Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 31, 2026

Administrator
Lifecare Roseau Manor
715 DELMORE DRIVE
ROSEAU, MN 56751

RE: CCN: 245470
Cycle Start Date: February 19, 2026

Dear Administrator:

On March 3, 2026, we informed you that we may impose enforcement remedies.

On March 31, 2026, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found 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 electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 19, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 19, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 19, 2026.

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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.

If you have not achieved substantial compliance by May 19, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lifecare Roseau Manor will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 19, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 19, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245470	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lifecare Roseau Manor	**715 DELMORE DRIVE , ROSEAU, Minnesota, 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
F0000	INITIAL COMMENTS On 3/24/26 through 3/25/26, 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 complaint was reviewed. H54707680C (2793049). As a result of the survey a deficiency issued at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		04/06/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure utilization of appropriate	F0689	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? -On 3/25/26, leadership team went to each resident's room that was care planned for a transfer using a sling. Sling type, size, and condition was verified according to care plan. All slings that did not match the care guide size/color were replaced with the correct sling. How will the facility identify other residents having the potential to be affected by the same deficient practice? -MDS nurse and COTA will continue to complete transfer rounds on every resident quarterly and with significant changes and complete transfer assessment to include transfer status. If lift is required for resident, the	04/10/2026

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 reverse for further 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.

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

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F0689 SS = D	Continued from page 1 sling sizes assessed for use with mechanical lift/stand devices for 3 of 4 residents (R1, R3, R4) reviewed for safe transfers with mechanical lift/stand devices. Findings Include: R1 R1's Transfer/Discharge Report indicated she admitted to the facility 6/30/21. R1's diagnoses included Multiple Sclerosis, dementia, weakness and dysphagia. R1's quarterly Minimum data set (MDS) dated 1/29/26, Identified moderate cognitive impairment and indicated she was dependent on staff for transfers. R1's Balance and Transfer Assessment dated 1/28/26, indicated all transfers were completed with a total body lift and two staff. R1 was unable to safely or consistently bear weight. R1 weighed 152.2 pounds (lbs.) and directed the use of a yellow (medium) bordered sling R1's care plan dated 2/5/26, identified a self care deficit related to disease process and directed staff to perform transfers with a full body lift and two staff. During observation on 3/25/26 at 8:16 a.m., R1 was seated in a wheelchair in the dining room. Underneath R1 was a black sling with green edges, which indicated a large sling. During observation on 3/25/26 at 10:18 a.m., R1 had two slings in her room, one on her wheelchair and one in her recliner. Both slings were a size large (green). During observation and interview on 3/25/26 at 10:33 a.m., NA-A verified the sling on R1's chair had been used to transfer her to bed and verified the sling was a size large. NA-A stated the care guide indicated a yellow (medium) sling. R3 R3's Transfer/Discharge Report indicated she admitted to the facility 8/8/24. R3's diagnoses included arthritis, reduced mobility and weakness. R3's quarterly MDS dated 1/29/26, identified severe cognitive impairment and indicated she was dependent on staff for all transfers. R3's Balance and Transfer Assessment dated 1/28/26,	F0689	Continued from page 1 size of the sling will be determined based on the manufacture's recommendations. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not recur? -Reviewed Hoyer, standing, and maxi move lift policies and the safe patient handling policy. Updated the policies to include ensuring the use of the correct sling per assessment. -Colored magnets that correlate with lift manufacture's lift sheet sizing chart, will be added to each resident that transfers with a lift that requires a sling on the bathroom door frame to give a visible reminder to all staff entering the room which color of sling should be used for transfers. MDS nurse will verify correct sling, and magnet is in resident's room during transfer rounds and will switch out the magnets when a change occurs. Education provided to all staff of the new process. Magnets will be stored at the charge nurse station to ensure magnets are added or changed out when appropriate. Re-education provided to staff to ensure they are checking care guides prior to transfers involving slings to ensure correct sling is being used and if they feel it is not the appropriate size, report to nurse to complete a new assessment to determine appropriate size of sling. How the facility will monitor it's corrective actions to ensure that the deficient practice is being corrected and will not recur? -DON or designee will complete audits for 12 weeks that the correct sling sizes and magnets are in residents' room for the applicable residents. Findings will be reported to the QAPI committee. The date the deficiency will be corrected: 4/10/26.	

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F0689 SS = D	Continued from page 2 indicated she did not ambulate and transferred with the use of a mechanical lift and two staff. R3 weighed 122.8 lbs. and directed the use of a red (small) sling. R3's care plan dated 2/5/26, identified a self care deficit related to shortness of breath and self-limits and directed the use of a mechanical lift for transfers. During observation on 3/25/26 at 8:32 a.m., R3 was seated in a wheelchair in the dining room. R3 had a black sling with Green edges (large) underneath her. During observation and interview on 3/25/26 at 9:18 a.m., R3 was in bed. R3 had a green (large) sling on her wheelchair. NA-A and NA-B confirmed they had transferred R3 using the large sling. NA-A reviewed the care guide and said staff should have used a red (small) sling to transfer R3. NA-A and NA-B stated they usually just used the sling that was in the room. NA-A and NA-B acknowledged they had not reviewed the care guide prior to the transfer. R4 R4's Transfer/Discharge Report indicated she admitted to the facility 4/27/23. R4's diagnoses included dementia, weakness and unsteadiness on feet. R4's quarterly MDS dated 3/12/26, identified severe cognitive impairment and indicated R4 was dependent on staff for transfers. R4's Transfer and Balance Assessment dated 3/11/26, indicated she was non-ambulatory and transferred using a mechanical stand and two staff. R4 weighed 118 lbs. and directed the use of a mechanical stand with a red (small) harness. R4's care plan dated 3/18/26, identified a self care deficit related to dementia and anxiety and directed the use of a standing lift and two staff for transfers. During observation on 3/25/26 at 8:54 a.m., NA-C and NA-B transferred R4 from the toilet to bed using the mechanical stand and a yellow (medium) harness. During interview on 3/25/26 at 9:26 a.m., NA-C stated the sling size was listed on the care guide and said R4 should have had a medium harness for transfers. NA-C reviewed the care guide and verified a red (small) sling was care planned for R4. NA-C said she used what was already in the room.	F0689		

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F0689 SS = D	Continued from page 3 During observation and interview on 3/25/26, an mechanical stand was observed on the secured unit with a yellow (medium) sling draped over it. NA-D said the sling size was based on height and weight. NA-D stated staff used the sling that was on the unit. During interview on 3/25/26 at 12:45 p.m., the assistant administrator stated prior to performing a transfer with a mechanical device, staff were expected to ensure the sling was placed properly, ensure lift was in good condition and ensure the sling/harness size was appropriate for the resident. Facility Policy Safe Patient Handling and Movement Policy undated, indicated it is the duty of employees to use mechanical lift devices in accordance with instructions and training.	F0689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 31, 2026

Administrator
Lifecare Roseau Manor
715 DELMORE DRIVE
ROSEAU, MN 56751

Re: State Nursing Home Licensing Orders
Event ID: 22BCDE-H1

Dear Administrator:

The above facility survey was completed on March 25, 2026 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 one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/25/2026**

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20000	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 3/24/26 through 3/25/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure. The following complaint was reviewed during the survey. H54707680C (2793049). As a result of the survey a licensing order issued at	20000		04/06/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/25/2026**

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20000	Continued from page 1 0830. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure utilization of appropriate sling sizes assessed for use with mechanical lift/stand devices for 3 of 4 residents (R1, R3, R4) reviewed for safe transfers with mechanical lift/stand devices. Findings Include: R1 R1's Transfer/Discharge Report indicated she admitted to the facility 6/30/21. R1's diagnoses included Multiple Sclerosis, dementia, weakness and dysphagia. R1's quarterly Minimum data set (MDS) dated 1/29/26, Identified moderate cognitive impairment and indicated she was dependent on staff for transfers. R1's Balance and Transfer Assessment dated 1/28/26, indicated all transfers were completed with a total body lift and two staff. R1 was unable to safely or consistently bear weight. R1 weighed 152.2 pounds (lbs.) and directed the use of a yellow (medium) bordered sling R1's care plan dated 2/5/26, identified a self care deficit related to disease process and directed staff to perform transfers with a full body lift and two staff. During observation on 3/25/26 at 8:16 a.m., R1 was	20830	How corrective action will be accomplished for those residents found to have been affected by the deficient practice? -On 3/25/26, leadership team went to each resident's room that was care planned for a transfer using a sling. Sling type, size, and condition was verified according to care plan. All slings that did not match the care guide size/color were replaced with the correct sling. How will the facility identify other residents having the potential to be affected by the same deficient practice? -MDS nurse and COTA will continue to complete transfer rounds on every resident quarterly and with significant changes and complete transfer assessment to include transfer status. If lift is required for resident, the size of the sling will be determined based on the manufacture's recommendations. What measures will be put into place, or systematic changes made, to ensure the deficient practice will not recur? -Reviewed Hoyer, standing, and maxi move lift policies and the safe patient handling policy. Updated the policies to include ensuring the use of the correct sling per assessment. -Colored magnets that correlate with lift manufacture's lift sheet sizing chart, will be added to each resident that transfers with a lift that requires a sling on the bathroom door frame to give a visible reminder to all staff entering the room which color of sling should be used for transfers. MDS nurse will verify correct sling, and magnet is in resident's room during transfer rounds and will switch out the magnets when a change occurs. Education provided to all staff of the new process. Magnets will be stored at the charge nurse station to ensure magnets are added or changed out when appropriate. Re-education provided to staff to ensure they are checking care guides prior to transfers involving slings to ensure correct sling is being used and if they feel it is not the appropriate size, report	04/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/25/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lifecare Roseau Manor	**715 DELMORE DRIVE , ROSEAU, Minnesota, 56751**

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20830	Continued from page 2 seated in a wheelchair in the dining room. Underneath R1 was a black sling with green edges, which indicated a large sling. During observation on 3/25/26 at 10:18 a.m., R1 had two slings in her room, one on her wheelchair and one in her recliner. Both slings were a size large (green). During observation and interview on 3/25/26 at 10:33 a.m., NA-A verified the sling on R1's chair had been used to transfer her to bed and verified the sling was a size large. NA-A stated the care guide indicated a yellow (medium) sling. R3 R3's Transfer/Discharge Report indicated she admitted to the facility 8/8/24. R3's diagnoses included arthritis, reduced mobility and weakness. R3's quarterly MDS dated 1/29/26, identified severe cognitive impairment and indicated she was dependent on staff for all transfers. R3's Balance and Transfer Assessment dated 1/28/26, indicated she did not ambulate and transferred with the use of a mechanical lift and two staff. R3 weighed 122.8 lbs. and directed the use of a red (small) sling. R3's care plan dated 2/5/26, identified a self care deficit related to shortness of breath and self-limits and directed the use of a mechanical lift for transfers. During observation on 3/25/26 at 8:32 a.m., R3 was seated in a wheelchair in the dining room. R3 had a black sling with Green edges (large) underneath her. During observation and interview on 3/25/26 at 9:18 a.m., R3 was in bed. R3 had a green (large) sling on her wheelchair. NA-A and NA-B confirmed they had transferred R3 using the large sling. NA-A reviewed the care guide and said staff should have used a red (small) sling to transfer R3. NA-A and NA-B stated they usually just used the sling that was in the room. NA-A and NA-B acknowledged they had not reviewed the care guide prior to the transfer. R4 R4's Transfer/Discharge Report indicated she admitted to the facility 4/27/23. R4's diagnoses included dementia, weakness and unsteadiness on feet.	20830	Continued from page 2 to nurse to complete a new assessment to determine appropriate size of sling. How the facility will monitor it's corrective actions to ensure that the deficient practice is being corrected and will not recur? -DON or designee will complete audits for 12 weeks that the correct sling sizes and magnets are in residents' room for the applicable residents. Findings will be reported to the QAPI committee. The date the deficiency will be corrected: 4/10/26.	

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20830	Continued from page 3 R4's quarterly MDS dated 3/12/26, identified severe cognitive impairment and indicated R4 was dependent on staff for transfers. R4's Transfer and Balance Assessment dated 3/11/26, indicated she was non-ambulatory and transferred using a mechanical stand and two staff. R4 weighed 118 lbs. and directed the use of a mechanical stand with a red (small) harness. R4's care plan dated 3/18/26, identified a self care deficit related to dementia and anxiety and directed the use of a standing lift and two staff for transfers. During observation on 3/25/26 at 8:54 a.m., NA-C and NA-B transferred R4 from the toilet to bed using the mechanical stand and a yellow (medium) harness. During interview on 3/25/26 at 9:26 a.m., NA-C stated the sling size was listed on the care guide and said R4 should have had a medium harness for transfers. NA-C reviewed the care guide and verified a red (small) sling was care planned for R4. NA-C said she used what was already in the room. During observation and interview on 3/25/26, an mechanical stand was observed on the secured unit with a yellow (medium) sling draped over it. NA-D said the sling size was based on height and weight. NA-D stated staff used the sling that was on the unit. During interview on 3/25/26 at 12:45 p.m., the assistant administrator stated prior to performing a transfer with a mechanical device, staff were expected to ensure the sling was placed properly, ensure lift was in good condition and ensure the sling/harness size was appropriate for the resident. Facility Policy Safe Patient Handling and Movement Policy undated, indicated it is the duty of employees to use mechanical lift devices in accordance with instructions and training. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures as they relate to mechanical lift/stand transfers, and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.	20830		

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20830	Continued from page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		