into the wheelchair and wheeled into the dining room at 7:00 a.m. a total of 3 hours and 15 minutes earlier. NA-A stated R25 was to be repositioned every 2 hours and have the incontinent brief checked / changed. On 3/12/15, at 10:30 a.m. RN-A verified R25's care plan was not followed related to the every two hour and as needed repositioning and incontinence care. The facility Repositioning, Toileting, and Exercise policy dated 6/09, indicated staff would provide an opportunity for motion, exercise and elimination during each two-hour period unless there was a specific physician order to be on a different schedule or if the individual care plan indicated a different plan was more appropriate.	F 282		

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F 311	Continued From page 9	F 311		
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, interview and document review, the facility failed to provide ambulation services in order to improve and/or maintain the resident's ability to ambulate for 1 of 1 resident (R12) who was on an ambulation program. Findings include: R12's quarterly Minimum Data Set (MDS) dated 1/27/15, indicated R12's diagnosis include dementia, hearing loss, edema and falls. The MDS indicated R12 was cognitively impaired and required extensive assist with bed mobility, transfers, toilet use, personal hygiene and dressing. The MDS also indicated R12 required supervision with ambulation, used a walker and wheelchair. R12's Fall Care Area Assessment (CAA) dated 6/4/14, indicated R12 had impaired balance and gait problems, such as unsteady gait. R12's care plan dated 3/11/15, indicated R12 had memory impairment and frequent disorientation. The care plan also indicated R12 was on a walking program and directed staff to assist R12 with ambulation with walker to and	F 311	The facility provides ambulation services in order to improve/maintain residents ability to ambulate with ambulation programs. For resident #12, therapy re-screened resident to determine resident's current ambulation needs. The care plan and care guide worksheets were updated and are currently being followed. For all residents, education will be provided to all staff at mandatory staff meetings on April 8, 9, 14, 15, 2015 regarding need for staff to continue following care plans and care guidelines worksheets according to each resident individualized need to maintain or improve current condition through ambulation programs. DON or designee will do random observation audits 3 x weekly x 4 weeks to ensure compliance with ambulation programs. Results will be reported to QAPI committee.	4/21/15

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F 311	Continued From page 10 from all meals and day and evening activities for eight or more minutes per walk, taking more than 15 minutes daily with a goal to walk 300 feet per walking episode, every shift, R12's All Administration Record by Resident form dated 3/15, indicated staff was to continue to assist R12 with ambulation with walker to and from all meals and activities day and evening for 8 or more minutes per walk, taking more than 15 minutes daily. Goal was to walk 300 feet per walking episode. R12's physical therapy (PT) note dated 2/10/15, indicated R12 was assessed due to foot pain however, during the evaluation R12 denied any foot pain therefore no new recommendations needed at that time. R12's nurse Progress Notes dated from 2/27/15, to 3/11/15, revealed R12's ambulation consisted of the following: -3/1/15, ambulated 150 feet. -3/2/15, ambulated from bed to bathroom and back to bed. -3/3/15, ambulated 30 feet in room. -3/4/15, ambulated 250 feet to and from dining room. -3/6/15, ambulated 240 feet. -3/6/15, ambulated 675 feet. -3/7/15, ambulated 1025 feet. -3/8/15, ambulated to and from dining room two times. -3/10/15, ambulated 875 feet and 240 feet. -3/11/15, ambulated 160 feet.	F 311		

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F 311	Continued From page 11 On 3/10/15, at 8:00 a..m. R12 was observed seated in her wheelchair at the dining room table. On 3/11/15, at 7:55 a.m. R12 was observed seated in her wheelchair at the dining room table, independently eating. On 3/12/15, at 8:20 a.m. nursing assistant (NA)-A confirmed R12 had not ambulated to breakfast as directed. On 3/12/15, at 8:25 a.m. registered nurse (RN)-B verified R12's care plan and goal for ambulation and confirmed it was not followed as directed. RN-B also stated R12's goal distance should be changed to only walking to and from the bathroom because in the past three months R12 had become more dependent on the wheelchair. On 3/12/15, at 12:30 p.m. R12 was observed to walk from the dining room to her room with staff assist. The facility Repositioning, Toileting, and Exercise policy dated 6/09, indicated staff would provide an opportunity for motion, exercise, and elimination during each two-hour period unless there was a specific physician order to be on a different schedule or if the individual care plan indicated a different plan was more appropriate.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		4/21/15

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F 312	Continued From page 12 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely incontinence care as directed by the individualized care plan for 1 of 1 dependent resident (R25) observed incontinent of bowel. Findings include: R25's quarterly Minimum Data Set (MDS) dated 1/22/15, indicated R25's was diagnosed with hemiplegia (paralysis of one side of the body), organic brain syndrome and urinary retention. The MDS also indicated R25 had cognitive impairment, required extensive assist with bed mobility, toilet use, dressing and was non-ambulatory. The MDS also indicated R25 was frequently incontinent of bowel and had an indwelling catheter. R25's Urinary Incontinence and Indwelling Catheter CAA dated 8/21/14, indicated R25 had an indwelling Foley catheter related to unspecified bladder disorder and prostatitis resulting in inability to void and required staff assistance to manage toileting process. The CAA also indicated R25 was at risk for infections, skin	F 312	The policy for repositioning, toileting, and incontinence care has been updated. For resident #25, the MDS, CAA, Braden Scale, care plan and care guide worksheets have been reviewed and updated as needed to ensure resident is receiving timely incontinence care according to care plan. To ensure timely incontinence care for all residents, education will be provided at mandatory staff meetings on April 8, 9, 14, 15, 2015 regarding staff need to correctly follow care plans and care guide worksheets, thereby ensuring each resident's individualized need for timely incontinence care is met. DON or designee will do random audits 3 x weekly x 4 weeks to ensure compliance with timely incontinence care as directed by care plan. Results will be reported to QAPI committee.	

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F 312	Continued From page 13 breakdown, pain, frustration and adverse behaviors. R25's The checklist, Skin Risk Factors and Interventions form dated 11/4/14, indicated R25 required a mechanical lift for all transfers, was non-ambulatory, wore a pad/brief and was turned and repositioned every two hours and as needed (PRN) while in the wheelchair. R25's Individual Resident Care Plan dated 1/22/15, indicated R25 was incontinent of bowel and required two staff assist to check and change R25's incontinent product and provide peri care with each incontinent episode as needed. The plan also directed staff to turn and reposition R25 every 2 hours. On 3/10/15, at 7:05 a.m. R25 was observed seated in the wheelchair at the dining room table. -At 8:00 a.m. R25 was observed being assisted with breakfast by staff. -At 9:10 a.m., 9:30 a.m., 9:45 a.m., and 10:00 a.m., R25 was observed to remain seated in the wheelchair at the dining room table, sleeping. -At 10:05 a.m. the surveyor asked nursing assistant (NA)-A when she was going to provide cares to R25. NA-A stated she would let the surveyor know when they were ready to provide R25's cares. -At 10:15 a.m. NA-A and NA-B were observed to transfer R25 from the wheelchair and into bed via a mechanical lift. R25's coccyx was observed bright red with creases and his incontinent brief had a moderate amount of bowel movement (BM) in it. NA-A was observed to provide peri-care and apply Avilone skin barrier cream to R25's peri	F 312		

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F 312	Continued From page 14 area. On 3/10/15, at 10:25 a.m. NA-A stated R25 was assisted into the wheelchair and wheeled into the dining room at 7:00 a.m., three hours and 15 minutes earlier. NA-A verified R25 was to be repositioned and provided incontinence care every two hours and confirmed he was not. NA-A added, staff had been running behind schedule because the night shift had worked short therefore were unable to provide morning cares and dressing to the two residents on each of the four wings, as assigned which had put day the shift behind. On 3/12/15, at 10:30 a.m. registered nurse (RN)-A verified R25's care plan was correct and R25 was to be repositioned every two hours and would expect his incontinent brief to be checked for incontinence and changed at the same time when repositioned because R25 never used the toilet. The facility Repositioning, Toileting, and Exercise policy dated 6/09, indicated staff would provide an opportunity for motion, exercise, and elimination during each two-hour period unless there was a specific physician order to be on a different schedule or if the individual care plan indicated a different plan was more appropriate.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		4/21/15

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F 314	Continued From page 15 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning assistance in order to minimize and prevent the development of pressure ulcers for 1 of 1 resident (R25) who was identified at risk for pressure ulcers. Findings include: R25's Pressure Ulcer Care Area Assessment (CAA) dated 8/21/14, indicated R25 had a stroke, dementia and hemiplegia. The CAA also indicated R25's Braden scale (a tool used to predict pressure ulcers) indicated R25 was at risk for pressure ulcers. R25's Urinary incontinence and Indwelling Catheter CAA dated 8/21/14, indicated R25 had an indwelling Foley catheter related to unspecified bladder disorder and prostatitis with inability to void and he required staff assist to manage toileting process. R25 was at risk for infections, skin breakdown, pain, frustration, and adverse behaviors.	F 314	The facility ensures residents will be provided timely repositioning assistance in order to minimize and prevent development of pressure ulcers. The policy for repositioning, toileting, and incontinence has been updated. For resident #25, the MDS, CAA, Braden Scale, and care plan were reviewed and resident is being repositioned timely according to the care plan. To ensure timely repositioning assistance for all residents, education will be provided at mandatory staff meetings on April 8, 9, 14, 15, 2015 regarding staff need to correctly follow care plans and care guide worksheets, ensuring each resident's individualized need for repositioning timely per car plan is met. DON or designee will do random audits 3 x weekly x 4 weeks to ensure compliance with timely repositioning care as directed per care plan. Results reported to QAPI committee.	

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F 314	Continued From page 16	F 314		

R25's The Checklist, Skin Risk Factors and Interventions form dated 11/4/14, indicated R25 utilized a mechanical lift for all transfers, was non-ambulatory, wore an incontinent pad/brief and was turned and repositioned every two hours and as needed (PRN) while in the wheelchair.

R25's quarterly Minimum Data Set (MDS) dated 1/22/15, indicated R25 was diagnosed with hemiplegia (paralysis of one side of the body) and organic brain syndrome. The MDS also indicated R25 had impaired cognition, required extensive assist with bed mobility, toileting and was non-ambulatory. The MDS also indicated R25 was frequently incontinent of bowel, had an indwelling catheter and was at risk of developing pressure ulcers.

R25's Individual Resident Care Plan dated 1/22/15, indicated R25 was at high risk for pressure ulcers and directed staff to turn and reposition R25 every two hours.

On 3/10/15, at 7:05 a.m. R25 was observed in the dining room at the dining table seated in a wheelchair.
-At 8:00 a.m. R25 was observed being assisted with breakfast by staff.
-At 9:10 a.m., 9:30 a.m., 9:45 a.m., and 10:00 a.m., R25 was observed to remain seated in the wheelchair at the dining room table, sleeping.
-At 10:05 a.m. the surveyor asked nursing assistant (NA)-A when she was going to provide R25 cares. NA-A informed the surveyor she would let her know.
-At 10:15 a.m. NA-A and NA-B were observed to transfer R25 from his wheelchair into bed via a

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F 314	Continued From page 17 mechanical lift. R25's coccyx was observed bright red with creases and the incontinent brief had bowel movement (BM) in it. NA-A was observed to provide peri-care and apply Avilone barrier cream to the peri are. On 3/10/15, at 10:25 a.m. NA-A stated R25 was provided morning cares, assisted into the wheelchair and transported to the dining room at 7:00 a.m., three hours and 15 minutes earlier. NA-A verified R25 was to be repositioned every two hours. NA-A stated the staff were running behind schedule due to the night shift being short of staff and were unable to provide morning cares to two residents on each of the four wings as assigned therefore the day shift was behind schedule due to the extra work needed. On 3/12/15, at 10:30 a.m. registered nurse (RN)-A verified R25's care plan was correct and R25 was to bed repositioned every two hours and as needed. The facility Repositioning, Toileting, and Exercise policy dated 6/09, indicated staff would provide an opportunity for motion, exercise, and elimination during each two-hour period unless there was a specific physician order to be on a different schedule or if the individual care plan indicated a different plan was more appropriate.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		4/21/15

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F 329	Continued From page 18 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and monitor the effectiveness of non-pharmacological interventions and medication usage related to the use of as needed (PRN) antianxiety medication for 1 of 2 residents (R12) who received PRN antianxiety medication (Xanax) and Remeron (antidepressant) for sleep. In addition, the facility failed to monitor for side effects of anticoagulant (blood thinning) medication use for 2 of 5 residents (R53, R24) who received anticoagulant medication (Coumadin). Findings include:	F 329	The facility ensures each residents drug regimen is free from unnecessary drugs. For resident #12, a new sleep assessment was completed and care plan updated regarding antidepressant use of Remeron on 3/24/15. A new behavior tracking log was implemented 4/01/15 and is currently being utilized for monitoring non-pharmaceutical interventions and need for prn Xanax usage. Also, for resident #53 and #24, the care plans have been updated to include monitoring for side effects of anticoagulant (blood thinning)	

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F 329	Continued From page 19 R12's medical record lacked documentation of non pharmacological interventions attempted prior to the administration of Xanax and lacked documentation of the effectiveness of the medication. R12's quarterly Minimum Data Set (MDS) dated 1/27/15, identified R12 had severe cognitive impairment, dementia, anxiety, insomnia, depression and did not have trouble falling asleep or staying asleep. The MDS also indicated R12 had no behavior issues. R12's Behavior Care Area Assessment (CAA) dated 6/4/14, indicated R12 had mixed anxiety depressive disorder, progressive dementia, short term memory impairment with impaired decision making ability and problems with disorientation. The CAA also indicated R12 was at risk for further cognitive loss, miscommunication, unmet needs, frustration, anxiety and depression. R12's Psychotropic Medication CAA dated 6/4/14, indicated R12 had anxiety, depression and dementia. The CAA also indicated R12 received Remeron and Xanax (PRN) which had been discontinued 7/13, due to lack of use and then restarted. The CAA indicated R12 was at risk for worsening symptoms of anxiety and depression and adverse behaviors and unmet needs, medications to be monitored per facility policy. R12's Sleep Monitoring Form dated 6/29/13, to 7/6/13, indicated from 6/29/13, to 6/30/13, provided documentation of R12's hourly sleep pattern from 11:00 p.m. to 6:00 a.m. However, the sleep pattern documentation for 7/1/13,-7/6/13, was blank. There was no current sleep monitoring form available.	F 329	medications. For all residents a new behavioral tracking log has been implemented 4/01/15 which includes assessment and monitoring of effectiveness of non-pharmaceutical interventions and outcomes related to psychotropic medication use. A Warfarin monitoring tool is in place and up to date for each resident receiving anticoagulant (blood thinning) medications. The facility has combined the monthly psychotropic monitoring committee meeting with behavioral monitoring committee meeting to provide greater emphasis on non-pharmaceutical interventions and gradual dose reduction (GDR). Education given at staff meetings on 3/26/15, 3/27/15, and 4/01/15 regarding behavior tracking log and directions regarding completion of the document along with instruction on need for non-pharmaceutical interventions before using prn psychotropic medications. Staff educated on awareness of side effects regarding use of anticoagulant medications, including bleeding and bruising. DON or designee will monitor behavior logs and Coumadin monitoring tools weekly x 4 weeks and with any new admission to ensure proper documentation is utilized.	

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F 329	Continued From page 20 R12's physician visit Progress Note dated 2/10/15, indicated R12 had mixed anxiety depressive disorder and currently received Xanax 0.25 milligrams (mg) twice daily as needed for sleep and Remeron 15 mg nightly which was started on 8/14/13, which was an increase in dose from 7.5 mg which was started 7/26/13. R12's undated Behavior Tracking Log form was blank with no target behaviors identified nor interventions documented. The undated R12 Xanax Oral Tablet form indicated from 2/12/15, until 3/11/15, R12 received as needed Xanax 21 times however, there was no documentation related to non pharmalogical's attempted prior to the administration of the medication or if the medication was effective or not. R12's care plan dated 3/11/5, indicated R12 had anxiety with anxious episodes and may need frequent reassurance, had insomnia, had repetitive health complaints with sad/pained/worried facial expressions crying, tearfulness, repetitively up and down with inability to stay in one place, voiding on the floor. The care plan also indicated R12 had occasional negative statements-regrets of living so long, repetitive questions related to time of day and daily routine, repetitive verbalizations, anger/easily annoyed with others and self deprecation with statements such as she's useless and stupid. The care plan indicated R12 received Xanax 0.25 mg twice a day as needed for anxiety and Remeron 15 mg every evening. The care plan directed staff to assist R12 with adjustment to floor and routine changes, provide	F 329		

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F 329	Continued From page 21 orientation and cues as needed, provide cues and encourage participation to promote compliance, spend 1:1 time with R12, call family and encourage family to make frequent visits, speak to R12 calmly and with simple terms, decrease stimuli, provide calm environment, monitor agitation, sadness, restlessness, depression, anxiety and attention seeking behaviors. Monitor for pain and intervene as needed, monitor for changes in condition and for side effects of mood altering medications. The care plan also directed staff to use relaxation techniques such as massage, music and explain all cares/procedures in simple terms and to maintain consistent environment. R12's Pharmacist's Drug Regimen Review form identified on 11/18/14, the Remeron dose had been increased. The review note dated 12/19/14, identified the PRN Xanax use and recommended no reduction in Remeron. The pharmacist also reviewed R12's medication regimen on 1/29/15, and 2/17/15, with no recommendations provided. R12's Progress Note dated 2/12/15, at 3:07 a.m. indicated R12 was wandering in room, searching in drawers, closets and was up seven times before 2:00 a.m. and staff were unsure of what R12 needed. The note indicated Xanax was given for anxiousness however, there was no documentation of what non pharmacological interventions were attempted prior to the administration of the medication nor documentation of the effectiveness of the medication.	F 329		

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F 329	Continued From page 22 R12's Progress Note dated 2/22/15, indicated R12 was anxious and confused, was searching for her mother, anxious about going to church as it was not a catholic service and was upset about having trouble hearing. The note indicated Xanax 0.25 mg was given and R12's ears were assessed and determined to have significant amount of cerumen in them which ear wax drops were applied. There was no documentation of what non pharmacological's were attempted prior to the administration of the medication nor follow up documentation to indicate if the medication was effective or not. R12's Progress Noted dated 3/10/15, indicated R12 was very restless and anxious and up and down several times therefore Xanax 0.25 mg was given. There was no documentation of non pharmalogical interventions attempted prior to the administration of the medication nor follow up documentation to indicate if the medication was effective or not. R12's Progress Note dated 3/11/15, at 5:33 a.m. indicated R12 was up to the bathroom three times, looking in drawers and closet twice and wandering in room. Xanax given for anxiousness. There was no documentation of non pharmalogical intervention attempted prior to the administration of the medication nor follow up documentation to indicate if the medication was effective. R12's Progress Note dated 311/15, at 2:02 p.m. indicated Xanax 0.25 mg was given due R12's anxiousness, crying/ tearful stating she could just	F 329		

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die. The note also indicated R12 was reassured and assisted back to her room, provided toileting assistance and assisted into recliner however, no improvement in mood noted so medication was given. There was no follow documentation to indicate if the medication was effective or not.

On 3/11/15, at 2:30 p.m. licensed practical nurse (LPN)-B confirmed R12 had received Xanax because mornings and late afternoon she often experienced increased anxiety. Upon review of R12's Medication Administration Record (MAR) LPN-B verified R12 had received PRN Xanax 6 out of the past 7 days.

On 3/12/15, at 8:20 a.m. nursing assistant (NA)-C stated R12 did not walk to the dining room with her walker due to her anxiety level. Adding R12 was anxious, depressed and stated that morning she wanted to kill herself.

On 3/12/15, at 8:25 a.m. NA-B stated R12 had been feeling anxious.

On 3/12/15, at 9:30 a.m. NA-C stated R12 had gotten up at 6:40 a.m. that morning and was talking about wanting to kill herself. NA-C stated that was a daily event with her. NA-C verified she had told LPN-A.

On 3/12/15, at 9:45 a.m. LPN-A stated NA-C had reported to her that R12 was anxious. LPN-A stated she did not give the PRN Xanax right away because R12 usually settled down once she was in the dining room and eating breakfast.

On 3/12/15, at 11:30 a.m.. registered nurse

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F 329	Continued From page 24 (RN)-B verified R12 did receive Remeron 15 mg for sleep and Xanax 0.25 mg bid PRN. Upon review of R12's medical record, RN-B verified the Remeron was started 7/26/13, then increased on 8/14/13, to 15 mg. RN-B also verified R12's seven 7 day sleep monitoring/study had incomplete data and that a new 7 day sleep study would be initiated. In addition, RN-B verified R12 was administered the PRN Xanax and lacked documentation if any non-pharmalogical interventions were used or were effective prior to the administration of the medication and also lacked documentation of the effectiveness of the medication once administered. RN-B stated the facility would initiate behavior documentation / tracking on R12's Behavior Tracking Log. On 3/12/15, at 3:00 p.m. NA-A stated R12's sleep pattern varied from day to day. A facility policy, Psychotropic Medication Monitoring, dated 4/10, indicated alternative non-medication interventions would be attempted to alter behavior before initiation of psychotropic medication. The policy indicated if medication was ordered for sleep/insomnia, a sleep log would be completed on night shift for one week. Nursing would then evaluate if medication was effective and notify physician if required. R53 was receiving Coumadin without monitoring for potential adverse effects. R53's Diagnosis List, dated 3/11/15, indicated R53 had diagnoses that included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hypertension and status	F 329		

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F 329	Continued From page 25 post cerebrovascular accident (CVA/(stroke). R53's quarterly Minimum Data Set (MDS) dated 2/10/15, indicted R53 was cognitively intact and received anticoagulant medication daily. The Physician Orders dated 3/11/15, indicated R53 received Coumadin 6 mg by mouth daily for atrial fibrillation. R53's current Care Plan identified R53 had cardiovascular diagnoses including hypertension, atrial fibrillation, congestive heart failure. The care plan also identified R53 received Coumadin 6 mg daily; however, it did not address monitoring for potential adverse effects of the medication. On 03/12/2015 8:44 a.m. R53 was observed lying in bed, his skin was observed to be intact without bruising noted to his face, arms or legs. On 3/12/15, at 8:07 a.m. RN-A confirmed there was no formal monitoring performed for the adverse effects of Coumadin for R53. RN-A confirmed R53's care plan lacked interventions to address monitoring for adverse effects of Coumadin. On 3/12/15, at 1:35 p.m. the director of nursing (DON) confirmed side effect monitoring for Coumadin should have been included on R53's care plan. R24 received Coumadin without monitoring for potential adverse effects. R24's Diagnosis Listing by Resident dated 3/13/15, indicated R24 had diagnoses that	F 329		

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included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), angina, hypertension and congestive heart failure.

R24's quarterly Minimum Data Set (MDS) dated 2/24/15, indicted R24 was cognitively intact and received anticoagulant medication daily.

R24's Physician Orders dated 2/25/15, identified R24 received Coumadin 2.5 milligrams (mg) by mouth daily for atrial fibrillation.

R24's current Care Planning Report identified R24 had cardiovascular diagnoses including hypertension, angina, atrial fibrillation, congestive heart failure, and had a cardiac pacemaker. The care plan also identified R24 received Coumadin daily, however, did not address monitoring for potential adverse effects of the medication.

On 3/11/15 at 9:01 a.m. R24 was observed during morning cares. Her skin was observed to be intact without bruising noted to her face, arms, hands, back, torso or legs.

On 3/12/15, at 11:39 a.m. RN-A confirmed there was no formal monitoring performed for the adverse effects of Coumadin for R24. RN-A also confirmed R24's care plan lacked interventions to address monitoring for adverse effects of Coumadin.

On 3/12/15, at 2:01 p.m. the DON confirmed side effect monitoring for Coumadin should have been included on R24's care plan.

A policy regarding the care of residents receiving anticoagulant therapy was requested and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 27 LifeCare Medical Center Anticoagulation Management Program Inpatient Program dated 12/1/14, was provided. The program identified their goal was improved anticoagulant control through extensive education, monitoring, adjustment and follow up of patients receiving warfarin (Coumadin). The program also identified contraindications, precautions and adverse effects included bleeding, skin necrosis and major bleeding related to the use of Coumadin.	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 425	The policy of Roseau Manor is to	4/21/15

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	245470	A. BUILDING _____ B. WING _____	03/12/2015

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 425	Continued From page 28 review, the facility failed to administer medication as directed by manufacturer's directions for 1 of 1 resident (R2) who received an inhaler. Findings include: On 3/11/15, at 7:30 a.m. licensed practical nurse (LPN)-A was observed to hand R2 an Advair diskette inhaler. R2 held the diskette while he administered his medication and handed the device back to licensed practical nurse (LPN)-A. After the administration of the medication, LPN-A did not offer water to R12 in order to swish / rinse the mouth. At 9:20 a.m. the manufactures recommendations were reviewed with the LPN-A, the paper insert in the Advair box indicated a water swish was to be offered after administration of the medication. According to the facility's Nursing 2015 Drug Handbook, after administering an Advair diskus, staff were to instruct patient to rinse mouth after inhalation to prevent oral candidiasis. On 3/11/15, at 12:00 p.m. registered nurse (RN)-B verified LPN-A should have offered R2 water so he could have swished / rinsed his mouth. The facility policy "Administration of Medications" dated 3/09, indicated staff were ensure the five rights of medication administration are followed.	F 425	administer medications ordered by the provider to ensure the 5 rights of medication administration are followed. For resident #2, on 3/11/15 the manufacturer's directions were added to physician order regarding Advair Discus inhaler: Offer water and encourage to rinse mouth and spit after administration to prevent thrush. The care plan was also updated. For all residents, the manufacturer's directions regarding instruction to rinse mouth after use were added to all resident physician orders who receive steroid inhalers/nebulizers. All resident care plans were also updated to reflect this change. Education will be provided at mandatory LPN/RN nursing staff meetings on April 8, 9, 14, 15, 2015 regarding facility policy regarding administration of medications to ensure 5 rights of medication administration are followed and that residents are instructed to rinse/swish mouth with water after steroid inhaler/nebulizer use. DON or designee will conduct post meeting test regarding 5 rights of medication administration along with need to rinse/swish after steroid inhaler/nebulizer use. A score of 90% or greater will be required or nurses will need to re-test.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463		4/21/15

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F 463	Continued From page 29 The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident call lights were functioning and in good repair for 2 of 30 residents (R36, R50) whose rooms were reviewed for call lights. Findings include: On 3/9/15 at 5:52 p.m., R50's bathroom call light was tested and worked properly however, when the cord was pulled the button on the wall plate to turn off the call light was broken. The wall plate was loose and needed to be pulled forward in order to reach reset button. On 3/10/14 at 9:43 a.m., R36 was observed sleeping in her reclining chair. A call light was observed clipped to the chair. When the call light was tested, it did not activate. R36's care plan indicated R36 had cognitive deficits and intermittent confusion. The plan also indicated R36 was at risk for falls, was able to use the call light and directed staff to keep the call light within R36's reach. On 3/10/15, at 10:13 a.m. licensed practical nurse (LPN)-A verified R36 was able to use her call light	F 463	The nurses station is equipped to receive resident calls through a communication system from resident rooms, toileting, and bathing facilities. For residents #36 and #50 the call lights are currently functioning and in good repair. The communication system for all resident rooms, toileting, and bathing facilities have been checked and are in working order. The facility has an annual procedure in place for scheduled preventative maintenance to routinely test call lights for proper functioning per maintenance department. Education will be provided at mandatory staff meetings on April 8, 9, 14, 15, 2015 for nursing regarding policy regarding call lights along with instruction to immediately report defective call lights to maintenance per electronic maintenance request form. DON or designee will perform random audits 2 x weekly x 4 weeks to ensure proper functioning of call lights in residents rooms, toileting, and bathing facilities.	

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F 463	Continued From page 30 and stated she was not aware the call light was not working. LPN-A turned on the call light and confirmed it was not working. LPN-A disconnected the call light from the wall and plugged in another call light which also did not work when tested. LPN-A determined the reset button on the wall was sticking and she would notify the maintenance department. On 3/11/15, at 1:54 p.m. maintenance staff (M)-A stated the facility did not have a preventative maintenance schedule in place to routinely test the call lights for proper functioning. M-A stated when staff or a resident noticed a call light was not working, they were supposed to fill out a maintenance request slip so that it could be repaired. M-A stated yesterday he was notified of R36's call light and he had repaired it, however, was not aware of R50's bathroom call light in disrepair.	F 463		

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	245470	A. BUILDING **CN - ROSEAU C & NC** B. WING _____	**03/10/2015**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

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 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.

Lifecare Roseau Manor was built at two different times. The first building was an addition to the hospital and was built in 1972. It is 1-story with a basement and was determined to be Type II(111) construction with a 2- hour fire barrier between the hospital and the care manor. In 1993 an addition was built to the north of the original structure, is 1-story with a basement and determined to be Type II (000) construction. The facility is divided into 7 smoke zones, two on the basement level, by 30 minute and 2-hour fire barriers.

The facility is completely sprinkler protected and has a fire alarm system which includes corridor smoke detection throughout and in all common areas. All sleeping rooms have smoke detectors and all hazardous areas have automatic fire detectors in accordance with the Minnesota State 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 44 at the time of the survey.

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

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		

The requirement at 42 CFR, Subpart 483.70(a) is MET.