



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 18, 2026

Administrator  
WHITEWATER HEALTH SERVICES  
525 BLUFF AVENUE  
ST CHARLES, MN 55972

RE: CCN: 245270  
Cycle Start Date: July 2, 2026

Dear Administrator:

On September 9, 2026, we informed you of imposed enforcement remedies.

On September 16, 2026, the Minnesota Department of Health completed a revisit and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

## REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 2, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 2, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 2, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been

determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 2, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, WHITEWATER HEALTH SERVICES will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 2, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## 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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

#### DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor  
Rochester District Office  
Health Regulation Division  
Minnesota Department of Health  
3425 40th Avenue NW, Suite 115  
Rochester, MN 55901  
Email: [jennifer.kolsrud@state.mn.us](mailto:jennifer.kolsrud@state.mn.us)  
Office: (507) 206-2727

#### 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 2, 2027 if your facility does not achieve substantial compliance. This

action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

## APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services  
Departmental Appeals Board, MS 6132  
Director, Civil Remedies Division  
330 Independence Avenue, S.W.  
Cohen Building – Room G-644  
Washington, D.C. 20201  
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to [tamika.brown@cms.hhs.gov](mailto:tamika.brown@cms.hhs.gov).

## 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](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

#### INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

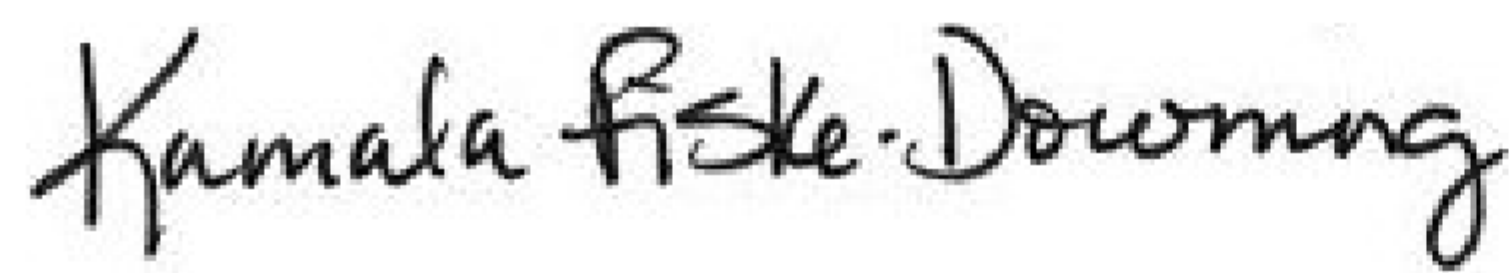
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments 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.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing  
Compliance Analyst | Federal Enforcement  
Health Regulation Division  
**Minnesota Department of Health**  
[Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)  
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered  
September 23, 2026

Administrator  
WHITEWATER HEALTH SERVICES  
525 BLUFF AVENUE  
ST CHARLES, MN 55972

RE: CCN: 245270  
Cycle Start Date: July 2, 2026

**This letter will replace the letter sent on September 18, 2026. No deficiencies were re-cited. This facility was back in compliance at the revisit.**

Dear Administrator:

On September 9, 2026 we notified you a remedy was imposed. On September 10 and September 16, 2026 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 18, 2026.

As authorized by CMS the remedy of:

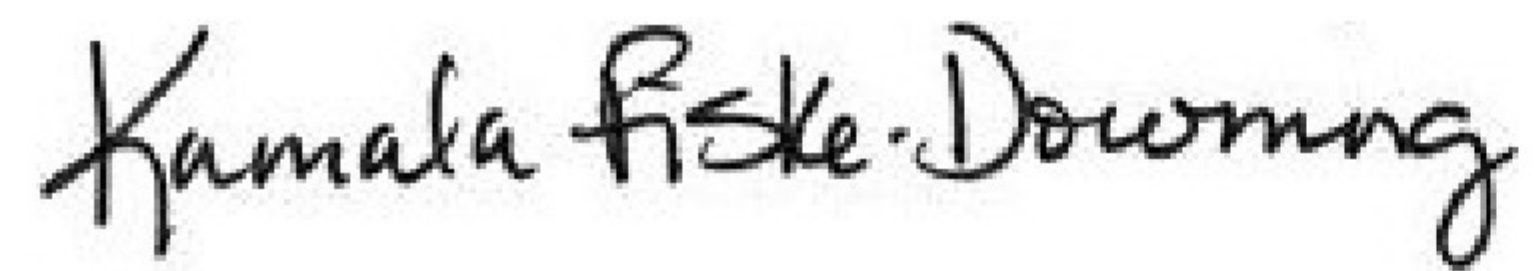
- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 2, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 9, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 2, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 18, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing  
Compliance Analyst | Federal Enforcement  
Health Regulation Division  
**Minnesota Department of Health**  
[Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)  
Office: 651-201-4112



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

July 22, 2026

Administrator  
WHITEWATER HEALTH SERVICES  
525 BLUFF AVENUE  
ST CHARLES, MN 55972

RE: CCN: 245270

Cycle Start Date: July 2, 2026

Dear Administrator:

On July 2, 2026, 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:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: [jennifer.kolsrud@state.mn.us](mailto:jennifer.kolsrud@state.mn.us)

Office: (507) 206-2727

#### **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 **October 2, 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 **January 2, 2027** (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](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](mailto:travis.ahrens@state.mn.us)  
Web: [www.sfm.dps.mn.gov](http://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, appearing to read "H. Zahler". The signature is stylized with a large, looped "H" and a cursive "Zahler".

Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Office: 651-201-4384  
Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245270 |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                                                 |  | (X3) DATE SURVEY COMPLETED<br><br>07/02/2026 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972                             |  |                                              |  |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                   |  |
| E0000                                                          | Initial Comments<br><br>On 6/29/26-7/2/26 , 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.<br><br>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               |                                                                                                                          |  | 08/18/2026                                   |  |
| F0000                                                          | INITIAL COMMENTS<br><br>On 6/29/26-7/2/26 , a standard recertification survey (S#5270037) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed: H52703062C (iQIES # 3044016), H52703063C (iQIES #3038293), H52703065C (iQIES #3028994), H52703064C (iQIES #2962111) NO deficiencies were cited.<br><br>The following complaints were reviewed: H52701473C (iQIES #2985978) with deficiencies cited at F580<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.<br><br>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               |                                                                                                                          |  | 08/18/2026                                   |  |

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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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245270 |  | (X2) MULTIPLE CONSTRUCTION<br><br>A. BUILDING<br><br>B. WING                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X3) DATE SURVEY COMPLETED<br><br>07/02/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                     |  | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              | (X5)<br>COMPLETION<br>DATE |
| F0584<br>SS = E                                                | <p>Safe/Clean/Comfortable/Homelike Environment</p> <p>CFR(s): 483.10(i)(1)-(7)</p> <p>§483.10(i) Safe Environment.</p> <p>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to maintain a clean, homelike</p> |                                                                     |  | F0584                                                                                        | <p>F0584 – Safe/Clean/Comfortable/Homelike Environment</p> <p>Resident: No current residents specifically identified. Refrigerator located in dining hall was removed from service on 07/23/2026.</p> <p>Like Residents: Current residents who receive supplemental drinks have the potential to be affected by this alleged deficient practice. Director of Nursing/designee reviewed the identified residents to ensure no adverse effects or GI symptoms were identified on 7/29/26. Current residents who eat in the dining room receiving meals on trays have the potential to be affected by this alleged deficient practice. No adverse effects were identified. Residents were approached with change in practice of not leaving the tray during meal service and two residents requested keeping their trays. Care plans update.</p> <p>Education: On 7/24/2026, Executive Director/designee re-educated the Dietary Manager on refrigeration cleaning schedule. On 7/24/2026, the Dietary Manager/designee started re-educating dietary staff members on refrigeration cleaning schedule.</p> <p>On 7/14/26 Director of nursing/designee started re-educating licensed nurses, certified nursing assistance and the interdisciplinary team on when passing trays in the dining room, plates and drinks should be removed from the delivery tray and set on the table in front of the resident creating a homelike environment.</p> <p>Audit: Executive Director/designee will complete an audit on kitchen refrigeration cleaning schedule/kitchen work orders to ensure that a clean environment is maintained. Audits will be conducted two times per week for five weeks, or until substantial compliance is maintained. Results of this audit will be brought to Quality Assurance Performance Improvement for review and further recommendations.</p> <p>Director of Nursing/designee will complete an audit on meal delivery service, in the dining room, to ensure a homelike environment is being provided. Audits will be conducted three times</p> |                                              | 08/18/2026                 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245270 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                     |                                                                                                                                                                                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>07/02/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 |                                                                                                                                                                                                                                                                                          |                                              |                            |
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| F0584<br>SS = E                                                | <p>Continued from page 2</p> <p>environment when it was identified a refrigerator used to supply resident supplement drinks were not cleaned. In addition, during dining, meals were served on trays. This failure had an opportunity to affect all residents who received supplemental drinks and who received meals in the dining rooms.</p> <p>Findings include:</p> <p>During the initial kitchen tour on 6/29/2026 at 10:35 a.m., with cook (C)-A verified the refrigerator in the dining room where the residents house supplement is kept had a large amount of ice built up on the top freezer part with an unknown item within the ice. C-A indicated uncertain who was in charge to clean, monitor or who to report it to.</p> <p>During an interview on 7/01/2026 at 11:45 a.m., maintenance-B said when staff have things that need to be looked at, they are to place a ticket in the TELS. Maintenance-B indicated the TELS is where we would get notified of something needing fixed.</p> <p>During an observation and interview on 7/01/2026 5:50 p.m., administrator verified the ice buildup in the dining room refrigerator.</p> <p>During an interview on 7/01/2026 at 5:55 p.m., administrator, vice president of success (VPS)-A and B verified a TELS request should have been placed for maintenance to review the ice buildup. Administer reviewed the TELS report history and verified it was not reported regarding the ice buildup in the dining refrigerator.</p> <p>Trays</p> <p>During an observation on 6/29/2026 at 11:59 a.m., during noon meal, staff bring food to the resident on a tray. The tray includes drinks, dishes with miscellaneous items, and hot plate. The staff place the tray in front of the resident and leave it in front of them.</p> <p>During an observation on 6/29/2026 at 5:34 p.m., supper meals served to residents on trays.</p> <p>During an observation on 6/30/2026 at 12:32 p.m., noon meal was served to residents and left on trays.</p> <p>During an observation and interview on 7/1/01/2026 at 12:00 p.m., registered nurse (RN)-A verified the noon meal was served and food left on the trays and placed in front of the resident. RN-A indicated she recalled this occurring for some time at least two</p> |                                                                  |  | F0584                                                                                        | <p>Continued from page 2</p> <p>per week for five weeks, or until substantial compliance is maintained. Results of this audit will be brought/ to Quality Assurance Performance Improvement for review and further recommendations.</p> <p>Facility will be in compliance by 8/18/26</p> |                                              | 08/18/2026                 |

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| F0584<br>SS = E                                                | <p>Continued from page 3<br/>years.</p> <p>During an interview on 7/01/2026 at 7:24 p.m., VPS-A verified the meals are served on trays and left in front of the residents. VPS-A felt it has been like that since before thecurrent administrator. VPS-A confirmed it is not homelike.</p> <p>Facility policy tilted, Safe and Homelike Environment dated 6/16/2022 includes Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean. The facility will create and maintain, to the extent possible, a homelike environment that deemphasizes the institutional character of the setting. General considerations, eliminate the use of meal trays during dining service, unless otherwise requested by the resident.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                  |  | F0584                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                              | 08/18/2026                 |
| F0908<br>SS = E                                                | <p>Essential Equipment, Safe Operating Condition</p> <p>CFR(s): 483.90(d)(2)</p> <p>§483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to maintain equipment in good working order for 1 kitchen dishwashing system and surrounding area.</p> <p>Findings include:</p> <p>During the initial kitchen tour on 6/29/2026 at 10:35 a.m., Cook (C)-A identified dishwasher and off to the left underneath counter a metal device with a large amount of water flowing from it. surrounding the device the tile floor was buckled and the trim around the perimeter of the wall was peeled back. C-A indicated maintenance has known of the water leak for about a month.</p> <p>During an observation and interview on 7/01/2026 at 11:45 a.m., maintenance (M)-B was asked to review the leak in the kitchen. After walking in the kitchen, M-B quickly went to the area and turned the water off. M-B was made aware on 6/30/26 from M-A. M-B indicated staff are to use the TELS system (a systems to give updates to maintenance of things needing attention). He reviewed TELS and verified staff did not report. M-B confirmed the damage was not new and should have been reported sooner. M-B indicated a plumber will be coming to assess.</p> |                                                                  |  | F0908                                                                                        | <p>F0908 – Essential Equipment, Safe Operating Condition (dishwasher and surrounding area)</p> <p>Resident: No current residents were specifically identified. Plummer repaired leak on 07/01/2026. Medal device, located off to the left underneath counter by dishwasher, was removed on 7/2/2026. Surrounding area was repaired on 7/29/26.</p> <p>Like residents: Current residents have the potential to be affected by this alleged deficient practice. No adverse effects were identified. Director of Nursing/designee reviewed the identified residents to ensure no adverse effects or GI symptoms were identified.</p> <p>Education: On 7/15/26 Executive Director/designee re-educated the Dietary Manager on how to alert maintenance of work requests. On 7/15/26 Dietary Manager/designee started re-educating dietary staff members of the process of completing a maintenance work order, location of work orders slips and where to place them once they are filled out.</p> <p>Audits: Executive Director/designee will conduct an audit on kitchen staff's understanding of how to complete a work order for maintenance repairs/cleaning. Audits will be conducted two times per week of 2 dietary staff members for five weeks, or until substantial compliance is maintained. Results of this audit will be brought to Quality</p> |                                              | 08/18/2026                 |

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| F0908<br>SS = E                                                | Continued from page 4<br>During an interview on 7/01/2026 at 5:55 p.m., administrator, vice president of success (VPS)-A and B, indicated the expectation would be staff to report things needing fixed to use the TELS system. Administrator indicated being updated of the plumber called to review the leak in the kitchen and confirmed did not observe the damage themselves.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                     |  | F0908                                                                                        | Continued from page 4<br>Assurance Performance Improvement for review and further recommendations.<br><br>Facility will be in compliance by 8/18/26.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              | 08/18/2026                 |
| F0550<br>SS = D                                                | Resident Rights/Exercise of Rights<br><br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br><br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br><br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. |                                                                     |  | F0550                                                                                        | F0550 – Resident Rights/Exercise of Rights<br><br>Resident: R1 continues to reside at the facility. R1's immobilizer was laundered on 07/01/26. Order entered for nurse to check for cleanliness daily and care plan updated. Received new immobilizer on 7/14/26. New order to spot clean and care plan updated. R1 was interviewed by Executive Director on 7/29/26 to identify adverse effects or trauma. R1 had no adverse effects identified from this alleged deficient practice.<br><br>Like Residents: Current residents with a brace/splint/immobilizer have the potential to be affected by this alleged deficient practice. On 7/14/26 Director of nursing/designee completed an audit of residents who utilize a brace/splint/immobilizer, four residents were identified. Devices were checked for cleanliness. Orders were entered for nurses to check for cleanliness daily and care plan updated. No residents were affected.<br><br>Education: On 7/14/26 Director of Nursing/designee started re-educating licensed nurses on how to enter orders to check device daily for cleanliness and send to laundry as needed or spot clean, certified nursing assistants re-educated on notifying nurse if they see a device that needs cleaning.<br><br>Audit: Director of Nursing/designee will audit devices for cleanliness twice a week for five weeks or until substantial compliance is maintained. Results of this audit will be brought to Quality Assurance Performance Improvement for review and further recommendations.<br><br>Facility will be in compliance by 8/18/26. |                                              | 08/18/2026                 |

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| F0550<br>SS = D                                                | <p>Continued from page 5</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to maintain dignity when it was identified a brace was not cleaned regularly for 1 of 1 resident (R1) reviewed for dignity.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) assessment, dated 4/11/26, indicated R1 was not cognitively impaired. In addition, needed partial to moderate assistance to dress upper body.</p> <p>R1's care plan includes a focus for ADL (activity of daily living) assist of one staff for dressing, related to recurrent dislocation of right shoulder, and at risk for loss of range of motion and to apply device (specify-immobilizer) per physician orders.</p> <p>R1's orders include, the immobilizer should be removed twice daily, including for showers, to check underlying skin to ensure no rubbing. The immobilizer should be on at all times, otherwise.</p> <p>During an observation on 6/29/2026 at 4:57 p.m. R1 had a brace on right shoulder which wrapped around his trunk. The brace is dirty and or stained.</p> <p>During an observation and interview on 7/01/2026 at 12:03 p.m., registered nurse (RN)-A indicated there is an order to check the skin under the brace for R1 and R1 often removes the brace himself. At times when off it has been washed, although not recently and we try to complete it once a month. R1 was sitting in the dining room eating lunch and RN-A verified the brace was dirty and confirmed it needed to be washed. RN-A indicated it looks to be food from eating and wiping his hands on the brace.</p> <p>During an interview on 7/01/2026 at 12:11 p.m., environmental services (ES)-A indicated they are the ones who wash the braces for the residents but do not dry them. ES-A verified being familiar with R1's brace and said, "o' yes, but we have not washed that for a while."</p> <p>During an interview on 7/01/2026 7:22 p.m. vice president of success (VPS)-A and B, verified resident's devices should be washed when identified dirty by staff as it could be an infection control concern.</p> |                                                                  |  | F0550                                                                                        |                                                                                                                          |                                              | 08/18/2026                 |

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| F0580<br>SS = D                                                | <p>Notify of Changes (Injury/Degrade/Room, etc.)</p> <p>CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes.</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident</p> <p>representative(s).</p> <p>§483.10(g)(15)</p> <p>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in</p> |                                                                  |  | F0580                                                                                        | <p>F0580 – Notify of Changes (Injury/Degrade/Room, etc.)</p> <p>Resident: R31 no longer resides in facility.</p> <p>Like Residents: Current residents with discharge orders have the potential to be affected by this alleged deficient practice. On 7/29/26 Vice President of Success completed a look back period for residents who were discharged as planned in July 2026. 1 resident noted to have a planned discharge during this time, resident discharged as planned. No adverse effects were identified.</p> <p>Education: On 7/15/2026 Vice President of Success/designee started re-educating licensed nurses, executive director, director of nursing, assistant director of nursing and social services on provider notification if resident does not discharge as planned.</p> <p>Audits: Director of Nursing/designee will complete an audit on physician notification if a resident's discharge does not happen as planned. Audits will be conducted weekly for five weeks or until substantial compliance is maintained. Results of this audit will be brought to Quality Assurance Performance Improvement for review and further recommendations.</p> <p>Facility will be in compliance by 8/18/26.</p> |                                              | 08/18/2026                 |

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| F0580<br>SS = D                                                | <p>Continued from page 7</p> <p>§483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review facility failed to notify the physician with a change of condition for 1 of 1 resident (R31) reviewed for discharge.</p> <p>Findings include:</p> <p>R31's Quarterly Minimum Data Set (MDS) assessment, dated 5/7/26 includes intact cognition with no mood or behaviors.</p> <p>R31's focus care plan indicates residents shows potential for discharge, will be discharged to home when clinical and rehabilitation goals are met.</p> <p>R31's physician encounter visit dated 3/24/26, indicates Nursing home discharge. Discharge preparation time spent with patient 40 minutes including the following tasks, reviewed the electronic medical record, updating epic problem list, medication,... time electronically signed 4:35 p.m., with another date and time of 3/27/26 at 2:25 p.m.</p> <p>R31's patient message dated 3/24/26 at 4:36 p.m., indicates discharge recommendation faxed to facility on 3/24/26 at 4:50 p.m.</p> <p>R31's record lacked communication with the provider R31 remained in the facility after signed discharged orders were received.</p> <p>R31's physician became aware R31 remained in the facility on 4/15/26 when R31 was sent to the emergency room (ED).</p> <p>R31's progress note dated 4/16/26 from nurse practitioner reads, "does not appear on-call provider was notified of acute change in condition and ED transfer, acknowledged. Note he was seen for SNF (skilled nursing facility) discharge visit by MD (medical doctor) on 3/24/26</p> <p>R31 record revealed they were discharged on 6/6/26.</p> <p>During an interview on 7/01/2026 at 6:13 p.m., administrator, vice president of success (VPS)-A and B verified the order was received to discharge R31.</p> |                                                                  |  | F0580                                                                                        |                                                                                                                          |                                              | 08/18/2026                 |

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| F0580<br>SS = D                                                | Continued from page 8<br>When asked why, they indicated there was a snag in the payor source. Although confirmed they should have updated the physician of the change.<br><br>During an interview on 7/07/2026 at 2:19 p.m., medical providers social services indicated the facility did not update the medical doctor of the change in condition, admission to the ED or that the resident remained in the nursing home after orders were given to discharge the resident.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                  |  | F0580                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                              | 08/18/2026                 |
| F0657<br>SS = D                                                | Care Plan Timing and Revision<br><br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br><br>§483.21(b)(2) A comprehensive care plan must be-<br><br>(i) Developed within 7 days after completion of the comprehensive assessment.<br><br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br><br>(A) The attending physician.<br><br>(B) A registered nurse with responsibility for the resident.<br><br>(C) A nurse aide with responsibility for the resident.<br><br>(D) A member of food and nutrition services staff.<br><br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review the facility failed to appropriately assess and reevaluate interventions discussed in a timely manner to help prevent future falls for 1 of 4 residents (R1) reviewed for accidents who had 23 falls. |                                                                  |  | F0657                                                                                        | F0657- Care Plan Timing and Revision<br><br>Resident: R1 continues to reside at facility. Interdisciplinary Team met on 7/28/2026, reviewed and re-evaluated fall interventions care plan and updated interventions appropriately.<br><br>Like Residents: Current residents that have fallen have potential to be affected by this alleged deficient practice. On 7/30/26 Director of Nursing/designee completed an audit of current residents that have fallen to ensure fall care plan interventions are accurate and appropriate.<br><br>Education: On 7/7/2026, Vice President of Success/designee started re-educating the Interdisciplinary Team on fall prevention and management including review/revision of care plan, focusing on root cause analysis and documentation.<br><br>On 7/14/26, the Director of Nursing/designee started re-educating licensed nurses on fall prevention management program, updating care plans, resource of fall interventions, and completion of documentation. Knowledge check was completed with licensed nurses to validate understanding of fall program, interventions and documentation completion needed.<br><br>Audit: Executive Director/designee will conduct an audit on post fall IDT note, post fall assessment documentation and review/revision of care plan interventions. Audits will be conducted three times per week for five weeks, or until substantial compliance is maintained. Results of this audit will be brought to Quality Assurance Performance Improvement for review and further recommendations. |                                              | 08/18/2026                 |

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| F0657<br>SS = D                                                | <p>Continued from page 9</p> <p>Findings include:</p> <p>R1 admitted to the facility 1/20/2026</p> <p>R1's care plan focus area dated 1/21/26 indicated R1 is at increased risk for actual fall related to history of (h/o) falls, impaired decision making, failure to recognize physical limitations, impaired safety awareness, and attempts to self-transfer. R1's goal is to minimize risk of falls. Original interventions included; ensure R1 is wearing appropriate footwear (gripper socks or shoes), have commonly used articles within easy reach, provide assist to transfer and ambulate as needed, reinforce wheelchair safety as needed such as locking brakes, report development of pain, bruises, change in mental status, ADL function, appetite, or neurological status post fall, and therapy to work on transfer, walking, strengthen.</p> <p>R1's quarterly Minimum Data Set (MDS) assessment dated 4/11/2026, includes mild cognition, no mood or behavior concerns. Requires substantial to max assist where a helper does more than half the effort for toileting, bathing, dressing, and personal hygiene. R1 is dependent on others for putting on and off footwear.</p> <p>During an interview on 6/29/2026 at 12:52 p.m., R1 said staff have told him he has fallen some 17 times since admission. When asked what he was trying to do R1 stated, he dropped glasses, trying to do things for himself instead of calling staff. R1 said the reason he is in the nursing home is due to a fall at home.</p> <p>R1's medical record identified 23 falls with the first one documented on his admission of 1/20/26 through 6/13/26. 21 falls were un-witnessed.</p> <p>R1's first 10 falls lacked a post fall assessment. The first one was not completed until 2/28/26. The assessment included new immediate intervention; would be to keep in common area when up in wheelchair, place slide strips, locking bed, moving bed against the wall, reminders frequently, hourly checks. Education given of the importance to wait for staff members.</p> <p>R1's record revealed interdisciplinary team (IDT) met on 4/28/26 to discuss the 4/28/26 fall. IDT note read the resident fell using the urinal at bedside, 18th fall since admit, and several of them were R1 using the urinal, IDT feels R1 will need to demonstrate the use of the urinal at bedside safely</p> |                                                                  |  | F0657                                                                                        | <p>Continued from page 9</p> <p>Facility will be in compliance by 8/18/26.</p>                                           |                                              | 08/18/2026                 |

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| F0657<br>SS = D                                                | <p>Continued from page 10<br/>where he doesn't need to stand up. IDT will ask<br/>therapy for ideas. Care plan to be updated.</p> <p>R1's therapy note 4/30/26 reads co-treatment<br/>details: PT/OT (Physical/Occupational Therapy)<br/>cotreat for urinal use and ambulation. R1 stood for 3<br/>minutes to utilize urinal.</p> <p>R1 record lack any further update and R1 continued<br/>to fall using his urinal on 5/8/26, and when using<br/>the toilet on 6/13/26.</p> <p>During an interview on 7/02/2026 at 12:26 p.m.,<br/>administrator and vice president of success (VPS)-A<br/>and B would expect interventions spoke about at IDT<br/>are followed and reviewed.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |  | F0657                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                              | 08/18/2026                 |
| F0690<br>SS = D                                                | <p>Bowel/Bladder Incontinence, Catheter, UTI</p> <p>CFR(s): 483.25(e)(1)-(3)</p> <p>§483.25(e) Incontinence.</p> <p>§483.25(e)(1) The facility must ensure that resident<br/>who is continent of bladder and bowel on admission<br/>receives services and assistance to maintain<br/>continence unless his or her clinical condition is or<br/>becomes such that continence is not possible to<br/>maintain.</p> <p>§483.25(e)(2)For a resident with urinary incontinence,<br/>based on the resident's comprehensive assessment,<br/>the facility must ensure that-</p> <p>(i) A resident who enters the facility without an<br/>indwelling catheter is not catheterized unless the<br/>resident's clinical condition demonstrates that<br/>catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an<br/>indwelling catheter or subsequently receives one is<br/>assessed for removal of the catheter as soon as<br/>possible unless the resident's clinical condition<br/>demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives<br/>appropriate treatment and services to prevent urinary<br/>tract infections and to restore continence to the<br/>extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence,<br/>based on the resident's comprehensive assessment,<br/>the facility must ensure that a resident who is<br/>incontinent of bowel receives appropriate treatment</p> |                                                                  |  | F0690                                                                                        | <p>F0690 – Bowel/Bladder Incontinence, Catheter, UTI</p> <p>Resident: R5 continues to reside at<br/>facility. R5 urinary incontinence care plan and int<br/>erventions were revised on 7/24/2026.</p> <p>Like residents: Executive Director completed<br/>a 14-day look back to identify residents with<br/>incontinence. 16 residents were identified to have<br/>the potential to be affected by this alleged deficient<br/>practice. Urinary incontinent care plan and<br/>interventions reviewed and revised as needed.</p> <p>Education: On 7/14/2026, the Director<br/>of Nursing/designee started re-educating licensed<br/>nurses and certified nursing assistants of<br/>incontinence interventions, ensuring completion and<br/>documentation is accurate. Knowledge check<br/>completed with licensed nurses and certified nursing<br/>assistants to validate understanding of incontinence<br/>interventions, ensuring completion and<br/>documentation is accurate.</p> <p>Audit: Director of Nursing/designee will<br/>conduct an audit on residents with episodes<br/>of incontinence to ensure care plan is followed<br/>related to urinary interventions. Audits will be<br/>conducted for 2 residents, on various<br/>shifts, three times a week for five weeks, or until<br/>substantial compliance is maintained. Results of this<br/>audit will be brought to Quality Assurance<br/>Performance Improvement for review and further<br/>recommendations.</p> |                                              | 08/18/2026                 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245270 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                     |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>07/02/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 |                                                                                                                          |                                              |                            |
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| F0690<br>SS = D                                                | <p>Continued from page 11<br/>and services to restore as much normal bowel<br/>function as possible.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and record review,<br/>the facility failed to follow care plan interventions<br/>requested by the resident for 1 of 1 resident (R5)<br/>reviewed for bladder incontinence.</p> <p>Findings include:</p> <p>R5 Quarterly Minimum Data Set (MDS) assessment<br/>dated 5/7/26, included intact cognition, no mood or<br/>behaviors, frequently incontinent with no toileting<br/>program.</p> <p>R5's care plan focus area for urinary incontinence<br/>related to functional incontinence with an<br/>intervention of a toileting plan: check and change<br/>every 2 hours starting in the am, between meals and<br/>at 10:30 p.m., then at 2-3 a.m., last check at 5a.m.</p> <p>During an observation and interview on 6/29/2026 at<br/>3:52 p.m., R5 lying in bed when asked about going<br/>to the bathroom, R5 said, she does not make it to<br/>the restroom all the time. Staff are to check and<br/>change her or go to the bathroom every two hours.<br/>R5 continues and said it does not happen all the<br/>time and added some staff are better than others.</p> <p>R5's care conference summary dated 4/2/26 reads<br/>resident requested care conference to discuss<br/>having more input in her cares. R5 felt staff were not<br/>listening to her when R5 was telling staff she had a<br/>urinary tract infection. Intervention in place was to<br/>check on resident every 2 hours to see if she needs<br/>to be changed.</p> <p>R5's quarterly Clinical Review Bladder and Bowel<br/>assessment dated 4/25/26 reads bladder incontinent<br/>and is wet 1-2 times daily.</p> <p>An email communication provided, including R5,<br/>involved the regional ombudsman regarding her<br/>cares. The ombudsman attended R5's April care<br/>conference where it was discussed R5's toileting<br/>and check and change every 2 hours.</p> <p>R5 checks and change at night and every 2-hour,<br/>check list was provided for the following dates<br/>6/29/26 through 7/2/26 indicating on 7/1/26 R5 was<br/>checked and changed at 6am, 8am, 10am, and noon.</p> <p>During an interview on 7/01/2026 at 8:45 a.m.,<br/>nursing assistant (NA)-A said R5 had not gotten up</p> |                                                                  |  | F0690                                                                                        | <p>Continued from page 11<br/>Facility will be in compliance by 8/18/26.</p>                                             |                                              | 08/18/2026                 |

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| F0690<br>SS = D                                                | <p>Continued from page 12<br/>for the day yet. When asked the last time R5 was checked and changed, NA-A indicated the night shift at 6am.</p> <p>During an observation on 7/01/2026 at 8:49 a.m., NA-A entered R5's room and walked right out.</p> <p>During an observation on 7/01/2026 at 9:26 a.m., activity staff knocked on the door open, walked in and out then closed door.</p> <p>During an observation and interview on 7/01/2026 at 11:50 a.m., NA-A indicated R5 is up and in her chair. R5 was sitting in her chair. When asked when staff got her up R5 said staff got her up about half hour ago.</p> <p>During an interview on 7/01/2026 at 12:13 p.m., NA-A was asked if R5 was wet with urine when she got her ready for the day. NA-A said yes and R5 was taken to the toilet where she continued to urinate and had a bowel movement.</p> <p>During an interview on 7/01/2026 at 2:04 p.m. NA-A verified she did not check on R5 until 10:30 a.m., NA-A indicated she did go in the room once but, R5 was having breakfast. NA-A confirmed R5's care plan includes check and change every 2 hours. NA-A confirmed she did not follow R5's care plan to check and change her every 2 hours. NA-A indicated they do not chart in real time and must complete at the end of the day.</p> <p>During an interview on 7/01/2026 at 6:05 p.m., administrator vice president of success (VPS)-A and B said they would expect staff to follow the care plan for checking and changing.</p> |                                                                  |  | F0690                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                              | 08/18/2026                 |
| F0842<br>SS = D                                                | <p>Resident Records - Identifiable Information</p> <p>CFR(s): 483.20(f)(5),483.70(h)(1)-(5)</p> <p>§483.20(f)(5) Resident-identifiable information.</p> <p>(i) A facility may not release information that is resident-identifiable to the public.</p> <p>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(h) Medical records.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                  |  | F0842                                                                                        | <p>F0842 – Resident Records – Identifiable Information</p> <p>Resident: R29 no longer resides in facility.</p> <p>Like Residents: Current residents that have expired have the potential to be affected by this alleged deficient practice. Vice President of Success completed an audit on 7/29/2026 of residents who expired i n the last 14 days. Documentation was accurate f or death records.</p> <p>Education: On 7/29/26 Vice President of Success re-educated Executive Director and Director of</p> |                                              | 08/18/2026                 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245270 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X3) DATE SURVEY COMPLETED<br><br>07/02/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              |                            |
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| F0842<br>SS = D                                                | <p>Continued from page 13</p> <p>§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain-</p> |                                                                  |  | F0842                                                                                        | <p>Continued from page 13</p> <p>Nursing validating accurate documentation is completed for death records.</p> <p>On 7/27/26, the Director of Nursing/designee started re-educating licensed nurses on accurate documentation for death records.</p> <p>Audit: Director of Nursing/designee will conduct audits on death record documentation weekly times 5 weeks. Results of this audit will be brought to Quality Assurance Performance Improvement for review and further recommendations.</p> <p>Facility will be in compliance by 8/18/26.</p> |                                              | 08/18/2026                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 |                                                                                                                          |                                              |                            |
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| F0842<br>SS = D                                                | <p>Continued from page 14</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review the facility failed to maintain a medical record that was complete, accurate and readily accessible for 1 of 1 resident (R29) reviewed for death record.</p> <p>Findings include:</p> <p>R29's Hospital Discharge summary revealed being discharged to the nursing home on 4/8/26 in stable condition.</p> <p>R29's Provider Orders for Life-Sustaining Treatment (POLST) dated 4/9/2026 reads attempt CPR.</p> <p>R29's death record reads date of death 4/14/26</p> <p>R29's Minimum Data Set assessment dated 4/17/26 indicates death in facility.</p> <p>R29's progress lacked documentation of R29 death in the facility or what had happened.</p> <p>R29's encounter date 4/14/26 at 9:58 a.m., received call R29 passed away this morning, CPR started, 911 called.</p> <p>State agency asked for R29's incident report and or medical record to include items that would have anything to do with the day of R29's death. Upon follow of request, it was brought to the attention there was no incident report or progress note of what occurred the day of R29's death.</p> <p>During an interview on 7/01/2026 at 6:52 p.m., administrator, vise president of success (VPS) A and B verified the facility did not have documents of</p> |                                                                  |  | F0842                                                                                        |                                                                                                                          |                                              | 08/18/2026                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                |                                                                     |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 |                                                                                                                          |                                              |                            |
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| F0842<br>SS = D                                                | Continued from page 15<br>what occurred the morning of 4/14/26 regarding R29<br>death. VPS-A offered to review a notebook of notes<br>taken during an interdisciplinary team meeting (IDT)<br>discussed the death in facility. |                                                                     |  | F0842                                                                                        |                                                                                                                          |                                              | 08/18/2026                 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245270 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILD...<br><br>B. WING                  |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>06/30/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 |                                                                                                                          |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |  | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                              | (X5)<br>COMPLETION<br>DATE |
| K0000<br>Bldg. 01                                              | <div>INITIAL COMMENTS</div> <div>FIRE SAFETY</div> <div>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/30/2026. At the time of this survey, WHITEWATER HEALTH SERVICES 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.</div> <div>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.</div> <div>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.</div> <div>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</div> <div>If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required.</div> <div>Healthcare Fire Inspections</div> <div>State Fire Marshal Division</div> <div>445 Minnesota St., Suite 145</div> |                                                                  |  | K0000                                                                                        |                                                                                                                          |                                              | 08/18/2026                 |

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

|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
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| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 |                                                                                                                          |                                              |                            |
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| K0000<br>Bldg. 01                                              | <p>Continued from page 1<br/>St. Paul, MN 55101-5145, OR</p> <p>By email to:</p> <p>FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <p>A detailed description of the corrective action taken or planned to correct the deficiency.</p> <p>Address the measures that will be put in place to ensure the deficiency does not reoccur.</p> <p>Indicate how the facility plans to monitor future performance to ensure solutions are sustained.</p> <p>Identify who is responsible for the corrective actions and monitoring of compliance.</p> <p>The actual or proposed date for completion of the remedy.</p> <p>WHITEWATER HEALTH SERVICES is a 1 story building with partial basements.</p> <p>The building was constructed at 2 different times. The original building was constructed in 1967 and is a 1 structure with partial basement and was determined to be Type II ( 111 ) construction. In 1969 a 1 story addition with partial basement was constructed and determined to be of Type II ( 111 ) construction.</p> <p>Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.</p> <p>The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification.</p> |                                                                  |  | K0000                                                                                        |                                                                                                                          |                                              | 08/18/2026                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                    |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 |                                                                                                                          |                                              |                            |
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| K0000<br>Bldg. 01                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Continued from page 2                                                                                                                                                                                                                                                                                                              |                                                                  |  | K0000                                                                                        |                                                                                                                          |                                              | 08/18/2026                 |
| K0353<br>SS = F<br>Bldg. 01                                                                                                                                                                                                                                                                                                                                                                                                                                        | The facility has a capacity of 45 beds and had a census of 27 at the time of the survey.                                                                                                                                                                                                                                           |                                                                  |  | K0353                                                                                        | Deficiency K0353: Defective Sprinkler Heads                                                                              |                                              | 08/18/2026                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:                                                                                                                                                                                                                                                            |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Sprinkler System - Maintenance and Testing                                                                                                                                                                                                                                                                                         |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CFR(s): NFPA 101                                                                                                                                                                                                                                                                                                                   |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Sprinkler System - Maintenance and Testing                                                                                                                                                                                                                                                                                         |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | a) Date sprinkler system last checked                                                                                                                                                                                                                                                                                              |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | b) Who provided system test                                                                                                                                                                                                                                                                                                        |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | c) Water system supply source                                                                                                                                                                                                                                                                                                      |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.                                                                                                                                                                                                                             |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
| 9.7.5, 9.7.7, 9.7.8, and NFPA 25                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                    |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
| This STANDARD is NOT MET as evidenced by:                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                    |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
| Based on observation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, section(s) 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, 5.2.1.1.2(5)(6). These deficient findings could have a widespread impact on the residents within the facility. |                                                                                                                                                                                                                                                                                                                                    |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
| Findings include:                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                    |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |
| On 06/30/2026 at 11:15 AM, it was revealed by observation in the WEST Shower Room, exhibited                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                    |                                                                  |  |                                                                                              |                                                                                                                          |                                              |                            |

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| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              |                            |
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| K0353<br>SS = F<br>Bldg. 01                                    | Continued from page 3<br>signs of debris loading sprinkler head(s).<br><br>On 06/30/2026 at 11:20 AM, it was revealed by observation in the EAST Shower Room, exhibited signs of paint on the deflector of a sprinkler head.<br><br>An interview with the Maintenance Director verified these deficient findings at the time of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                  |  | K0353                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                              | 08/18/2026                 |
| K0372<br>SS = F<br>Bldg. 01                                    | Subdivision of Building Spaces - Smoke Barrie<br><br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br><br>2012 EXISTING<br><br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br><br>19.3.7.3, 8.6.7.1(1)<br><br>Describe any mechanical smoke control system in REMARKS.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on a review of available documentation and staff interview, the facility failed to properly maintain fire/smoke dampers in accordance with NFPA 101 (2012 edition), Life Safety Code, section(s) 8.4.6, 8.5.5, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section(s) 6.4, 6.5, 6.6. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 06/30/2026 between 09:00 AM and 1:30 PM, it was revealed by a review of available documentation that vendor documentation was unavailable to confirm fire / smoke damper testing had been completed since 12/08/2021 |                                                                  |  | K0372                                                                                        | Deficiency K0372: Lack of Fire Damper Testing Documentation<br><br>The Maintenance Director received an inspection report for fire damper testing from Winona Heating and Ventilation on 6/30/2026. The Maintenance Director and Executive Director will ensure testing reports are received after future scheduled inspections.<br><br>Please refer to Attachment 2: Winona Heat and Ventilation work order and damper assessment.<br><br>Facility will be in compliance by 8/18/26 |                                              | 08/18/2026                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                              |                            |
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| K0372<br>SS = F<br>Bldg. 01                                    | Continued from page 4<br>An interview with the Maintenance Director verified this deficient finding at the time of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                  |  | K0372                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                              | 08/18/2026                 |
| K0761<br>SS = F<br>Bldg. 01                                    | <div>Maintenance, Inspection &amp; Testing - Doors</div> <div>CFR(s): NFPA 101</div> <div>Maintenance, Inspection &amp; Testing - Doors</div> <div>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.</div> <div>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.</div> <div>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.</div> <div>Written records of inspection and testing are maintained and are available for review.</div> <div>19.7.6, 8.3.3.1 (LSC)</div> <div>5.2, 5.2.3 (2010 NFPA 80)</div> <div>This STANDARD is NOT MET as evidenced by:</div> <div>Based on observation and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, section(s) 19.2.2.2, 7.2.1.15 and NFPA 80 (2010 edition), section(s) 5.2.1. This deficient finding could have a widespread impact on the residents within the facility.</div> <div>Findings include:</div> <div>On 06/30/2026 between 09:00 AM and 1:30 PM, it was revealed by observation that Kitchen / Dishwashing fire rated door did not self-close and seal the opening upon test.</div> <div>An interview with the Maintenance Director verified this deficient finding at the time of discovery.</div> |                                                                  |  | K0761                                                                                        | <div>Deficiency K0761: Kitchen/Dishwashing Fire Rated Door Not Self-Closing</div> <div>Maintenance Director repaired the kitchen fire door on 7/7/2026. The Maintenance Director then did a full building walk through to ensure all other self-closing doors were operating properly. The Maintenance Director now has a monthly review of all self–closing doors in the building, and it has been added to the preventative maintenance program.</div> <div>Please refer to pictures 3A, 3B, and 3C</div> <div>Facility will be in compliance by 8/18/26</div> |                                              | 08/18/2026                 |
| K0914<br>SS = F<br>Bldg. 01                                    | <div>Electrical Systems - Maintenance and Testing</div> <div>CFR(s): NFPA 101</div> <div>Electrical Systems - Maintenance and Testing</div>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                  |  | K0914                                                                                        | <div>Deficiency K0914: Electrical Outlet Testing Incomplete</div> <div>The Maintenance Director corrected all documentation related to outlet testing on 7/8/2026.</div>                                                                                                                                                                                                                                                                                                                                                                                         |                                              | 08/18/2026                 |

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| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 |                                                                                                                                                                                                                                                                                                                                                                             |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                  |  | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                    |                                              | (X5)<br>COMPLETION<br>DATE |
| K0914<br>SS = F<br>Bldg. 01                                    | <p>Continued from page 5</p> <p>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.</p> <p>6.3.4 (NFPA 99)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on a review of available documentation and staff interview, the facility failed to conduct annual electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4.1, 6.3.4.1.3, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 06/30/2026 between 09:00 AM and 1:30 PM, it was revealed by a review of available documentation that documentation presented associate to annual electrical outlet testing was incomplete in data capture associated with outlets being tested, missing technician(s) completing testing, missing date(s) of testing, and confirmation when annual testing was completed.</p> <p>An interview with the Maintenance Director verified these deficient findings at the time of discovery.</p> |                                                                  |  | K0914                                                                                        | <p>Continued from page 5</p> <p>Executive Director re-educated Maintenance Director on 7/8/26 on how to complete outlet testing paperwork properly. The Maintenance Director will ensure annual outlet testing is complete per the maintenance preventative program.</p> <p>Please refer to pictures 4A, 4B, 4C and 4D</p> <p>Facility will be in compliance by 8/18/26</p> |                                              | 08/18/2026                 |
| K0923<br>SS = F<br>Bldg. 01                                    | <p>Gas Equipment - Cylinder and Container Storag</p> <p>CFR(s): NFPA 101</p> <p>Gas Equipment - Cylinder and Container Storage</p> <p>Greater than or equal to 3,000 cubic feet</p> <p>Storage locations are designed, constructed, and</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  |  | K0923                                                                                        | <p>Deficiency K0923: Med Gas (O2) Room Mixed Storage</p> <p>The Maintenance Director corrected the Med Gas Room on 7/1/2026 by removing the combustible storage and cylinder were put in the corresponding rack for Full and Empty. A green sign reading "FULL" and a red sign reading</p>                                                                                  |                                              | 08/18/2026                 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>245270 |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILD...<br><br>B. WING                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X3) DATE SURVEY COMPLETED<br><br>06/30/2026 |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                              |                            |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                  |  | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                   |                                              | (X5)<br>COMPLETION<br>DATE |
| K0923<br>SS = F<br>Bldg. 01                                    | <p>Continued from page 6<br/>ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.</p> <p>&gt;300 but &lt;3,000 cubic feet</p> <p>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.</p> <p>Less than or equal to 300 cubic feet</p> <p>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.</p> <p>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."</p> <p>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 confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>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(s) 11.3, 11.3.2.3, 11.6.2.3, 11.6.5. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 06/30/2026 at 11:30 AM, it was revealed by observation that in the Med Gas ( O2 ) Room there was mixed storage of empty / full cylinders and</p> |                                                                  |  | K0923                                                                                        | <p>Continued from page 6<br/>"EMPTY" have been added to the Med Gas room. Director of Nursing/designee re-educated licensed nurses starting on 7/24/26 on proper Oxygen Cylinder Storage and Handling. The Maintenance Director has added a full inspection of the Med Gas (O2) Room (Oxygen Storage Room) to his weekly maintenance preventative program. Please refer to pictures 5A, 5B, 5C and Attachment 5: Oxygen Training Form</p> <p>Facility will be in compliance by 8/18/26</p> |                                              | 08/18/2026                 |

FORM CMS-2567 (02/99) Previous Versions Obsolete      Event ID: 231B54-L1      Facility ID: 00942      If continuation sheet Page 8 of 8