Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 4, 2026

Administrator
WHISPERING CREEK
102 EAST NORTH STREET
JANESVILLE, MN 56048

RE: CCN:245440
Cycle Start Date: May 27, 2026

Dear Administrator:

On May 27, 2026, a survey was completed at your facility by the Minnesota Department(s) 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 August 27, 2026 (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 November 27, 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,

Sincerely,

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

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 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING CREEK	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 5/26/26-5/27/26, 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		07/08/2026
F0000	INITIAL COMMENTS On 5/26/26-5/27/26, 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		07/08/2026
F0851 SS = D	Payroll Based Journal 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	F0851	The issue in questino wasn't that we didn't have proper nursing coverage, but rather that the file uploaded 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:	06/12/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0851 SS = D	Continued from page 1 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. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS.	F0851	Continued from page 1 The Administrator is now responsible for the uploading of information to the CMS PBJ website. He was trained by the outgoing submitter and submitted his first report for the first quarter of 2026. The Office Manager will reach out to all nursing pool companies to request PBJ staffing data, and will make sure that all staffing date is received timely and that nursing pool hours are entered into the PBJ website. After uploading the data, the Adminsitrator will run the Job Title Report for all RN's. This report shows RN hours by day for the quarter. Hours will be tied out to ensure that all worked ours are accounted for in the PBJ report and the at least 8 hours of RN time is worked each day. The Job Title Report will be shared at the quarterly QA Committee meeting to verify compliance.	06/12/2026

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F0851 SS = D	Continued from page 2 §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 and/or complete data for staffing information based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 1, 2026), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: CMS PBJ (payroll-based journal) Staffing Data Report dated Quarter 1, 2026 (October 1 – December 31) triggered for failure to have licensed nursing coverage 24 hours/day. The four infraction dates included: 10/4/25, 10/5/25, 11/15/25, and 11/16/25. During record review, reviewed nursing staff schedules and daily staffing postings for the infraction dates. On each of the four dates, licensed nurses had been scheduled 24 hours/day. During record review, timecard sheets and/or agency invoices for each of the five employed and one agency nurse covering the 12 shifts were reviewed and indicated the nurses who had been scheduled had been paid for working the shifts. During an interview on 5/27/26 at 9:03 a.m., licensed practical nurse (LPN)-A stated a nurse worked in the charge nurse capacity every shift – either an LPN or a registered nurse. During an interview on 5/27/26, at 9:57 a.m., the administrator was informed the facility PBJ report had triggered for failure to have licensed nursing coverage 24 hours/day on 10/5/25, 10/5/25, 11/15/25, and 11/16/25. The administrator was informed schedules, time sheets and agency invoices verified licensed nursing staff had worked the infraction dates. The administrator stated the facility scheduled one licensed nurse each shift; they checked and verified all shifts were covered. Data for employed nurses and data from staffing agencies were uploaded to the CMS database. The administrator couldn’t explain the discrepancy. During an interview on 5/27/26 at 10:07 a.m., the administrator stated he realized the problem. The	F0851		06/12/2026

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F0851 SS = D	Continued from page 3 individual who uploaded the data had not been informed the facility had started utilizing a particular agency in 2025, and had not added those agency nurses to the database. During an interview on 5/27/26 at 2:26 p.m., the director of nursing (DON) stated she did scheduling for the nursing staff, and verified a licensed nurse was scheduled as the charge nurse for each shift. The facility Reporting Direct Care Staffing Information (Payroll-Based Journal) policy with revised date of August 2022, indicated direct care staffing information was reported electronically to CMS through the Payroll-Based Journal system. Complete and accurate direct care staffing information was reported electronically to CMS through the Payroll-Based Journal (PBJ) system in a uniform format specified by CMS. For auditing purposes, reported staffing information was based on payroll records, invoices, tied back to a contract, or other verifiable information.	F0851		06/12/2026

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	245440	A. BUILDING **01 - MAIN BUILD...** B. WING	**05/27/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/27/2026. 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		06/11/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0000 Bldg. 01	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: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. 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	K0000		06/11/2026

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K0000 Bldg. 01	Continued from page 2 census of 32 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		06/11/2026
K0541 SS = F Bldg. 01	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain chute doors and safety measures of the garbage chute systems per NFPA 101 (2012 edition), section(s) 19.5.4.4, 9.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/27/2026 at 11:00 AM, it was revealed by observation that the Laundry Chute door did not function properly upon test to close and seal the vertical opening.	K0541	K0541 This issue was that our shoot damper did not have a latch. A gate latch was added to the left side of the shoot damper. It has been testing for latching purposes. If the fuseable link would melt, the damper will shut and latch. The Maintenance Director will test this on a quartely basis to ensure that it is still latching properly. Results of the quarterly test will be reported to the QA Committe at its quarterly meeting to discuss findings and the need for further maintenance	06/18/2026

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K0541 SS = F Bldg. 01	Continued from page 3 On 05/27/2026 at 11:30 AM, it was revealed by observation that the Laundry Chute discharge was not equipped with a means to close and maintain seal the vertical opening. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0541		06/18/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed initiate an electrical equipment – testing and maintenance program in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8. This deficient finding could have a widespread impact on the residents within the facility.	K0921	KO921 This is a new requirement going forward and we have now initiated phase one of our plan. We have started the process by first inspecting all of our beds. We have a form we received from the Office of the Fire Marshall and this is the form we are using to document our inspection. Over the course of the next year we will be adding any electrical medical devices to our inspection list. Any new admissions will automatically have any medical devices they bring along with them inspected and added to the list. Audits will conducted for the next two quarters to ensure that the list is being updated with new admissions and with the ongoing evaluation of the building. Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional staff training	06/12/2026

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K0921 SS = F Bldg. 01	Continued from page 4 Findings include: On 05/27/2026 between 9:30 AM and 12:30 PM, it was revealed by a review of available documentation that no documentation was presented to confirm that a PCREE program was in place. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0921		06/12/2026
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid	K0923	K923 Oxygen storage tanks were immediately organized to avoid mixing empty/full cylinders. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1)Licensed nurses will be educated on the facility policy oxygen storage prior to our compliance date. On-call licensed nurses who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. 2)Oxygen storage room will be audited 3 times weekly to ensure tanks are stored according to facility policy when not in use. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3)Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional staff training. Date of completion: June 18, 2026	06/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245440	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/27/2026**

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WHISPERING CREEK	**102 EAST NORTH STREET , JANESVILLE, Minnesota, 56048**

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K0923 SS = F Bldg. 01	Continued from page 5 confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.2.3, 11.6.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/27/2026 at 11:15 AM, it was revealed by observation that in the Med Gas (O2) Room there was mixed storage of empty / full cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0923		06/18/2026
K0712 SS = E Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1, 4.7.4 These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K0712	K0712 The issue was one of randomness. To mitigate this issue we have drawn up a schedule that maps out the fire drills for the entire year. It is by shift and makes sure each shirt is hit once a quarter. We feel it is random and will allow us to meet this requirement. Audits will be conducted over the next two quarters to verify that the schedule is being followed. Audit results will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional needs. Date of completion: June 11,2026	06/11/2026

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K0712 SS = E Bldg. 01	Continued from page 6 On 05/27/2026 between 9:30 AM and 12:30 PM, it was revealed by review of available documentation, that documentation presented for review identified lack of randomness in date and timestamps. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712		06/11/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 31, 2026

Administrator
WHISPERING CREEK
102 EAST NORTH STREET
JANESVILLE, MN 56048

RE: CCN: 245440
Cycle Start Date: May 27, 2026

Dear Administrator:

On July 30, 2026, the Minnesota Department(s) of Health and Public Safety, 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,

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

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E0000	Initial Comments On 5/26/26-5/27/26, 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		07/08/2026
F0000	INITIAL COMMENTS On 5/26/26-5/27/26, 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		07/08/2026
F0851 SS = D	Payroll Based Journal 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	F0851	The issue in questino wasn't that we didn't have proper nursing coverage, but rather that the file uploaded 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:	06/12/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0851 SS = D	Continued from page 1 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. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS.	F0851	Continued from page 1 The Administrator is now responsible for the uploading of information to the CMS PBJ website. He was trained by the outgoing submitter and submitted his first report for the first quarter of 2026. The Office Manager will reach out to all nursing pool companies to request PBJ staffing data, and will make sure that all staffing date is received timely and that nursing pool hours are entered into the PBJ website. After uploading the data, the Adminsitrator will run the Job Title Report for all RN's. This report shows RN hours by day for the quarter. Hours will be tied out to ensure that all worked ours are accounted for in the PBJ report and the at least 8 hours of RN time is worked each day. The Job Title Report will be shared at the quarterly QA Committee meeting to verify compliance.	06/12/2026

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F0851 SS = D	Continued from page 2 §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 and/or complete data for staffing information based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 1, 2026), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: CMS PBJ (payroll-based journal) Staffing Data Report dated Quarter 1, 2026 (October 1 – December 31) triggered for failure to have licensed nursing coverage 24 hours/day. The four infraction dates included: 10/4/25, 10/5/25, 11/15/25, and 11/16/25. During record review, reviewed nursing staff schedules and daily staffing postings for the infraction dates. On each of the four dates, licensed nurses had been scheduled 24 hours/day. During record review, timecard sheets and/or agency invoices for each of the five employed and one agency nurse covering the 12 shifts were reviewed and indicated the nurses who had been scheduled had been paid for working the shifts. During an interview on 5/27/26 at 9:03 a.m., licensed practical nurse (LPN)-A stated a nurse worked in the charge nurse capacity every shift – either an LPN or a registered nurse. During an interview on 5/27/26, at 9:57 a.m., the administrator was informed the facility PBJ report had triggered for failure to have licensed nursing coverage 24 hours/day on 10/5/25, 10/5/25, 11/15/25, and 11/16/25. The administrator was informed schedules, time sheets and agency invoices verified licensed nursing staff had worked the infraction dates. The administrator stated the facility scheduled one licensed nurse each shift; they checked and verified all shifts were covered. Data for employed nurses and data from staffing agencies were uploaded to the CMS database. The administrator couldn’t explain the discrepancy. During an interview on 5/27/26 at 10:07 a.m., the administrator stated he realized the problem. The	F0851		06/12/2026

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F0851 SS = D	Continued from page 3 individual who uploaded the data had not been informed the facility had started utilizing a particular agency in 2025, and had not added those agency nurses to the database. During an interview on 5/27/26 at 2:26 p.m., the director of nursing (DON) stated she did scheduling for the nursing staff, and verified a licensed nurse was scheduled as the charge nurse for each shift. The facility Reporting Direct Care Staffing Information (Payroll-Based Journal) policy with revised date of August 2022, indicated direct care staffing information was reported electronically to CMS through the Payroll-Based Journal system. Complete and accurate direct care staffing information was reported electronically to CMS through the Payroll-Based Journal (PBJ) system in a uniform format specified by CMS. For auditing purposes, reported staffing information was based on payroll records, invoices, tied back to a contract, or other verifiable information.	F0851		06/12/2026