Electronically delivered
April 3, 2025

Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, MN 56751

RE: CCN: 245470
Cycle Start Date: March 21, 2025

Dear Administrator:

On March 21, 2025, a survey was completed at your facility by the Minnesota Department of Health 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 constituted immediate jeopardy (Level J),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On March 17, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding

of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 21, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Lifecare Roseau Manor is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 21, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health

625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245470	A. BUILDING _____ B. WING _____	C 03/21/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/20/25 through 3/21/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaints were reviewed: H54701180C (MN00111463), H54701700C (MN00108681) and a deficiency was issued at F689 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to adequately supervise and respond to an alarm sounding exit door for 1 of 3 residents (R1) reviewed for elopement risks. R1 exited the facility without staff knowledge and was found by	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed

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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F 689	Continued From page 1 a visitor on the ground with WC next to them outside the facility door. R1 had abrasions and bent glasses. The immediate jeopardy began on 3/13/25, at approximately 12:45 p.m., when R1 was found outside the facility on the ground next to his wheelchair. The IJ was identified on 3/21/25, and the administrator was notified of the IJ on 3/21/25, at 12:50 p.m. The immediate jeopardy was removed on 3/17/25, and the deficient practice was corrected prior to the start of the survey and was therefore issued at past noncompliance. Findings include: On 3/21/25 at 8:53 a.m. video footage of the R1's elopement on 3/13/25 was reviewed. The video showed R1 at a set of closed double doors approximately six feet from the nurses' station and dining room entrance at 12:34 p.m. At 12:35 p.m., R1 was seen on the video opening the double doors and going through toward the front entry a few feet away. R1 was able to push on the door and go outside at 12:36 p.m. At 12:37 p.m., housekeeper (HK)-A approached the door and turned off the alarm that was sounding then left the area. R1's Admission Record indicated he admitted to the facility 9/21/23. Diagnosis included Alzheimer's and dementia. R1's quarterly Minimum Data Set (MDS) dated 2/27/25, identified severe cognitive impairment and indicated use of a wander alarm. The MDS indicated R1 had hallucinations, displayed physical and verbal behaviors and no wandering	F 689		

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F 689	Continued From page 2 behaviors during the assessment period. The MDS indicated R1 was independent with transfers and wheelchair mobility. R1's Elopement Risk Screening dated 2/20/25, indicated R1 was alert and oriented, voiced a desire to leave and had previous elopement attempts. R1's care plan dated 12/30/24, identified target behaviors that included argumentative, resistant to assistance with activities of daily living, verbal aggression and identified him as an elopement risk. The care plan directed staff to allow him to vent his frustration, distract with activities such as a marble game and call family if needed to assist with redirection. The care plan indicated R1 was independent with transfers and ambulation in his room and indicated he could self-propel his manual wheelchair. Facility incident reports identified the following: 11/28/24 at 1:23 p.m., visitor alerted nursing there was a man (R1) in a wheelchair outside the building. Visitor reported the man pushed on the front door as it was beeping until it opened, then went out the door. The visitor cleared the door alarm and alerted staff. R1 stated he was going to the store to get chewing tobacco. Nursing staff found him self-propelling his wheelchair behind the handicap parking area. There were cars driving around the area at the time. R1 was brought back into the building safely. Staff were notified and told to monitor R1's location. The incident report indicated R1 may have been disoriented/confused due to many residents and family members being in and out of the building for a holiday meal.	F 689		

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F 689	Continued From page 3 1/25/25, Staff was alerted to door alarm sounding and observed R1 outside attempting to get back in the building. A plow truck driver stopped and said he saw resident outside before staff arrived. He had been plowing snow at the time R1 eloped. R1 was wearing a heavy flannel shirt and shoes but no jacket. Will continue to monitor and ensure hourly checks for safety are completed. Double doors between nursing station and front door to be shut. 3/13/25 at 12:45 p.m., exit door alarm sounded when a visitor left the facility. Staff went to shut off the alarm and saw R1 sitting on the cement next to his wheelchair with a visitor attempting to assist him to sit up. R1 was seated on the curb straight out from the front door. R1 had abrasions to the right side of his forehead, his glasses were bent up against his face and he had a laceration to his nose, abrasions to thumb, both knees, elbow, and wrist. When asked what happened, R1 said "I was going around and down." When asked where he was going R1 said, "well, home." Immediate action taken included: hourly checks to monitor whereabouts, education provided to staff who had shut off the initial alarm and education initiated for all other staff. During interview on 3/21/25 at 7:26 a.m., the director of nursing stated she had been in the building on 3/13/25, when R1 eloped. The DON said she had viewed the camera footage and said the double doors had been closed since R1's last elopement but he had been able to open them. The DON said R1 had also attempted to go through the family dining room to get to the front door in the past. The DON said after the incident on 3/13/25, she sent education related to alarms	F 689		

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F 689	Continued From page 4 to all facility staff and to all staff at the attached hospital. The DON said they had collaborated with the fire Marshall and set up the door so it would not open if a wander alert was in the vicinity. The DON said the door had been wander alert activated but said if someone went through the door and a resident followed them out, the door would not alarm. The DON said now the door alarmed if a wander alert was nearby. The DON said the door had also been changed to alarm if open for 10 seconds compared to the previous 30 seconds. During interview on 3/21/25 at 7:36 a.m., HK-A stated on 3/13/25, she heard the alarm sounding at the entrance to the facility. HK-A stated the set of double doors between the nurses station and the entrance had been closed so she went through them, did a quick glance, and turned off the alarm and went back to what she had been doing. HK-A stated she had not gone outside to see if a resdient had left the building. During interview on 3/21/25 at 8:53 a.m. The quality specialist said part of the video footage was no longer available. She said when she viewed the footage the previous week it showed R1 got to the edge of the sidewalk and flip forward out of his wheelchair on the curb. During interview on 3/21/25 at 9:25 a.m. licensed practical nurse (LPN)-A stated R1 was confused and wanted to go home. LPN-A stated R1 would often sit by the front door and watch people come and go. LPN-A said on 3/13/25, she had been passing medications. She said her medication cart was right outside the dining room and the last time she had seen R1 he had been eating. LPN-A said the double doors leading to the entrance	F 689		

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F 689	Continued From page 5 were shut and said she saw a visitor leave and heard the alarm. LPN-A stated she looked outside and saw R1 sitting on the curb outside the door. She said R1 had several abrasions, a laceration to his nose and said his glasses were "smooshed." During interview on 3/21/25 at 11:14 p.m., the director of nursing (DON) identified the root cause of the elopement being the staff member shut off the alarm without looking to see if a resident had exited the building. The DON said R1 could have been more seriously injured. She stated if the weather had been colder, he could have suffered from hypothermia or death. An elopement policy was requested but not received. The past noncompliance immediate jeopardy began on 3/13/25. The immediate jeopardy was removed 3/17/25, and the deficient practice corrected after the facility implemented a systemic plan that included the following actions: - 3/13/25, Immediate education provided to the staff member that shut off the alarm. - 3/13/25 through 3/21/25,Education to all staff about alarms and process of checking outside for residents prior to shutting off an alarm and notification to nursing staff. - 3/17/25, Maintenance evaluated the door alarm and collaborated with the Fire Marshall to decrease the amount of time door opened if pushed. Maintenance also changed the wander alert alarm so it would activate when resident was near the door.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 3, 2025

Administrator
Lifecare Roseau Manor
715 Delmore Drive
Roseau, MN 56751

Re: Event ID: DP1Y11

Dear Administrator:

The above facility survey was completed on March 21, 2025 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 - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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	00579	A. BUILDING: _____ B. WING _____	C 03/21/2025

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/20/25 through 3/21/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H54701180C (MN00111463), H54701700C	2 000		

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2 000	Continued From page 1 (MN00108681) NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		