Electronically Delivered

August 20, 2026

Licensee
Lifecare Medical Center
201 10th Street Southeast
Roseau, MN 56751

RE: Project Number(s) SL30496017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 15, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating

factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30496	A. BUILDING: _____ B. WING _____	07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE MEDICAL CENTER	201 10TH STREET SE 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) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30496017-0 On July 13, 2026, through July 15, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 36 residents; 36 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 14, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares and medication administration for two of three employees (unlicensed personnel (ULP)-F, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	0 510		

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0 510	Continued From page 4 found to be pervasive). The findings include: During the entrance conference on July 13, 2026, at 11:27 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management and assistance with ADLs (activities of daily living) to residents at the facility. ULP-F ULP-F's Relias (online training platform) Transcript indicated ULP-F completed About Infection Control and Prevention and Bloodborne Pathogens and the Use of Standard Precautions on September 19, 2025, and September 23, 2025, respectively. In addition, ULP-F completed the Hand Hygiene skills checklist on June 5, 2025, and June 9, 2026, respectively. On July 14, 2026, at 7:04 a.m., the surveyor observed ULP-F complete scheduled morning medication and catheter cares for R6. ULP-F put on gloves, placed R6's medications into a paper cup from the medication deck (multicompartment holder to administer medications on a certain day and time set up by the licensee's nurse), and went to R6's room. ULP-F disconnected R6's overnight catheter bag, cleansed the catheter port with an alcohol swab, placed the alcohol swab on R6's side table, and connected R6's leg bag. With the same gloved hands, ULP-F put on R6's socks. ULP-F removed ULP-F's gloves, picked up R6's overnight catheter bag, and placed it in R6's bathroom. ULP-F completed a blood pressure check on R6's right arm, administered R6's medications, and documented in R6's electronic medication administration record (EMAR). The surveyor did not observe ULP-F complete hand hygiene before or after glove use.	0 510		

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0 510	Continued From page 5 In addition, the surveyor did not observe ULP-F disinfect R6's side table. On July 14, 2026, at 1:08 p.m., ULP-F stated ULP-F received infection control training upon hire and annually. ULP-F further stated ULPs were trained to complete hand hygiene before and after glove use by washing hands with soap and water in resident rooms or to use hand sanitizer provided by the licensee in the hallway. ULP-C ULP-C's Relias Transcript indicated ULP-C completed About Infection Control and Prevention and Bloodborne Pathogens and the Use of Standard Precautions on April 8, 2025, and April 15, 2025, respectively. In addition, ULP-C completed the Hand Hygiene skills checklist on April 3, 2025. On July 14, 2026, at 7:25 a.m., the surveyor observed ULP-C complete scheduled morning medication administration and assist with bathing and grooming for R5. ULP-C put on gloves, assisted R5 with a bed bath, applied a topical cream to R5's lower legs, and assisted R5 with dressing. With the same gloved hands, ULP-C administered one eye drop into each of R5's eyes, assisted R5 with applying product to R5's hair, provided R5 with R5's glasses and phone, and ULP-C removed ULP-C's gloves. The surveyor did not observe ULP-C complete hand hygiene before or after glove use. In addition, the surveyor did not observe ULP-C complete a glove change prior to the administration of R5's eye drops. On July 14, 2026, at 12:37 p.m., ULP-C stated ULPs received infection control training upon hire. ULP-C further stated ULPs were trained to	0 510		

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0 510	Continued From page 6 change gloves in between resident care and complete hand hygiene with hand sanitizer before and after glove use. On July 14, 2026, at 2:38 p.m., CNS-B stated ULPs were trained to complete hand hygiene anytime a ULP would enter or exit a resident room, after touching a resident, and before and after glove removal. CNS-B further stated ULPs were training on infection control, including hand hygiene, upon hire and annually. CNS-B stated CNS-B completed hand hygiene audits every Wednesday at the facility and provided education when hand hygiene was not performed at the appropriate time. The licensee's Procedure for Using Gloves policy dated January 28, 2025, indicated to wash hands before and after wearing gloves. The licensee's Hand Hygiene policy dated January 28, 2025, indicated hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. In addition, hands should be washed or decontaminated after moving gloves. The licensee's undated Hand Hygiene policy indicated hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands should be washed after removing gloves. In addition, alcohol-based hand sanitizers may be used instead of soap and water. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly	01290		

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01290	Continued From page 8 scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee's current background study clearance was affiliated with the correct health care facility identification number (HFID) for three of ten employees (director of maintenance (DM)-D, unlicensed personnel (ULP)-H, registered nurse (RN)-I). This had the potential to affect all residents living within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01290		

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01290	Continued From page 9 During the entrance conference on July 13, 2026, at 11:37 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record. DM-D DM-D was hired on January 8, 2024, to provide maintenance services at the assisted living facility. On July 13, 2026, at 1:53 p.m., the surveyor observed DM-D on a tour of the facility with the Minnesota Department of Health engineer surveyor. DM-D's employee record contained a cleared background study with the HFID 27672 for the licensee's sister facility and not the correct HFID 30496 for the licensee. ULP-H ULP-H was hired on June 17, 2026, to provide direct care services to residents at the assisted living facility. ULP-H's employee record contained a cleared background study with the HFID 579 for the licensee's sister skilled nursing facility and not the correct HFID 30496 for the licensee. RN-I RN-I was hired on January 22, 2024, to provide on call RN services for staff and residents at the assisted living facility. RN-I's employee record contained a cleared background study with the HFID 579 for the licensee's sister skilled nursing facility and not the correct HFID 30496 for the licensee.	01290		

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01290	Continued From page 10 On July 13, 2026, at 3:41 p.m., LALD-A stated the licensee's human resources department was responsible for completing employee background checks upon hire. LALD-A further stated DM-D, ULP-H, and RN-I were all current employees for the licensee and were not listed on the licensee's NETStudy 2.0 Roster. On July 14, 2026, at 2:18 p.m., LALD-A stated the human resources department had not affiliated DM-D, ULP-H, or RN-I with the licensee's HFID, however, the human resources department had access to all sister facilities background study rosters and would be notified if DM-D, ULP-H, or RN-I would become ineligible to work. The licensee's Background Screening/Fingerprinting/Reference Checks [sic] policy dated March 2009, indicated background studies will be conducted on all employees of (licensee name). The policy did not address background study affiliation. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557;	01500		

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01500	Continued From page 11 (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30496	A. BUILDING: _____ B. WING _____	07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE MEDICAL CENTER	201 10TH STREET SE 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) COMPLETE DATE
01500	Continued From page 12 isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received all the required content for annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 13, 2026, at 11:37 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record. ULP-E was hired on April 30, 2018, and effective August 1, 2021, began to provide direct care services to residents at the assisted living facility. ULP-E's employee record lacked review of the facility's policies and procedures relating to the provision of assisted living services and how to	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE MEDICAL CENTER	201 10TH STREET SE ROSEAU, MN 56751

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01500	Continued From page 13 implement those policies and procedures as required annually. On July 14, 2026, at 2:32 p.m., LALD-A stated LALD-A had thought the licensee assigned policy and procedure review on Relias (online training platform) as part of annual training topics to complete, however, LALD-A stated policy and procedure review was not listed on ULP-E's 2025 Relias transcript. On July 15, 2026, at 8:29 a.m., LALD-A stated employees of the licensee were not assigned to complete policy and procedure review for the licensee's 2025 annual training on Relias, however, LALD-A was aware policy and procedure review was required as a topic of annual training and employees had completed the review in 2024. The licensee's undated Annual Training- (licensee name) Learning Management System policy indicated department directors are responsible for reviewing the regulatory and accrediting requirements to determine training mandated for their departments, scheduling that training, and establishing time allowances for the Learning Management program. The policy did not address the content of annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01730	Continued From page 14 management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health	01730		

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01730	Continued From page 15 professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to develop and maintain a current individualized medication management plan for each resident to include all required content for one of three residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 13, 2026, at 11:27 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R5's diagnoses included rheumatoid arthritis, pulmonary hypertension (HTN- high blood pressure), and congestive heart failure (CHF). R5's HWS/ALF (housing with services/assisted living facility) Level of Care Tool (service plan) dated February 9, 2026, indicated R5's services included medication administration R5's prescriber orders dated April 17, 2026,	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE MEDICAL CENTER	201 10TH STREET SE ROSEAU, MN 56751

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01730	Continued From page 16 included an order for Systane Ophthalmic Gel (for dry eyes) 0.4-0.3% instill one drop into each eye every 24 hours as needed. R5's Medication Administration Record (MAR) dated June 2025, and July 2025, respectively, indicated to administer Systane Ophthalmic Gel one drop into each eye every 24 hours as needed. On July 14, 2026, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R5's scheduled morning medications including R5's Systane Ophthalmic Gel eye drops. During the observation, the surveyor observed R5's Systane Ophthalmic Gel eye drops stored on R5's bedside table. On July 14, 2026, at 12:39 p.m., ULP-C stated R5's eye drops were stored on R5's bedside table and the rest of R5's medications were stored in the locked medication cart or in a lock box located in R5's apartment. R5's Master Assessment- V 2 dated April 29, 2026, indicated medications will be securely stored by the provider, and extra medication will be in a locked box located in the locked cabinet of the nurse's office. R5's individualized medication management plan did not match current medication storage for R5's Systane Ophthalmic Gel eye drops. On July 15, 2026, at 10:40 a.m., CNS-B stated CNS-B had thought R5 had self-administered eye drops for dry eyes, however, CNS-B would have to look for additional documentation. CNS-B stated residents were assessed for self-administration of medications along with	01730		

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01730	Continued From page 17 storage of medications. On July 16, 2026, at 11:35 a.m., CNS-B emailed (electronic mail) the surveyor, which indicated CNS-B had not assessed R5 to store the Ophthalmic Systane Gel drops on R5's bedside table. The licensee's undated Individualized Medication, Treatment and Therapy Management Plans policy indicated the RN will develop a medication management plan for each resident including a description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions. In addition, medication, treatment, and therapy management plans will be current and updated when there are changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 18 services according to acceptable health care medical or nursing standards for medication setup by unlicensed personnel (ULP) for one of six residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 13, 2026, at 11:27 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R5's diagnoses included rheumatoid arthritis, pulmonary hypertension (HTN- high blood pressure), and congestive heart failure (CHF). R5's HWS/ALF (housing with services/assisted living facility) Level of Care Tool (service plan) dated February 9, 2026, indicated R5's services included medication administration. R5's prescriber orders dated April 17, 2026, included orders for potassium chloride (supplement) 20 milliequivalent (mEq) two tablets daily, Spironolactone (for CHF) 25 milligrams (mg) daily, furosemide (for CHF) 40 mg twice daily, metoprolol tartrate (for pulmonary HTN) 50 mg twice daily, and gabapentin (for neuropathy-damaged nerves) 100 mg three times daily.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 19 On July 14, 2026, at 6:59 a.m., the surveyor observed ULP-F compare R5's scheduled morning medication, noted above, to the electronic medication administration record (EMAR), put the medications into a paper cup, and hand the paper cup filled with medications to ULP-C. On July 14, 2026, at 7:25 a.m., the surveyor observed ULP-C enter R5's apartment. ULP-C assisted R5 with morning activities of daily living (ADL's) and administered R5's scheduled morning medications. ULP-C stated ULP-F was responsible for medication administration to all residents today (July 14, 2026) and since ULP-C was assisting with R5's morning cares it was easier for ULP-F to give ULP-C R5's scheduled morning medications to administer after cares. On July 14, 2026, at 8:58 a.m., ULP-F stated two ULPs work the day shift, with one ULP doing medication administration for all residents and one ULP assisted residents with cares. On July 14, 2026, at 1:10 p.m., ULP-F stated it was a normal process for the ULP administering medications to send R5's morning medications with the other ULP completing cares for R5. On July 14, 2026, at 2:37 p.m., CNS-B stated the ULP scheduled for medication administration was trained to complete the entire medication administration process and not to send medications with another ULP. CNS-B further stated the ULP administering medications was responsible for documenting the administration of medications. The licensee's undated Training Unlicensed [sic] Personnel for Medication, Treatment and Therapy	02320		

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LIFECARE MEDICAL CENTER	201 10TH STREET SE ROSEAU, MN 56751

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02320	Continued From page 20 Administration policy indicated ULPs providing medication administration will be trained and competent to follow the following procedure: the six rights of administration, infection control techniques, complete procedure for checking a resident's record and the nurse's written procedures specific to the resident, procedures for the proper methods to administer medications, and how to document services on the MAR (medication administration record). MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Bemidji District Office
Minnesota Department of Health
706 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

LIFECARE MEDICAL CENTER
201 10th Street SE
Roseau, MN 56751
Roseau County
Parcel:

Phone:

License Info

License: HFID 30496

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1002261103
Inspection Type: Full - Single
Date: 7/14/2026 Time: 11:00:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 3-500B Microbial Control: hot and cold holding
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: **SQUEEZE BOTTLES OF TCS DRESSINGS WERE OBSERVED TO BE STORED OUTSIDE OF MECHANICAL REFRIGERATION DURING MEAL TIMES AND THEN PLACED BACK INTO THE COOLER. STAFF WAS INSTRUCTED TO DISCARD THE DRESSINGS AND STORE THE DRESSINGS IN THE REFRIGERATED SALAD BAR MOVING FORWARD.**
Comply By: 7/14/2026 Originally Issued On: 7/14/2026

Food & Beverage General Comment

Discussion:

Handwashing - fact sheet and sign provided with report

Employee illness - fact sheet, decision guide and log provided with report

Safe cleaning, sanitizing and warewashing - fact sheet and sign provided with report

Safe cooling of TCS foods - fact sheet and infographic included with report

Food service among highly susceptible populations - fact sheet provided with report

Thermometer calibration - method and frequency

Note:
This establishment could benefit from an additional refrigeration unit so that one can be designated for cooling purposes. Currently, staff cools TCS food in the upright refrigerator. This creates a concern about the internal temperature of the refrigerator being raised and resulting in the possible temperature abuse of the other food items in the refrigerator.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Bemidji District Office inspection report number F1002261103 from 7/14/2026

NICOLE WILT
FOOD SERVICE MANAGER

Cassandra Hua, REHS
Public Health Sanitarian 3
218-308-2142
cassandra.hua@state.mn.us

Bemidji District Office
Minnesota Department of Health
706 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Establishment Info

LIFECARE MEDICAL CENTER
Roseau
County/Group: Roseau County

Inspection Info

Report Number: F1002261103
Inspection Type: Full
Date: 7/14/2026
Time: 11:00:00 AM

Equipment Temperature: Product/Item/Unit: AMBIENT TEMP**; Temperature Process:**
Location: ARCTIC AIR FREEZER at 0 Degrees F.
Comment: FROZEN SOLID
Violation Issued?: No

Food Temperature: Product/Item/Unit: GRAVY**; Temperature Process:** Cold-Holding
Location: TRAULSEN COOLER at 37 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT TEMP**; Temperature Process:**
Location: TRAULSEN FREEZER at 0 Degrees F.
Comment: FROZEN SOLID
Violation Issued?: No

Food Temperature: Product/Item/Unit: BUTTER**; Temperature Process:** Cold-Holding
Location: TRUE LOWBOY COOLER at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: PORK CHOPS, CORN, POTATOES**; Temperature Process:** Hot-Holding
Location: STEAM TABLE at 180 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MELON**; Temperature Process:** Cold-Holding
Location: SALAD BAR at 40 Degrees F.
Comment:
Violation Issued?: No

Bemidji District Office
Minnesota Department of Health
706 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Establishment Info

LIFECARE MEDICAL CENTER
Roseau
County/Group: Roseau County

Inspection Info

Report Number: F1002261103
Inspection Type: Full
Date: 7/14/2026
Time: 11:00:00 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** Dispenser
Location: 3-Comp Sink **Equal To** 704 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 704 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1002261103

Food Establishment Inspection Report

Bemidji District Office
Minnesota Department of Health
706 5th St NW, Suite A
Bemidji, MN 56601

No. of Risk Factor/Intervention/Violations	0	Date: 7/14/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:00 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
LIFECARE MEDICAL CENTER	201 10th Street SE	Roseau, MN	56751	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30496		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	IN	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Cassandra Hua

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL30496017-0	**Date:** 7/13/2026
Facility Name: LIFECARE MEDICAL CENTER	
Facility Address: 201 10TH STREET SE; ROSEAU, MN 56751	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Interior vertical shafts, including stairways, elevator hoistways, and service and utility shafts, that connect two of more stories of a building, shall be enclosed or protected. When openings are required to be protected, opening protectives shall be maintained self-closing. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.4, 1103.4.1]

   Comments: Inside Mechanical Room 1A, the gypsum board ceiling was damaged, creating an opening directly into the facility attic/rafter space. In addition, multiple electrical penetrations through the fire-resistance-rated walls were observed that had not been fire-stopped or sealed with an approved fire-resistant material.

3. Automatic fire extinguishing systems for commercial cooking shall be serviced at least once every six months. [Minn. Stat. 144G.45 subd. 2; MSFC 904.12.5.2]

   Comments: The inspection tag attached to the Ansul fire suppression system protecting the commercial kitchen hood indicated the last documented inspection and service was performed in November 2020. No documentation was provided to verify that the required semiannual inspections and maintenance had been completed since that date.