



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 22, 2025

Administrator
WHISPERING CREEK
102 EAST NORTH STREET
JANESVILLE, MN 56048

RE: CCN:245440

Cycle Start Date: August 6, 2025

Dear Administrator:

On August 6, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 6, 2025, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 6, 2026, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

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>

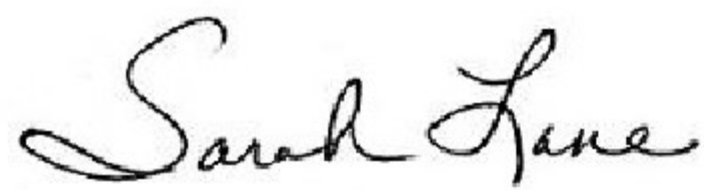
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Sarah Lane". The signature is written in a cursive, flowing style.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245440		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
NAME OF PROVIDER OR SUPPLIER WHISPERING CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET , JANESVILLE, Minnesota, 56048			
(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	
E0000	Initial Comments On 8/4/25-8/6/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			08/26/2025	
F0000	INITIAL COMMENTS On 8/4/25-8/6/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 substantial compliance with the regulations has been attained.		F0000			08/26/2025	
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the		F0641	F641 R25 quarterly MDS dated 6/20/25 was corrected on 8/11/25 to include anticoagulant medication. Certifying Accuracy of the Resident Assessment Policy and Procedure was reviewed and updated on 8/26/2025. The MDS coordinator who completed the 6/20/25 quarterly on R25 is no longer in a MDS coordinator role. The facility has hired a new MDS coordinator, effective 7/28/2025.		09/01/2025	

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
FORM CMS-2567 (02/99) Previous Versions Obsolete		Event ID: 1D0DEE-H1	Facility ID: 00681
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F0641 SS = D	Continued from page 1 appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident status was accurately identified on the Minimum Data Set (MDS) assessment for 1 of 2 resident (R25) reviewed for anticoagulant use. Findings include: R25's Face Sheet printed 8/6/25, included diagnoses of peripheral vascular disease (narrowing or blockage of blood vessels) , chronic atrial fibrillation (irregular heart rhythm), edema and chronic venous hypertension (high blood pressure in veins leading to insufficiency causing swelling) with ulcer and inflammation of bilateral lower extremities. R25's quarterly Minimum Data Set (MDS) dated 6/20/25, section N, included R25 was receiving a diuretic, antiplatelet, hypoglycemic and antidepressant medication. Anticoagulant medication was not checked as receiving. R25's physician orders dated 7/20/25, included warfarin		F0641	Continued from page 1 All current residents in the facility who are receiving anticoagulants will have their most current MDS audited to ensure anticoagulant medication is checked as receiving on the MDS. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: The current MDS coordinator will be reeducated on the facility policy, Certifying Accuracy of the Resident Assessment Policy and Procedure on 8/26/25 to always ensure accurate coding, including anticoagulants. Audits will be completed once weekly on three random residents for 3 months to ensure their most recent MDS assessment includes accurate coding of anticoagulant medication. Audits ongoing until reviewed at QA until determination made is no longer necessary. Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of completion: 9/1/25			

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F0641 SS = D	Continued from page 2 sodium (anticoagulant/blood thinner) 1 mg tablet by mouth six times per week on Monday, Tuesday, Wednesday, Thursday, Friday and Saturday and 1.5 mg tablet of warfarin sodium one time a week on Sunday. During interview on 8/6/25 at 3:35 a.m., the director of nursing confirmed the MDS was coded incorrectly and confirmed R25 had received warfarin when the MDS was completed in June 2025. During interview 8/6/25 at 3:05 p.m., registered nurse (RN)-C, also identified as MDS coordinator, stated R25 has always been on warfarin so she must have just forgotten to check the anticoagulant box when she completed R25's MDS in June 2025. A policy on MDS coding was requested and not received.		F0641				
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 fall risk interventions were completed after a fall for 1 of 2 residents (R6) identified at risk for falls to prevent further falls. Findings include: R6's Face Sheet printed 8/6/25, indicated R6 had diagnoses including heart failure, dementia, chronic kidney disease stage IV (severe irreversible damage to the kidneys) and chronic respiratory failure. R6's significant change Minimum Data Set (MDS) assessment dated 5/9/25, indicated R6 had a severe cognitive impairment with no delirium or behaviors. Activities of daily living (ADL's) included R6 uses a wheelchair and requires partial/moderate assistance for		F0689	F689 R6 had a lift chair assessment completed on 8/27/2025. Resident is unable to use lift mechanism on recliner chair. This change has been updated in the care plan 8/27/25. The lift chair assessment outcome was communicated to staff via the communication book on 8/27/2025. Falls and Fall Risk, Managing Policy and Procedure was reviewed and updated on 8/27/2025. A facility post fall checklist was created to include writing the resident intervention to staff in the nursing communication book. All current residents in the facility have their current fall interventions per care plan audited to ensure staff are aware of interventions and interventions are in place. Audit was completed by date of compliance. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: All Licensed Nurses will be re-educated on the facility policy Falls and Fall Risk, Managing by date of completion. Education of the policy was initiated on 8/27/2025. Education included: ensuring all new fall interventions are being implemented and documented in the nursing communication book. All nursing assistants and TMA's will be educated on the facility policy, Fall and Fall Risk, Managing. Education included; ensuring they refer to the nursing		09/01/2025	

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F0689 SS = D	Continued from page 3 oral care and eating, and substantial to maximal assistance for toileting, showering, personal hygiene, bed mobility and transfers. Walking was not attempted. R6 has had one fall without injury since prior assessment. R6's Care Area Assessment dated 5/9/25, indicated R6 was at risk for falls. See plan of care for fall interventions. Fall assessment last completed 8/4/25, identified R6 was at risk for falls and has had 1-2 falls in the past 3 months, has decreased safety awareness with impaired mobility. R6's plan of care last updated 5/27/25, indicated R6 was at risk for falls related to heart problems, terminal diagnosis of heart failure, takes medications that cause resident to be dizzy, tired, confused or weak and have trouble sleeping. Interventions included: bed low to the ground with wheels locked, remind to ask for help, therapy department performed Lift Chair Safety Assessment and is safe to use recliner chair in her room, keep important items within reach, frequent checks and night light on at night. Facility Incident Report dated 4/19/25 at 3:48 a.m., by licensed practical nurse (LPN)-A indicated R6 was trying to get up and go the bathroom and was found on the floor. Was observed in bed at 1:30 a.m. Current interventions and other factors included reclining chair, tray table, room close to nurses station, call light was in reach, but call light was not on. New intervention included floor alarm and teaching use of call light. No injuries noted. Interdisciplinary team review (IDT) completed 4/21/25, included R6 has had 1 fall within the last year. Intervention included floor alarm placed on floor while in bed and teaching of use of call light. Facility Incident Report dated 6/3/25 at 7:30 p.m., by LPN-B indicated resident was observed on floor and stated "I thought I could get into my bed myself so I tried." R6 stated she landed on buttocks then onto her back and hit her head on the floor. Current interventions and factors included low bed, attempting to transfer without staff assist, call light in reach but was not on. No injuries. New interventions included a personal alarm and teaching on safe transfer		F0689	Continued from page 3 communication book at the start of the shift to review new interventions. Audits will be completed on five random residents per week for three months to ensure their individual fall interventions have been communicated in the nursing communication book and are in place. Audits ongoing until reviewed at QA until determination made is no longer necessary. Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of completion: 9/1/25			

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F0689 SS = D	Continued from page 4 techniques, and use of call light for assistance. IDT review, undated, included personal alarm was placed on person. 2 falls within the last 2 months. Facility Incident Report 7/30/25 at 4:00 p.m., by registered nurse (RN)-A included resident was observed on floor in front of her recliner. Recliner was elevated for her legs to be up. Call light was in reach but call light was not on. No injuries noted. IDT team review, undated, included 3 falls with the past 3 months. New intervention included recliner was unplugged and foot elevation pedal will not be used. On observation and interview 8/4/25 at 3:34 p.m., R6 was sitting in her wheelchair with a personal alarm on her chair and clipped to resident. Family member (FM)-A was sitting in R6's recliner in her room and stated R6 used her lift chair and fell out last week. FM-A stated they notified her of the fall and said they were going to unplug the recliner. FM-A used buttons on side of recliner and recliner began to put feet up and stated "I guess they didn't unplug it as it still works." On observation and interview 8/5/25 at 9:23 a.m., R6 was sitting in her wheelchair with personal alarm on. R6 stated she does sit in her recliner sometimes but doesn't want to right now. R6 sorting through her drawers. Power recliner remains plugged in and working. On observation and interview 8/6/25 at 7:54 a.m., R8 was assisted to tub room by nursing assistant for hospice (NA)-A. Electric recliner continues to be plugged in and functioning. NA-A stated she has seen R6 in her recliner periodically when she comes. NA-A was unaware of any recent falls and is unsure if it should be plugged in or not. On interview 8/6/25 at 9:04 a.m., NA-B stated R6 has been evaluated for use of her electric chair and has been okayed to use it. NA-B stated she hasn't been told anything different and wasn't aware it needed to be unplugged. On interview 8/6/25 at 9:19 a.m., NA-C stated R6 does use her recliner and after lunch staff will generally put her in the recliner for awhile. NA-C stated we do have to watch her close or she will try to climb out of it when she gets tired of sitting there. NA-C stated he	F0689			

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F0689 SS = D	Continued from page 5 didn't believe R6 could use the electric chair control buttons but was not aware the recliner was not supposed to be plugged in. On interview 8/6/25 at 9:20 a.m., RN-B stated two weeks ago R6 was in her recliner with the legs up and she tried to climb out of it without putting the feet down. The recliner tipped down and she slid out. RN-B stated she was not aware the recliner was to be unplugged. RN-B confirmed the electric chair was plugged in and operational. On interview 8/6/25 at 10:42 a.m., the director of nursing (DON) stated she had heard the recliner was unplugged but never actually checked it herself. The DON stated it should not be plugged in and will see if therapy can evaluate R6 again for safe use and possibly remove the chair since it is easy for staff to just plug it back in if they want to use it. The DON stated after a new intervention is put into place, it should be documented in the communication book which staff review prior to working their next shift. The DON reviewed the communication book and stated no communication note was present regarding the unplugging of the electric chair. Facility Falls and Managing Fall risk policy dated 3/2018, included: -- Staff will implement a resident centered fall prevention plan to reduce the risk factor(s) of falls for each resident at risk or with a history of falls. -- If falling reoccurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. -- If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. -- Position-change alarms will be monitored for efficacy and staff will respond to alarms in a timely manner.	F0689			
F0851 SS = F	Payroll Based Journal	F0851	The issue in question wasn't that we didn't have proper nursing coverage, but rather that the file we uploaded		09/02/2025

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F0851 SS = F	Continued from page 6 CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.			F0851	Continued from page 6 to CMS may not have been accurate. We provided information showing that we met all nursing staffing requirements In an effort to ensure that the data we submit is accurate, we will take the following steps: We have contacted our payroll provider who produces the PBJ file for us. They have reviewed the database and have reindexed all of the files. They advised us to reset all nursing employees by deleting and then re-inputting the appropriate PBJ codes. They are confident that this will fix the issue. After the PBJ file is uploaded to the CMS server, our accountant will run a report from the CMS website breaking out RN and LPN hours by date. He will review the report to make sure that each day has the appropriate nursing hours listed. An audit will be conducted after the next two PJB reports are submitted to verify that the information that has been accepted by CMS is accurate. Audits will be ongoing until reviewed at QA and a determination has been made that they are no longer necessary. Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional programming needs. CORRECTION DATE: 09/02/2025		

FORM CMS-2567 (02/99) Previous Versions ObsoleteEvent ID: 1D0DEE-H1Facility ID: 00681If continuation sheet Page 7 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245440		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
NAME OF PROVIDER OR SUPPLIER WHISPERING CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET , JANESVILLE, Minnesota, 56048			
(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
F0851 SS = F	Continued from page 7 §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to submit accurate data for staffing information based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed- Quarter 2, 2025, (January to March), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: The CMS payroll-based journal (PBJ) staffing data report indicated the following infraction: Excessively Low Weekend Staffing- Submitted Weekend Staffing data is excessively low. During interview on 8/4/25 at 12:45 p.m., director of nursing (DON) stated she was unsure why they would have triggered for low staffing and that they always had staff on the weekends. DON further stated they used agency staff on weekends to fill shifts their staff could not cover. During interview on 8/4/25 at 1:10 p.m., administrator, who oversees submission of the PBJ data, stated he recalled there may have been a delay in getting staffing hours from the agencies they work with to fill shifts, and that may be why it appeared they had low weekend staffing. Administrator further stated he was not aware of actual low weekend staffing and that weekends were always staffed by hired staff or agency staff. Administrator stated he would work with agencies to get accurate staffing hours submitted. Review of facility provided documents titled 2025 Master Nursing Staff Schedule and Time Card Report dated 1/1/25 -3/31/25, indicated the facility did not have low weekend staffing on any weekend during that time period.			F0851			

FORM CMS-2567 (02/99) Previous Versions ObsoleteEvent ID: 1D0DEE-H1Facility ID: 00681If continuation sheet Page 8 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245440		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
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F0851 SS = F	Continued from page 8 A facility policy on Payroll Based Journal Submission was not received.			F0851			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245440		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 08/05/2025	
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/05/2025. At the time of this survey, WHISPERING CREEK was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR			K0000			08/29/2025

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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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. WHISPERING CREEK is a 1 story building with partial basement. The facility was constructed in 1965 and was determined to be of Type II (111) construction. An addition was added in 1994 and was determined to be type II (111). Because the original building and the addition are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 35 beds and had a census of 25 at the time of the survey.		K0000				

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K0000	Continued from page 2		K0000				
K0271 SS = F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed provide approved discharge walking surfaces as identified per NFPA 101 (2012 edition), Life Safety Code, section 19.2, 7.1.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/05/2025 between 11:00 AM, it was revealed by observation that exterior to South Exit Door exhibited a threshold to slab gap, greater than 1 inch, presenting a trip and fall hazard. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0271	K0271 – The gap was removed by applying concrete to even out the threshold and slab. The surface is now level. Audits will be conducted over the next two quarters to verify that the gap has not reemerged as the weather changes. Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional programming needs. Date of completion: August 18th, 2025		08/18/2025	
K0355 SS = C	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by:		K0355	K0355 We have contacted our vendor and alerted them to the issue. They will visit the site, update documentation on annual vendor maintenance of fire extinguishers, and revise their report to match current standards. The Maintenance Director will conduct an audit after this year's vendor maintenance of facility fire extinguishers is completed.		09/05/2025	

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K0355 SS = C	Continued from page 3 Based on a review of available documentation and staff interview, the facility failed to properly maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1, 7.2.4.5, 7.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/05/2025 between 9:30 AM and 12:30 PM, it was revealed by a review of available documentation, that records were not available associated to the annual vendor maintenance of the facility fire extinguishers. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0355	Continued from page 3 Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional programming needs. Date of completion: September 5, 2025		08/20/2025
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of			K0918	K0918 We contacted our vendor and a new battery was installed on August 2, 2025. The Maintenance Director will conduct an audit annually to ensure that the battery is within the operational standards . Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional programming needs. Date of completion: August 20, 2025		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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K0918 SS = F Bldg. 01	Continued from page 4 the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on observation, documentation review and staff interview, the facility failed to maintain the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 8.3, 8.4, 5.6.4.5.1 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/05/2025 between 11:30 AM, it was revealed by observation and review of vendor documentation that generator battery was dated 01/2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0918			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 22, 2025

Administrator
WHISPERING CREEK
102 EAST NORTH STREET
JANESVILLE, MN 56048

Re: State Nursing Home Licensing Orders

Event ID: 1D0DEE- H1

Dear Administrator:

The above facility survey was completed on 08/06/2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted 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:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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 08/06/2025	
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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 8/4/25-8/6/25, a standard licensing 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 Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.		20000			08/26/2025	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
STATE FORM		Event ID: 1D0DEE-H1	Facility ID: 00681
		If continuation sheet Page 1 of 7	

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 08/06/2025	
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20000	Continued from page 1 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. 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.		20000				
20550	Comprehensive Resident Assessment; Review CFR(s); MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident status was accurately identified on the Minimum Data Set (MDS) assessment for 1 of 2 resident (R25) reviewed for anticoagulant use. Findings include:		20550	corrected		09/01/2025	

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20550	Continued from page 2 R25's Face Sheet printed 8/6/25, included diagnoses of peripheral vascular disease (narrowing or blockage of blood vessels) , chronic atrial fibrillation (irregular heart rhythm), edema and chronic venous hypertension (high blood pressure in veins leading to insufficiency causing swelling) with ulcer and inflammation of bilateral lower extremities. R25's quarterly Minimum Data Set (MDS) dated 6/20/25, section N, included R25 was receiving a diuretic, antiplatelet, hypoglycemic and antidepressant medication. Anticoagulant medication was not checked as receiving. R25's physician orders dated 7/20/25, included warfarin sodium (anticoagulant/blood thinner) 1 mg tablet by mouth six times per week on Monday, Tuesday, Wednesday, Thursday, Friday and Saturday and 1.5 mg tablet of warfarin sodium one time a week on Sunday. During interview on 8/6/25 at 3:35 a.m., the director of nursing confirmed the MDS was coded incorrectly and confirmed R25 had received warfarin when the MDS was completed in June 2025. During interview 8/6/25 at 3:05 p.m., registered nurse (RN)-C, also identified as MDS coordinator, stated R25 has always been on warfarin so she must have just forgotten to check the anticoagulant box when she completed R25's MDS in June 2025. A policy on MDS coding was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee or resident assessment instrument (RAI) coordinator could review the RAI manual, review policies and procedures to ensure accurate coding of the MDS. The DON, designee or RAI coordinator could then perform audits to ensure compliance. The results of those audits could be taken to quality assurance performance improvement (QAPI) committee to determine compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20550			
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			20830	corrected		09/01/2025

If continuation sheet Page 3 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
NAME OF PROVIDER OR SUPPLIER WHISPERING CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET , JANESVILLE, Minnesota, 56048			
(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
20830	Continued from page 3 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 fall risk interventions were completed after a fall for 1 of 2 residents (R6) identified at risk for falls to prevent further falls. Findings include: R6's Face Sheet printed 8/6/25, indicated R6 had diagnoses including heart failure, dementia, chronic kidney disease stage IV (severe irreversible damage to the kidneys) and chronic respiratory failure. R6's significant change Minimum Data Set (MDS) assessment dated 5/9/25, indicated R6 had a severe cognitive impairment with no delirium or behaviors. Activities of daily living (ADL's) included R6 uses a wheelchair and requires partial/moderate assistance for oral care and eating, and substantial to maximal assistance for toileting, showering, personal hygiene, bed mobility and transfers. Walking was not attempted. R6 has had one fall without injury since prior assessment. R6's Care Area Assessment dated 5/9/25, indicated R6 was at risk for falls. See plan of care for fall interventions. Fall assessment last completed 8/4/25, identified R6 was at risk for falls and has had 1-2 falls in the past 3 months, has decreased safety awareness with impaired mobility. R6's plan of care last updated 5/27/25, indicated R6 was at risk for falls related to heart problems, terminal diagnosis of heart failure, takes medications that cause resident to be dizzy, tired, confused or weak and have trouble sleeping. Interventions included: bed low to the ground with wheels locked, remind to ask for help, therapy department performed Lift Chair Safety Assessment and is safe to use recliner chair in her room, keep important items within reach, frequent checks and night light on at night. Facility Incident Report dated 4/19/25 at 3:48 a.m., by licensed practical nurse (LPN)-A indicated R6 was trying to get up and go the bathroom and was found on the floor. Was observed in bed at 1:30 a.m. Current			20830			

If continuation sheet Page 4 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER WHISPERING CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET , JANESVILLE, Minnesota, 56048	
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20830	Continued from page 4 interventions and other factors included reclining chair, tray table, room close to nurses station, call light was in reach, but call light was not on. New intervention included floor alarm and teaching use of call light. No injuries noted. Interdisciplinary team review (IDT) completed 4/21/25, included R6 has had 1 fall within the last year. Intervention included floor alarm placed on floor while in bed and teaching of use of call light. Facility Incident Report dated 6/3/25 at 7:30 p.m., by LPN-B indicated resident was observed on floor and stated "I thought I could get into my bed myself so I tried." R6 stated she landed on buttocks then onto her back and hit her head on the floor. Current interventions and factors included low bed, attempting to transfer without staff assist, call light in reach but was not on. No injuries. New interventions included a personal alarm and teaching on safe transfer techniques, and use of call light for assistance. IDT review, undated, included personal alarm was placed on person. 2 falls within the last 2 months. Facility Incident Report 7/30/25 at 4:00 p.m., by registered nurse (RN)-A included resident was observed on floor in front of her recliner. Recliner was elevated for her legs to be up. Call light was in reach but call light was not on. No injuries noted. IDT team review, undated, included 3 falls with the past 3 months. New intervention included recliner was unplugged and foot elevation pedal will not be used. On observation and interview 8/4/25 at 3:34 p.m., R6 was sitting in her wheelchair with a personal alarm on her chair and clipped to resident. Family member (FM)-A was sitting in R6's recliner in her room and stated R6 used her lift chair and fell out last week. FM-A stated they notified her of the fall and said they were going to unplug the recliner. FM-A used buttons on side of recliner and recliner began to put feet up and stated "I guess they didn't unplug it as it still works." On observation and interview 8/5/25 at 9:23 a.m., R6 was sitting in her wheelchair with personal alarm on. R6 stated she does sit in her recliner sometimes but doesn't want to right now. R6 sorting through her drawers. Power recliner remains plugged in and working. On observation and interview 8/6/25 at 7:54 a.m., R8 was assisted to tub room by nursing assistant for hospice (NA)-A. Electric recliner continues to be plugged in and functioning. NA-A stated she has seen R6 in her recliner periodically when she comes. NA-A was unaware of any recent falls and is unsure if it should	20830		

If continuation sheet Page 5 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
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20830	Continued from page 5 be plugged in or not. On interview 8/6/25 at 9:04 a.m., NA-B stated R6 has been evaluated for use of her electric chair and has been okayed to use it. NA-B stated she hasn't been told anything different and wasn't aware it needed to be unplugged. On interview 8/6/25 at 9:19 a.m., NA-C stated R6 does use her recliner and after lunch staff will generally put her in the recliner for awhile. NA-C stated we do have to watch her close or she will try to climb out of it when she gets tired of sitting there. NA-C stated he didn't believe R6 could use the electric chair control buttons but was not aware the recliner was not supposed to be plugged in. On interview 8/6/25 at 9:20 a.m., RN-B stated two weeks ago R6 was in her recliner with the legs up and she tried to climb out of it without putting the feet down. The recliner tipped down and she slid out. RN-B stated she was not aware the recliner was to be unplugged. RN-B confirmed the electric chair was plugged in and operational. On interview 8/6/25 at 10:42 a.m., the director of nursing (DON) stated she had heard the recliner was unplugged but never actually checked it herself. The DON stated it should not be plugged in and will see if therapy can evaluate R6 again for safe use and possibly remove the chair since it is easy for staff to just plug it back in if they want to use it. The DON stated after a new intervention is put into place, it should be documented in the communication book which staff review prior to working their next shift. The DON reviewed the communication book and stated no communication note was present regarding the unplugging of the electric chair. Facility Falls and Managing Fall risk policy dated 3/2018, included: -- Staff will implement a resident centered fall prevention plan to reduce the risk factor(s) of falls for each resident at risk or with a history of falls. -- If falling reoccurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. -- If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling,			20830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
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20830	Continued from page 6 until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. -- Position-change alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review, and revise policies and procedures related to resident falls. The DON or designee could develop a process for implementing fall interventions. The DON or designee could educate staff and leadership on the process. The DON or designee could monitor and audit falls and take those findings to the quality assurance performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20830			

STATE FORMEvent ID: 1D0DEE-H1Facility ID: 00681If continuation sheet Page 7 of 7



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 22, 2025

Administrator
WHISPERING CREEK
102 EAST NORTH STREET
JANESVILLE, MN 56048

RE: CCN:245440

Cycle Start Date: August 6, 2025

Dear Administrator:

On August 6, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 6, 2025, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 6, 2026, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

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>

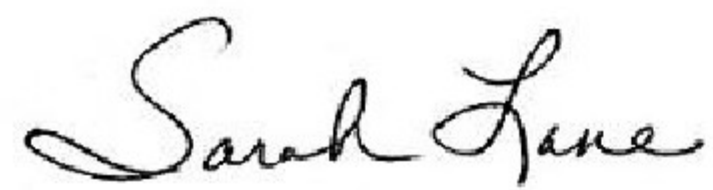
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Sarah Lane". The signature is written in a cursive, flowing style.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245440		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
NAME OF PROVIDER OR SUPPLIER WHISPERING CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET , JANESVILLE, Minnesota, 56048			
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E0000	Initial Comments On 8/4/25-8/6/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			08/26/2025	
F0000	INITIAL COMMENTS On 8/4/25-8/6/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 substantial compliance with the regulations has been attained.		F0000			08/26/2025	
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the		F0641	F641 R25 quarterly MDS dated 6/20/25 was corrected on 8/11/25 to include anticoagulant medication. Certifying Accuracy of the Resident Assessment Policy and Procedure was reviewed and updated on 8/26/2025. The MDS coordinator who completed the 6/20/25 quarterly on R25 is no longer in a MDS coordinator role. The facility has hired a new MDS coordinator, effective 7/28/2025.		09/01/2025	

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
FORM CMS-2567 (02/99) Previous Versions Obsolete		Event ID: 1D0DEE-H1	Facility ID: 00681
		If continuation sheet Page 1 of 9	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245440		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
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F0641 SS = D	Continued from page 1 appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident status was accurately identified on the Minimum Data Set (MDS) assessment for 1 of 2 resident (R25) reviewed for anticoagulant use. Findings include: R25's Face Sheet printed 8/6/25, included diagnoses of peripheral vascular disease (narrowing or blockage of blood vessels) , chronic atrial fibrillation (irregular heart rhythm), edema and chronic venous hypertension (high blood pressure in veins leading to insufficiency causing swelling) with ulcer and inflammation of bilateral lower extremities. R25's quarterly Minimum Data Set (MDS) dated 6/20/25, section N, included R25 was receiving a diuretic, antiplatelet, hypoglycemic and antidepressant medication. Anticoagulant medication was not checked as receiving. R25's physician orders dated 7/20/25, included warfarin		F0641	Continued from page 1 All current residents in the facility who are receiving anticoagulants will have their most current MDS audited to ensure anticoagulant medication is checked as receiving on the MDS. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: The current MDS coordinator will be reeducated on the facility policy, Certifying Accuracy of the Resident Assessment Policy and Procedure on 8/26/25 to always ensure accurate coding, including anticoagulants. Audits will be completed once weekly on three random residents for 3 months to ensure their most recent MDS assessment includes accurate coding of anticoagulant medication. Audits ongoing until reviewed at QA until determination made is no longer necessary. Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of completion: 9/1/25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245440		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
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F0641 SS = D	Continued from page 2 sodium (anticoagulant/blood thinner) 1 mg tablet by mouth six times per week on Monday, Tuesday, Wednesday, Thursday, Friday and Saturday and 1.5 mg tablet of warfarin sodium one time a week on Sunday. During interview on 8/6/25 at 3:35 a.m., the director of nursing confirmed the MDS was coded incorrectly and confirmed R25 had received warfarin when the MDS was completed in June 2025. During interview 8/6/25 at 3:05 p.m., registered nurse (RN)-C, also identified as MDS coordinator, stated R25 has always been on warfarin so she must have just forgotten to check the anticoagulant box when she completed R25's MDS in June 2025. A policy on MDS coding was requested and not received.		F0641				
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 fall risk interventions were completed after a fall for 1 of 2 residents (R6) identified at risk for falls to prevent further falls. Findings include: R6's Face Sheet printed 8/6/25, indicated R6 had diagnoses including heart failure, dementia, chronic kidney disease stage IV (severe irreversible damage to the kidneys) and chronic respiratory failure. R6's significant change Minimum Data Set (MDS) assessment dated 5/9/25, indicated R6 had a severe cognitive impairment with no delirium or behaviors. Activities of daily living (ADL's) included R6 uses a wheelchair and requires partial/moderate assistance for		F0689	F689 R6 had a lift chair assessment completed on 8/27/2025. Resident is unable to use lift mechanism on recliner chair. This change has been updated in the care plan 8/27/25. The lift chair assessment outcome was communicated to staff via the communication book on 8/27/2025. Falls and Fall Risk, Managing Policy and Procedure was reviewed and updated on 8/27/2025. A facility post fall checklist was created to include writing the resident intervention to staff in the nursing communication book. All current residents in the facility have their current fall interventions per care plan audited to ensure staff are aware of interventions and interventions are in place. Audit was completed by date of compliance. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: All Licensed Nurses will be re-educated on the facility policy Falls and Fall Risk, Managing by date of completion. Education of the policy was initiated on 8/27/2025. Education included: ensuring all new fall interventions are being implemented and documented in the nursing communication book. All nursing assistants and TMA's will be educated on the facility policy, Fall and Fall Risk, Managing. Education included; ensuring they refer to the nursing		09/01/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245440		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
NAME OF PROVIDER OR SUPPLIER WHISPERING CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET , JANESVILLE, Minnesota, 56048			
(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	
F0689 SS = D	Continued from page 3 oral care and eating, and substantial to maximal assistance for toileting, showering, personal hygiene, bed mobility and transfers. Walking was not attempted. R6 has had one fall without injury since prior assessment. R6's Care Area Assessment dated 5/9/25, indicated R6 was at risk for falls. See plan of care for fall interventions. Fall assessment last completed 8/4/25, identified R6 was at risk for falls and has had 1-2 falls in the past 3 months, has decreased safety awareness with impaired mobility. R6's plan of care last updated 5/27/25, indicated R6 was at risk for falls related to heart problems, terminal diagnosis of heart failure, takes medications that cause resident to be dizzy, tired, confused or weak and have trouble sleeping. Interventions included: bed low to the ground with wheels locked, remind to ask for help, therapy department performed Lift Chair Safety Assessment and is safe to use recliner chair in her room, keep important items within reach, frequent checks and night light on at night. Facility Incident Report dated 4/19/25 at 3:48 a.m., by licensed practical nurse (LPN)-A indicated R6 was trying to get up and go the bathroom and was found on the floor. Was observed in bed at 1:30 a.m. Current interventions and other factors included reclining chair, tray table, room close to nurses station, call light was in reach, but call light was not on. New intervention included floor alarm and teaching use of call light. No injuries noted. Interdisciplinary team review (IDT) completed 4/21/25, included R6 has had 1 fall within the last year. Intervention included floor alarm placed on floor while in bed and teaching of use of call light. Facility Incident Report dated 6/3/25 at 7:30 p.m., by LPN-B indicated resident was observed on floor and stated "I thought I could get into my bed myself so I tried." R6 stated she landed on buttocks then onto her back and hit her head on the floor. Current interventions and factors included low bed, attempting to transfer without staff assist, call light in reach but was not on. No injuries. New interventions included a personal alarm and teaching on safe transfer		F0689	Continued from page 3 communication book at the start of the shift to review new interventions. Audits will be completed on five random residents per week for three months to ensure their individual fall interventions have been communicated in the nursing communication book and are in place. Audits ongoing until reviewed at QA until determination made is no longer necessary. Audits will be brought to the QA committee monthly to discuss findings and need for further auditing and/or additional staff training. Date of completion: 9/1/25			

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F0689 SS = D	Continued from page 4 techniques, and use of call light for assistance. IDT review, undated, included personal alarm was placed on person. 2 falls within the last 2 months. Facility Incident Report 7/30/25 at 4:00 p.m., by registered nurse (RN)-A included resident was observed on floor in front of her recliner. Recliner was elevated for her legs to be up. Call light was in reach but call light was not on. No injuries noted. IDT team review, undated, included 3 falls with the past 3 months. New intervention included recliner was unplugged and foot elevation pedal will not be used. On observation and interview 8/4/25 at 3:34 p.m., R6 was sitting in her wheelchair with a personal alarm on her chair and clipped to resident. Family member (FM)-A was sitting in R6's recliner in her room and stated R6 used her lift chair and fell out last week. FM-A stated they notified her of the fall and said they were going to unplug the recliner. FM-A used buttons on side of recliner and recliner began to put feet up and stated "I guess they didn't unplug it as it still works." On observation and interview 8/5/25 at 9:23 a.m., R6 was sitting in her wheelchair with personal alarm on. R6 stated she does sit in her recliner sometimes but doesn't want to right now. R6 sorting through her drawers. Power recliner remains plugged in and working. On observation and interview 8/6/25 at 7:54 a.m., R8 was assisted to tub room by nursing assistant for hospice (NA)-A. Electric recliner continues to be plugged in and functioning. NA-A stated she has seen R6 in her recliner periodically when she comes. NA-A was unaware of any recent falls and is unsure if it should be plugged in or not. On interview 8/6/25 at 9:04 a.m., NA-B stated R6 has been evaluated for use of her electric chair and has been okayed to use it. NA-B stated she hasn't been told anything different and wasn't aware it needed to be unplugged. On interview 8/6/25 at 9:19 a.m., NA-C stated R6 does use her recliner and after lunch staff will generally put her in the recliner for awhile. NA-C stated we do have to watch her close or she will try to climb out of it when she gets tired of sitting there. NA-C stated he	F0689			

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F0689 SS = D	Continued from page 5 didn't believe R6 could use the electric chair control buttons but was not aware the recliner was not supposed to be plugged in. On interview 8/6/25 at 9:20 a.m., RN-B stated two weeks ago R6 was in her recliner with the legs up and she tried to climb out of it without putting the feet down. The recliner tipped down and she slid out. RN-B stated she was not aware the recliner was to be unplugged. RN-B confirmed the electric chair was plugged in and operational. On interview 8/6/25 at 10:42 a.m., the director of nursing (DON) stated she had heard the recliner was unplugged but never actually checked it herself. The DON stated it should not be plugged in and will see if therapy can evaluate R6 again for safe use and possibly remove the chair since it is easy for staff to just plug it back in if they want to use it. The DON stated after a new intervention is put into place, it should be documented in the communication book which staff review prior to working their next shift. The DON reviewed the communication book and stated no communication note was present regarding the unplugging of the electric chair. Facility Falls and Managing Fall risk policy dated 3/2018, included: -- Staff will implement a resident centered fall prevention plan to reduce the risk factor(s) of falls for each resident at risk or with a history of falls. -- If falling reoccurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. -- If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. -- Position-change alarms will be monitored for efficacy and staff will respond to alarms in a timely manner.	F0689			
F0851 SS = F	Payroll Based Journal	F0851	The issue in question wasn't that we didn't have proper nursing coverage, but rather that the file we uploaded		09/02/2025

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F0851 SS = F	Continued from page 6 CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.			F0851	Continued from page 6 to CMS may not have been accurate. We provided information showing that we met all nursing staffing requirements In an effort to ensure that the data we submit is accurate, we will take the following steps: We have contacted our payroll provider who produces the PBJ file for us. They have reviewed the database and have reindexed all of the files. They advised us to reset all nursing employees by deleting and then re-inputting the appropriate PBJ codes. They are confident that this will fix the issue. After the PBJ file is uploaded to the CMS server, our accountant will run a report from the CMS website breaking out RN and LPN hours by date. He will review the report to make sure that each day has the appropriate nursing hours listed. An audit will be conducted after the next two PJB reports are submitted to verify that the information that has been accepted by CMS is accurate. Audits will be ongoing until reviewed at QA and a determination has been made that they are no longer necessary. Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional programming needs. CORRECTION DATE: 09/02/2025		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245440		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
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F0851 SS = F	Continued from page 7 §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to submit accurate data for staffing information based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed- Quarter 2, 2025, (January to March), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: The CMS payroll-based journal (PBJ) staffing data report indicated the following infraction: Excessively Low Weekend Staffing- Submitted Weekend Staffing data is excessively low. During interview on 8/4/25 at 12:45 p.m., director of nursing (DON) stated she was unsure why they would have triggered for low staffing and that they always had staff on the weekends. DON further stated they used agency staff on weekends to fill shifts their staff could not cover. During interview on 8/4/25 at 1:10 p.m., administrator, who oversees submission of the PBJ data, stated he recalled there may have been a delay in getting staffing hours from the agencies they work with to fill shifts, and that may be why it appeared they had low weekend staffing. Administrator further stated he was not aware of actual low weekend staffing and that weekends were always staffed by hired staff or agency staff. Administrator stated he would work with agencies to get accurate staffing hours submitted. Review of facility provided documents titled 2025 Master Nursing Staff Schedule and Time Card Report dated 1/1/25 -3/31/25, indicated the facility did not have low weekend staffing on any weekend during that time period.			F0851			

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F0851 SS = F	Continued from page 8 A facility policy on Payroll Based Journal Submission was not received.			F0851			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245440		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 08/05/2025	
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/05/2025. At the time of this survey, WHISPERING CREEK was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR			K0000			08/29/2025

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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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. WHISPERING CREEK is a 1 story building with partial basement. The facility was constructed in 1965 and was determined to be of Type II (111) construction. An addition was added in 1994 and was determined to be type II (111). Because the original building and the addition are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 35 beds and had a census of 25 at the time of the survey.		K0000				

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K0000	Continued from page 2		K0000				
K0271 SS = F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed provide approved discharge walking surfaces as identified per NFPA 101 (2012 edition), Life Safety Code, section 19.2, 7.1.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/05/2025 between 11:00 AM, it was revealed by observation that exterior to South Exit Door exhibited a threshold to slab gap, greater than 1 inch, presenting a trip and fall hazard. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0271	K0271 – The gap was removed by applying concrete to even out the threshold and slab. The surface is now level. Audits will be conducted over the next two quarters to verify that the gap has not reemerged as the weather changes. Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional programming needs. Date of completion: August 18th, 2025		08/18/2025	
K0355 SS = C	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by:		K0355	K0355 We have contacted our vendor and alerted them to the issue. They will visit the site, update documentation on annual vendor maintenance of fire extinguishers, and revise their report to match current standards. The Maintenance Director will conduct an audit after this year's vendor maintenance of facility fire extinguishers is completed.		09/05/2025	

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K0355 SS = C	Continued from page 3 Based on a review of available documentation and staff interview, the facility failed to properly maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1, 7.2.4.5, 7.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/05/2025 between 9:30 AM and 12:30 PM, it was revealed by a review of available documentation, that records were not available associated to the annual vendor maintenance of the facility fire extinguishers. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0355	Continued from page 3 Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional programming needs. Date of completion: September 5, 2025			
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of		K0918	K0918 We contacted our vendor and a new battery was installed on August 2, 2025. The Maintenance Director will conduct an audit annually to ensure that the battery is within the operational standards . Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional programming needs. Date of completion: August 20, 2025		08/20/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245440		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING		(X3) DATE SURVEY COMPLETED 08/05/2025	
NAME OF PROVIDER OR SUPPLIER WHISPERING CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET , JANESVILLE, Minnesota, 56048			
(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	
K0918 SS = F Bldg. 01	Continued from page 4 the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on observation, documentation review and staff interview, the facility failed to maintain the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 8.3, 8.4, 5.6.4.5.1 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/05/2025 between 11:30 AM, it was revealed by observation and review of vendor documentation that generator battery was dated 01/2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0918				



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 22, 2025

Administrator
WHISPERING CREEK
102 EAST NORTH STREET
JANESVILLE, MN 56048

Re: State Nursing Home Licensing Orders

Event ID: 1D0DEE- H1

Dear Administrator:

The above facility survey was completed on 08/06/2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted 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:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
NAME OF PROVIDER OR SUPPLIER WHISPERING CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET , JANESVILLE, Minnesota, 56048			
(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
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 8/4/25-8/6/25, a standard licensing 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 Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.			20000			08/26/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
STATE FORM		Event ID: 1D0DEE-H1	Facility ID: 00681

If continuation sheet Page 1 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
NAME OF PROVIDER OR SUPPLIER WHISPERING CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET , JANESVILLE, Minnesota, 56048			
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20000	Continued from page 1 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. 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.			20000			
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident status was accurately identified on the Minimum Data Set (MDS) assessment for 1 of 2 resident (R25) reviewed for anticoagulant use. Findings include:			20550	corrected		09/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
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20550	Continued from page 2 R25's Face Sheet printed 8/6/25, included diagnoses of peripheral vascular disease (narrowing or blockage of blood vessels) , chronic atrial fibrillation (irregular heart rhythm), edema and chronic venous hypertension (high blood pressure in veins leading to insufficiency causing swelling) with ulcer and inflammation of bilateral lower extremities. R25's quarterly Minimum Data Set (MDS) dated 6/20/25, section N, included R25 was receiving a diuretic, antiplatelet, hypoglycemic and antidepressant medication. Anticoagulant medication was not checked as receiving. R25's physician orders dated 7/20/25, included warfarin sodium (anticoagulant/blood thinner) 1 mg tablet by mouth six times per week on Monday, Tuesday, Wednesday, Thursday, Friday and Saturday and 1.5 mg tablet of warfarin sodium one time a week on Sunday. During interview on 8/6/25 at 3:35 a.m., the director of nursing confirmed the MDS was coded incorrectly and confirmed R25 had received warfarin when the MDS was completed in June 2025. During interview 8/6/25 at 3:05 p.m., registered nurse (RN)-C, also identified as MDS coordinator, stated R25 has always been on warfarin so she must have just forgotten to check the anticoagulant box when she completed R25's MDS in June 2025. A policy on MDS coding was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee or resident assessment instrument (RAI) coordinator could review the RAI manual, review policies and procedures to ensure accurate coding of the MDS. The DON, designee or RAI coordinator could then perform audits to ensure compliance. The results of those audits could be taken to quality assurance performance improvement (QAPI) committee to determine compliance and the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20550			
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			20830	corrected		09/01/2025

If continuation sheet Page 3 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING 		(X3) DATE SURVEY COMPLETED 08/06/2025	
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20830	Continued from page 3 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 fall risk interventions were completed after a fall for 1 of 2 residents (R6) identified at risk for falls to prevent further falls. Findings include: R6's Face Sheet printed 8/6/25, indicated R6 had diagnoses including heart failure, dementia, chronic kidney disease stage IV (severe irreversible damage to the kidneys) and chronic respiratory failure. R6's significant change Minimum Data Set (MDS) assessment dated 5/9/25, indicated R6 had a severe cognitive impairment with no delirium or behaviors. Activities of daily living (ADL's) included R6 uses a wheelchair and requires partial/moderate assistance for oral care and eating, and substantial to maximal assistance for toileting, showering, personal hygiene, bed mobility and transfers. Walking was not attempted. R6 has had one fall without injury since prior assessment. R6's Care Area Assessment dated 5/9/25, indicated R6 was at risk for falls. See plan of care for fall interventions. Fall assessment last completed 8/4/25, identified R6 was at risk for falls and has had 1-2 falls in the past 3 months, has decreased safety awareness with impaired mobility. R6's plan of care last updated 5/27/25, indicated R6 was at risk for falls related to heart problems, terminal diagnosis of heart failure, takes medications that cause resident to be dizzy, tired, confused or weak and have trouble sleeping. Interventions included: bed low to the ground with wheels locked, remind to ask for help, therapy department performed Lift Chair Safety Assessment and is safe to use recliner chair in her room, keep important items within reach, frequent checks and night light on at night. Facility Incident Report dated 4/19/25 at 3:48 a.m., by licensed practical nurse (LPN)-A indicated R6 was trying to get up and go the bathroom and was found on the floor. Was observed in bed at 1:30 a.m. Current			20830			

If continuation sheet Page 4 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER WHISPERING CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 102 EAST NORTH STREET , JANESVILLE, Minnesota, 56048	
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20830	Continued from page 4 interventions and other factors included reclining chair, tray table, room close to nurses station, call light was in reach, but call light was not on. New intervention included floor alarm and teaching use of call light. No injuries noted. Interdisciplinary team review (IDT) completed 4/21/25, included R6 has had 1 fall within the last year. Intervention included floor alarm placed on floor while in bed and teaching of use of call light. Facility Incident Report dated 6/3/25 at 7:30 p.m., by LPN-B indicated resident was observed on floor and stated "I thought I could get into my bed myself so I tried." R6 stated she landed on buttocks then onto her back and hit her head on the floor. Current interventions and factors included low bed, attempting to transfer without staff assist, call light in reach but was not on. No injuries. New interventions included a personal alarm and teaching on safe transfer techniques, and use of call light for assistance. IDT review, undated, included personal alarm was placed on person. 2 falls within the last 2 months. Facility Incident Report 7/30/25 at 4:00 p.m., by registered nurse (RN)-A included resident was observed on floor in front of her recliner. Recliner was elevated for her legs to be up. Call light was in reach but call light was not on. No injuries noted. IDT team review, undated, included 3 falls with the past 3 months. New intervention included recliner was unplugged and foot elevation pedal will not be used. On observation and interview 8/4/25 at 3:34 p.m., R6 was sitting in her wheelchair with a personal alarm on her chair and clipped to resident. Family member (FM)-A was sitting in R6's recliner in her room and stated R6 used her lift chair and fell out last week. FM-A stated they notified her of the fall and said they were going to unplug the recliner. FM-A used buttons on side of recliner and recliner began to put feet up and stated "I guess they didn't unplug it as it still works." On observation and interview 8/5/25 at 9:23 a.m., R6 was sitting in her wheelchair with personal alarm on. R6 stated she does sit in her recliner sometimes but doesn't want to right now. R6 sorting through her drawers. Power recliner remains plugged in and working. On observation and interview 8/6/25 at 7:54 a.m., R8 was assisted to tub room by nursing assistant for hospice (NA)-A. Electric recliner continues to be plugged in and functioning. NA-A stated she has seen R6 in her recliner periodically when she comes. NA-A was unaware of any recent falls and is unsure if it should	20830		

If continuation sheet Page 5 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
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20830	Continued from page 5 be plugged in or not. On interview 8/6/25 at 9:04 a.m., NA-B stated R6 has been evaluated for use of her electric chair and has been okayed to use it. NA-B stated she hasn't been told anything different and wasn't aware it needed to be unplugged. On interview 8/6/25 at 9:19 a.m., NA-C stated R6 does use her recliner and after lunch staff will generally put her in the recliner for awhile. NA-C stated we do have to watch her close or she will try to climb out of it when she gets tired of sitting there. NA-C stated he didn't believe R6 could use the electric chair control buttons but was not aware the recliner was not supposed to be plugged in. On interview 8/6/25 at 9:20 a.m., RN-B stated two weeks ago R6 was in her recliner with the legs up and she tried to climb out of it without putting the feet down. The recliner tipped down and she slid out. RN-B stated she was not aware the recliner was to be unplugged. RN-B confirmed the electric chair was plugged in and operational. On interview 8/6/25 at 10:42 a.m., the director of nursing (DON) stated she had heard the recliner was unplugged but never actually checked it herself. The DON stated it should not be plugged in and will see if therapy can evaluate R6 again for safe use and possibly remove the chair since it is easy for staff to just plug it back in if they want to use it. The DON stated after a new intervention is put into place, it should be documented in the communication book which staff review prior to working their next shift. The DON reviewed the communication book and stated no communication note was present regarding the unplugging of the electric chair. Facility Falls and Managing Fall risk policy dated 3/2018, included: -- Staff will implement a resident centered fall prevention plan to reduce the risk factor(s) of falls for each resident at risk or with a history of falls. -- If falling reoccurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. -- If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling,			20830			

If continuation sheet Page 6 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2025	
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20830	Continued from page 6 until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. -- Position-change alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review, and revise policies and procedures related to resident falls. The DON or designee could develop a process for implementing fall interventions. The DON or designee could educate staff and leadership on the process. The DON or designee could monitor and audit falls and take those findings to the quality assurance performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20830			

STATE FORM

Event ID: 1D0DEE-H1

Facility ID: 00681

If continuation sheet Page 7 of 7



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 5, 2026

Administrator
WHISPERING CREEK
102 EAST NORTH STREET
JANESVILLE, MN 56048

RE: CCN: 245440
Cycle Start Date: August 6, 2025

Dear Administrator:

On September 19, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 5, 2026

Administrator
WHISPERING CREEK
102 EAST NORTH STREET
JANESVILLE, MN 56048

Re: Reinspection Results
Event ID: 1D0DEE-H1

Dear Administrator:

On September 19, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 6, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 5, 2026

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A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 5, 2026

Administrator
WHISPERING CREEK
102 EAST NORTH STREET
JANESVILLE, MN 56048

Re: Reinspection Results
Event ID: 1D0DEE-H1

Dear Administrator:

On September 19, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 6, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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