STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245470	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lifecare Roseau Manor	715 Delmore Drive Roseau, MN 56751

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to follow through on a grievance regarding medication found in recliner for 1 of 1 resident (R2) reviewed for grievances.Findings include: R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 had severe cognitive impairment and diagnoses included dementia, anxiety, and depression. R2's care plan revised 2/10/26, identified R2 preferred medications crushed in vanilla pudding.An e-mail dated 2/12/26 at 5:31 p.m., identified family member (FM)-B reported to registered nurse (RN)-B that FM-B reported to the charge nurse two whole pills were found on R2's chair (one with an imprint C) and R2's Wanderguard (device to monitor exiting) was found on R2's bed footboard. FM-B identified R2's medications were crushed, and the family was unsure if the pills found were missing doses or dropped pills. The e-mail included three photos. The first photo was a broken pill with an imprinted c and light orange in color. The second photo was a pill broken in half, orange in color and partially dissolved. The third photo was a Wanderguard wrapped around the footboard.During a telephone interview on 2/17/26 at 5:45 p.m., FM-A stated on 2/12/26 FM-A and FM-B were at the facility to visit R2. FM-A and FM-B found a pill in R2's chair in R2's room, then found another on the floor even though R2 took her medications crushed. When FM-A and FM-B brought the pill to nursing, they were told the facility could not determine what the medication was nor where it came from. FM-A stated it made her feel awful that R2 was cared for this way. FM-A brought other concerns to the director of nursing (DON), however, FM-A stated she was just told it shouldn't be that way, but the facility didn't really do anything about it.During an interview on 2/18/26 at 5:00 p.m., FM-B stated it was crazy. On 1/12/26, after visiting R2, FM-B and FM-A found a pill in R2's chair. FM-B took a photo of the pill and brought the pill to the charge nurse. R2's wandguard was also at the foot of R2's bed. The following day, FM-B sent an e-mail to the care coordinator. FM-B stated it was half a pill that had been scored with another small portion next to it. FM-B stated she was told it was weird because R2's medications were crushed before administration. FM-B stated she was told the care coordinator spoke with staff who didn't know what the pill was. During an interview on 2/19/26 at 8:36 a.m., registered nurse (RN)-A stated she was the care coordinator for R2. When a family member reports a concern, RN-A makes a note of it. RN-A or the social worker would interview the resident. If the resident cannot be interviewed, RN-A would figure out what she could and would report back to the family what was found. This should be documented in the resident's chart in a family communication note. However, RN-A stated there was no way to run a report for these concerns in order for the facility to track the different concerns to determine if there was a pattern. RN-A sated she was aware of FM-B's concern regarding an unknown medication found in R2's room. However, RN-A stated no formal grievance was documented and no formal grievance was completed. RN-A stated FM-B's email didn't provide how long the medication was there, where the chair came from because the chairs were not static to resident rooms, and there wasn't enough information for RN-A to investigate further. RN-A did not call and speak with FM-A to obtain clarifying information. RN-A took the photo from the e-mail and looked at R2's medication cassettes from the medication car and didn't find a match. RN-A did not review other resident (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication cassettes to determine if there was a possible match. RN-A then e-mailed FM-A to let her know she couldn't determine what the medication was nor where it came from. No further investigation was completed. During an interview with the director of nursing (DON) and licensed social worker (SS)-A on 2/19/26 at 9:52 a.m., SS-A stated most complaints come to her. Then, SS-A would talk to the DON and together they would determine a solution. The DON stated there was a formal grievance process, however, if they were able solve the problem the formal process wasn't followed.During an interview on 2/19/26 at 1:45 p.m., the administrator stated staff were expected to report complaints to the charge nurse who reported concerns to the administration. Staff were able to use e-mail or phone after hours and administration would follow up. An investigation and resolution should be documented.The Patient Complaint of Grievance Policy revised 10/11/24, identified the facility informed patients of their rights, including the right to resolution of grievance. Complaints and grievances related to patient care and services at the facility were addressed according to the following guidelines. Patients and/or their representatives voicing a complaint or making a grievance would not jeopardize the quality of care or access to future health care services.Procedure:A. Grievances submitted to facility personnel in writing, verbally, via e-mail, or over the telephone are forwarded to the Director of Quality & Risk Management or the Director of Clinic Operations, who are considered the patient advocate/patient representatives. In the event the Director of Quality & Risk Management or the Director of Clinic Operations is not available, this role will be assumed by the Chief Nursing Officer or other administrative personnel.B. The facility's staff in receipt of a grievance will communicate with the patient or their representative regarding the plan to investigate and follow-up the grievance.C. The investigation of the grievance shall be conducted by the Director of Quality & Risk Management or Director of Clinic Operations, who will collaborate with the areas involved. The medical staff peer review process will be used to investigate a grievance concerning the quality of medical care as needed.D. All grievances will have a prompt written or verbal response, within 7 days if possible depending upon the nature of the grievance. For more complicated grievances requiring extensive investigation and analysis, the Director of Quality & Risk Management will contact the patient or their representative stating that the hospital is still working on the response, which they should expect within 30 days if possible. Exception: Grievances regarding situations that endanger the patient shall be addressed immediately.E. All grievances are followed-up in writing. The final written response shall include the name of the facility, a contact person at the facility, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. All grievance response letters will be mailed to the patient's home address unless the patient or representative has asked otherwise.F. Tracking of complaints/grievances and identifying trends is an important part of the quality improvement process. Grievance information is aggregated, tracked, trended and communicated by the Director of Quality and Risk Management or designee to leadership on an as-needed basis.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to complete a comprehensive assessment following resident to resident incidents to maintain safety of the residents for 1 of 5 residents (R2) reviewed for dementia care.Findings include:R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 had severe cognitive impairment and diagnoses included dementia, anxiety, and depression. R2 exhibited physical behaviors directed towards others (for example: hitting, kicking, pushing, grabbing) 4-6 days, verbal behavioral symptoms directed towards others 4-6 days, other behavioral symptoms not directed towards others such as hitting/scratching self 1-3 days, rejection of care 4-6 days, and wandering 4-6 days. R2 required setting up or clean up assistance with eating, substantial/maximal assistance for toileting and was dependent on staff for all other care areas. R2 used antipsychotic, antianxiety, antidepressant, diuretic, and medications.R2's Delirium Care Area Assessment (CAA) dated 11/18/25, identified inattention, disorganized thinking, and altered level of consciousness had been R2's baseline since her initial admission more than nine months ago which led to her requiring 24-hour supervision and activities of daily living (ADL) assistance. This was not new or worsening. This had been R2's baseline for more than a year per R2's family. R2's Behavioral Symptoms CAA dated 11/18/25, identified R2's goal was to continue to attempt to express self and avoid complication such as social isolation and avoidance behaviors. Staff were to provide simple step by step instructions, allow time to process and respond, don't offer too many choices, repeat and rephrase as needed, provide verbal and nonverbal prompts and cues, approach in a calm and unhurried manner, offer smiles, list potential needs one at a time and observe for indication/acknowledgement that was what she wants/needs, provide reassurance, leave alone in safe situation and return later when unable to console or deescalate agitation, administer medications as ordered for anxiety, depression, agitation and observe for adverse effects and notify R2's physician of concerns, document target behaviors for physician to review with ongoing visits/consults. R2 was at risk for miscommunication, frustration, agitation, worsening symptoms of anxiety and depression, falls with injury, adverse effects of medications, social isolation, escalating adverse behaviors, unmanaged pain, and unmet needs. Medications were monitored per policy with behavioral health consultations.R2's Cognitive Loss/Dementia CAA dated 11/18/25, identified R2's goal was to continue to make her needs known, minimize risks, and avoid complications. Staff were to assist with communication with verbal and nonverbal prompts and cues, allow time to process and respond, offer reassurance, and allow to vent frustrations. R2 was at risk for miscommunication, frustration, anxiety, depression, adverse behaviors, and unmet needs.R2's Psychotropic Drug Use CAA dated 11/18/25, identified R2's goal was to continue to attempt to express self and avoid complications such as social isolation and avoidance behaviors. Staff were to provide simple step by step instructions, allow time to process and respond, don't offer too many choices, repeat and rephrase as needed, provide verbal and nonverbal prompts and cues, approach in a calm and unhurried manner, offer smiles, list potential needs one at a time and observe for indication/acknowledgement that is what she wants/needs, provide reassurance, leave alone in safe situation and return later when unable to console or deescalate agitation, administer medications as ordered for anxiety, depression, agitation and observe for adverse effects and notify R2's physician of concerns, document target behaviors for R2's physician to review with ongoing visits/consults. R2 was at risk for miscommunication, frustration, agitation, worsening symptoms of anxiety and depression, falls with injury, adverse effects of medications, social isolation, escalating adverse behaviors, unmanaged pain, and unmet needs. Medications are monitored per policy with behavioral health consultations.R2's care plan revised 2/10/26, identified R2's target behaviors included wandering, poor safety awareness, verbal aggression, physical aggression, crying out that was disruptive to others, unable to (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understand boundaries, elopement risk, and grabs on to other walkers/items. The care plan identified nonpharmacological interventions to try, such as calm, hurried approach; approach with 1 or 2 staff; leave alone and return later when safe to do so; and distract with snacks. R2's Physical Aggression Initiated dated 12/3/25 at 3:30 p.m., identified R2 was attempting to enter another resident's room. When the other resident said, go to your own room, R2 stated shut up you bitch and then swung her hand toward the other resident's face. The other resident raised her arm and stopped the blow with her forearm. Staff stepped between the residents and R2 swung a second time. R2's hand connected with the other resident's forehead before staff was able to completely stop R2. Staff reported the hit as weak. Immediate action taken was the residents were separated and redirected. However, the document failed to identify potential triggers for R2's behavior or potential interventions to prevent further incidents.R2's Physical Aggression Initiated dated 12/5/25 at 12:15 p.m., identified staff reported R2 hit another resident on the right shoulder four times as staff was attempting to get R2 to let go of the other resident's walker. Staff stated it was possible R2 was attempting to hit staff and not the other resident. R2 was unable to provide a description of the incident. The immediate action taken was staff intervened and redirected R2 with another activity. However, the document failed to identify potential triggers for R2's behavior or potential interventions to prevent further incidents. R2's nursing progress note dated 12/9/25 at 11:30 a.m., identified R2 had a behavioral health video appointment regarding management of psychotropic medications related to dementia with aggressive behaviors and anxiety. R2's provider was informed R2 had an increase in verbal and physical aggression toward staff and other residents. The incidents appeared to be triggered by R2 not getting her way (for example, being told she could not have something another resident already had) or when ADLs were being attempted. The noted further identified a review of R2's psychotropic medications were completed, but no nonpharmacological interventions were discussed. R2's Physical Aggression Initiated dated 12/18/25 at 6:00 p.m., R2 was attempted to squeeze between the wall and another resident's wheelchair in the dining room. Staff tried to tell R2 to stop because there was not enough room to safely pass. R2 became aggressive swinging out and hitting staff several times, pulling hair, pinching skin. The other resident also told her to stop, and R2 hit him once on the back of the neck. The other resident was not injured. A few minutes later R2 tried taking silverware from another resident. This resident asked her to stop, and R2 swung out at him, but he raised his arm and blocked R2's punch. The immediate action taken was R2 was redirected, staff took R2 for a walk down the hall and R2 eventually sat down in a chair. However, the document failed to identify potential triggers for R2's behavior or potential interventions to prevent further incidents. R2's nursing progress note dated 1/6/26 at 8:39 a.m., identified R2 had a behavioral health video appointment regarding management of psychotropic medications related to dementia with aggressive behaviors and anxiety. A review of staff notes was completed to evaluate whether the last medication change was effective. Based on documentation, R2 had been sleepier, has not been aggressive toward other residents but has been physically and verbally aggressive with staff at times when cares are attempted. The note further identified that a review of R2's psychotropic medications was completed, but no nonpharmacological interventions were discussed. During a telephone interview on 2/17/26 at 5:45 p.m., family member (FM)-A stated she and FM-B had visited R2 on 2/12/26. R2 had been up all night and hadn't had cares and eaten. FM-A stated the staff let R2 lie in bed all day and then R2 was up all night. FM-A stated they had discussed R2's behaviors with the facility many times and they were told the facility would provide more training to the staff on how to care for a resident with dementia.During an interview on 2/18/26 at 4:50 p.m., nursing assistant (NA)-A stated R2 had a lot of behaviors and could get combative with staff and other residents. You don't see it coming. NA-A stated she didn't trust R2 around the other residents and immediately stepped between them whether R2 was agitated or not because R2 could hit hard.During an interview on 2/18/26 at 5:00 p.m., FM-B stated there were times when family visited R2 didn't have her glasses, dinner will just sit there, and staff did not offer to assist R2. A lot of the time, R2 just remained in her bed or room in the dark with alarms blaring. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	FM-B stated it wasn't fair to R2, she's just existing. During an interview on 2/19/26 at 7:52 a.m., NA-B stated R2 was difficult resident and had a lot of behaviors. R2 was unpredictable and, in the previous weeks, R2's behavior had gotten a lot worse. R2 was very clingy and would hang on you. Staff tried their best to keep R2 away from other residents. For example, if a resident was sitting in a chair and R2 wanted to sit there or was trying to move the chair and staff tried to redirect R2, R2 would become angry and start hitting the staff and R2 could hit the other resident too. That's why staff tried to keep R2 away. R2 would cling to one person so staff would have to ask for help and the help had to do whatever was needed because R2 wouldn't let the staff go. Also, if the staff did get away from R2, that would make R2's behaviors worse. Staff just had to do their best to keep R2 away from the other residents. Some days, R2 would sleep all day. Some days, R2 was up all day. Staff never knew. Staff were just told that if R2 was sleeping to not ask if R2 wanted to get up. Staff were to be encouraging to R2 to get up for the day.During an interview on 2/19/26 at 8:09 a.m., trained medication aide (TMA)-A stated R2 was very combative. Any time staff had to touch R2 it made R2 more combative. R2 was unable to understand every small, direct communication and nothing calmed R2 except R2's family. R2 could be vulgar too. TMA-A stated she had never witnessed or been told R2 was combative with other residents.During an interview on 2/19/26 at 8:36 a.m., registered nurse (RN)-A stated staff were expected to report all resident-to-resident incidents immediately. First, staff were directed to ensure all residents were safe, separated and without injury. Then, the charge nurse would report the incident to the administrator and social worker. Then, an investigation of the incident would occur, and family was notified. All incidents were then discussed during the interdisciplinary team (IDT) meeting. For R2's resident-to-resident incidents, staff were just to monitor. The facility used the communication page of the electronic medical record system, however, RN-A stated she could not determine if a communication had been entered regarding R2's behaviors and/or possible interventions to prevent resident-to-resident incidents.R2's medical record lacked evidence a comprehensive assessment was completed following each incident to identify potential new interventions to keep R2 and others safe.During an interview with the director of nursing (DON) and licensed social worker (SS)-A on 2/19/26 at 9:52 a.m., the DON stated staff had been working with R2's behavioral health provider to adjust R2's medications but R2's family was hesitant to follow recommendations. R2 was difficult because there wasn't really any sign of aggression. R2 could be happy or R2 could be tired and could be fine. There wasn't any way to determine the trigger of R2's behaviors. However, the DON stated a lot of behaviors did occur when R2 was told no or during cares. During the facility's psychotropic meeting, staff review the behavior charting and see if there was anything the nursing assistants were seeing/charting but not reporting up. Then the care plan was reviewed and updated if needed. This was done quarterly. The DON stated she did not know what could have been care planned to help prevent R2's resident-to-resident incidents.During an interview on 2/19/26 at 1:45 p.m., the administrator stated staff were expected to recognize potential signs of aggressive behaviors, identify root causes, to create potential interventions to prevent incidents and to care according to what had been decided on as a team. Also, staff were expected to reassess and change the care plan as needed.The facility Care Planning policy revised 6/09, identified a care plan would be developed and maintained on each resident according to the RAI guidelines to provide mandated and essential information in an organized manner to develop and maintain a plan of care for each resident.A facility policy regarding dementia care was requested but not received.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and document review, the facility failed to ensure a schedule 2 narcotic (a medication with a high potential for abuse) was stored in a manner to prevent diversion for 1 of 3 units (Maple Unit); and failed to monitor temperature on a medication refrigerator temperatures of 1 of 2 medication fridges (Maple Unit) reviewed for medication storage. Findings include:During observation on 2/19/26 at 8:25 a.m., the director of nursing (DON) did a tour of the medication room on the Maple unit (memory care unit). Upon entering the locked medication room on the unit, it was observed there were keys in a lock on one of the cupboards. The DON reached up and pulled the cupboard door open as it was not locked. In the cupboard there was a 30-milliliter (ml) unopened bottle of liquid morphine (a scheduled 2 narcotic). The medication refrigerator did not have a thermometer inside of it nor was there evidence the temperatures were monitored. The refrigerator contained two vials of injectable lorazepam 2 milligrams (mg)/ml. for R22. The refrigerator had cool air coming out upon opening and the freezer had some frost buildup. During an interview on 2/19/26 at 8:40 a.m., the DON stated the liquid morphine needed to be double locked and it wasn't. When staff were done in the medication room, they should have locked all locks and taken the keys with them to ensure resident safety. The refrigerator temperature should be monitored daily and there should be a thermometer in the refrigerator to ensure the efficacy of the residents' medications were maintained. There was no evidence there was missing morphine, or the fridge temperature was out of range. During an interview on 2/23/26 at 9:35 a.m., the consulting pharmacist (CP) returned a call from 2/18/26. The CP stated that schedule 2 narcotics are to be double locked for safety and refrigerator needed the temperature to be monitored to ensure medication stability. The facility's Labeling and Storing of Medication policy dated May 2009, identified schedule 2 medications were to be locked with double locks. The policy did not address the monitoring of medication refrigerators.