

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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  Lifecare Roseau Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  715 Delmore Drive Roseau, MN 56751	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 [DATE], Identified moderate cognitive impairment and indicated she was dependent on staff for transfers. R1's Balance and Transfer assessment dated [DATE], 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 [DATE], identified severe cognitive impairment and indicated she was dependent on staff for all transfers. R3's Balance and Transfer assessment dated [DATE], 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 [NAME] 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 [DATE], identified severe cognitive impairment and indicated R4 was dependent on staff for transfers. R4's Transfer and Balance assessment dated [DATE], 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 (continued on next page)</p>		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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  Lifecare Roseau Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  715 Delmore Drive Roseau, MN 56751	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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, a 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.</p>