



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 28, 2025

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

RE: CCN: 245270

Cycle Start Date: May 14, 2025

Dear Administrator:

On June 30, 2025, and July 2, 2025, we notified you a remedy was imposed.

On August 14, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 23, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 14, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of July 2, 2025, 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 June 17, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 23, 2025, 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 Therefore, the NATCEP prohibition is rescinded.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,

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
PO Box 64975 | 625 Robert Street North  
St. Paul, MN 55164-0975  
Office: 651-201-4384  
Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)



Electronically delivered

August 28, 2025

Administrator

WHITEWATER HEALTH SERVICES

525 BLUFF AVENUE

ST CHARLES, MN 55972

Re: Reinspection Results

Event ID: HSOX11

Dear Administrator:

On June 25, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 14, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler".

Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
PO Box 64975 | 625 Robert Street North  
St. Paul, MN 55164-0975  
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Electronically delivered  
June 30, 2025

Administrator  
Whitewater Health Services  
525 Bluff Avenue  
St Charles, MN 55972

RE: CCN: 245270  
Cycle Start Date: May 14, 2025

Dear Administrator:

On May 30, 2025, we informed you that we may impose enforcement remedies.

On June 17, 2025, the Minnesota Department of Public Safety 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected is/are as follows:

K0346 - Fire Alarm System - Out of Service, S/S C  
K0354 - Sprinkler System - Out of Service, S/S C  
K0541 - Rubbish Chutes, Incinerators, and Laundry Chute, S/S D

## 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 August 14, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 14, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 14, 2025.

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 August 14, 2025, 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 August 14, 2025. 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 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

#### 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 November 14, 2025 (six months after the identification of noncompliance) 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](mailto: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,



Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
PO Box 64975 | 625 Robert Street North  
St. Paul, MN 55164-0975  
Office: 651-201-4384  
Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)



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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>A. BUILDING 01 - MAIN BUILDING 0...<br><br>B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | (X3) DATE SURVEY COMPLETED<br><br>06/17/2025 |  |
| 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                                                          | INITIAL COMMENTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                     | K0000               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                              |  |
| K0346<br>SS = C                                                | <p>Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey.</p> <p>Fire Alarm System - Out of Service</p> <p>CFR(s): NFPA 101</p> <p>Fire Alarm - Out of Service</p> <p>Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.</p> <p>9.6.1.6</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey.</p> |                                                                     | K0346               | <p>The Fire Alarm System Out of Service Policy was updated to include the AHJ Deputy Fire Marshal Inspector assigned to the St. Charles Area. Their point of contact and phone number have been added. The Fire Alarm Out of Service Policy was also updated to include AHJ- MN department of Health point of contact and phone number.</p> <p>The policies were put into the Emergency Operations Plan Binder and put at the nurses station for access.</p> <p>Executive Director or designee will monitor and update emergency contacts within the EOP Annually as required or more frequently if needed.</p> <p>All corrections were completed on 7/7/2025</p>      |  | 07/07/2025                                   |  |
| K0354<br>SS = C                                                | <p>Sprinkler System - Out of Service</p> <p>CFR(s): NFPA 101</p> <p>Sprinkler System - Out of Service</p> <p>Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service.</p> <p>18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)</p>                                                                                                        |                                                                     | K0354               | <p>The Sprinkler System Out of Service Policy was updated to include the AHJ Deputy Fire Marshal Inspector assigned to the St. Charles Area. Their point of contact and phone number have been added. The Sprinkler System Out of Service Policy was also updated to include AHJ- MN department of Health point of contact and phone number.</p> <p>The policies were put into the Emergency Operations Plan Binder and put at the nurses station for access.</p> <p>Executive Director or designee will monitor and update emergency contacts within the EOP Annually as required or more frequently if needed.</p> <p>All corrections were completed on 7/7/2025</p> |  | 07/07/2025                                   |  |

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

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



|                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                     |                                                                                                                                                                                                                                                                                                                                                   |  |                                              |  |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>245270 |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 0...<br><br>B. WING                                                                                                                                                                                                                                                                  |  | (X3) DATE SURVEY COMPLETED<br><br>06/17/2025 |  |
| 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                   |  |
| K0354<br>SS = C                                                | Continued from page 1<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     | K0354               |                                                                                                                                                                                                                                                                                                                                                   |  |                                              |  |
| K0541<br>SS = D<br><br>Bldg. 01                                | Rubbish Chutes, Incinerators, and Laundry Chu<br><br>CFR(s): NFPA 101<br><br>Rubbish Chutes, Incinerators, and Laundry Chutes<br><br>2012 EXISTING<br><br>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5.<br><br>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.<br><br>(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.)<br><br>(4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use.<br><br>19.5.4, 9.5, 8.4, NFPA 82<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey. |                                                                     | K0541               | The Maintenance Director fixed the laundry chute door by tightening the door closer and adjusting the hinge. On 7/7/2025 door closer was replaced.<br><br>Maintenance Director or designee will audit the laundry chute door (on the 100 wing) 3 times a week for 6 weeks to ensure compliance.<br><br>All corrections were completed on 7/7/2025 |  | 07/07/2025                                   |  |





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

Electronically delivered  
May 30, 2025

Administrator  
Whitewater Health Services  
525 Bluff Avenue  
St Charles, MN 55972

RE: CCN: 245270  
Cycle Start Date: May 14, 2025

Dear Administrator:

On May 14, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.



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

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

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

## DEPARTMENT CONTACT

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

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 August 14, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 14, 2025 (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:



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,



Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
PO Box 64975 | 625 Robert Street North  
St. Paul, MN 55164-0975  
Office: 651-201-4384  
Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)



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

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE<br/>ST CHARLES, MN 55972</b>                                                                                                                                                                                           |                            |                                                        |
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| F 000                                                                 | INITIAL COMMENTS<br><br>On 5/11/25 to 5/14/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<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. | F 000                                                                      |                                                                                                                                                                                                                                                                                     |                            |                                                        |
| F 554<br>SS=D                                                         | Resident Self-Admin Meds-Clinically Approp<br>CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure a self-administration of medication (SAM) assessment was completed for 1 of 1 resident's (R16) reviewed for medication administration.<br><br>Findings include:                                                                                                                                                                                                                                                                                                    | F 554                                                                      | F544 Self Administration of Medication<br>What Corrective actions will be accomplished for those residents found to have been affected by the deficient practice.<br>R16's POA/family does not want resident self-administering medications. All licensed staff were re-educated by | 6/12/25                    |                                                        |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE  |
| Electronically Signed                                                 |       | 06/09/2025 |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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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| F 554                                                                 | <p>Continued From page 1</p> <p>R16's quarterly Minimum Data Set (MDS) assessment dated 4/12/25 indicated R16 was cognitively intact.</p> <p>R16's provider orders, included an order for Nystatin antifungal powder to both breasts and groin folds every 12 hours as needed .</p> <p>During observation on 5/14/25 at 7:17 a.m., registered nurse (RN)-A dispensed antifungal powder in a medication cup, walked to R16's room, and handed the medication cup to the director of nursing (DON) who was already in the room. The DON then placed the cup of powder on R16's bedside table and left the room. The DON stated R16 was getting ready for the day and would apply the powder herself when she is ready.</p> <p>During interview on 5/14/25 at 10:55 a.m., RN-A stated she did not think any current residents had a SAM assessment. RN-A stated a SAM assessment is needed to determine if a resident is safe to administer prescribed medications. Once a resident is deemed safe, a provider order is required for medications to be left at bedside. RN-A stated the SAM assessment is important to make sure the resident does not forget to take the medication. RN-A indicate all prescribed medications required a SAM assessment prior to leaving the medication at the bedside. RN-A confirmed R16 did not have a SAM assessment on file.</p> <p>During an interview on 5/14/25 at 11:20 a.m., the assistant director of nursing (ADON) stated residents who chose to have medications left at bedside would require an assessment for safety</p> | F 554                                                                      | <p>reviewing the policies of Medication Administration and Medication Administration Self-Administration by Resident.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>No other residents were affected. All in house residents had the potential to be affected.</p> <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>All licensed staff were re-educated by reviewing the policies of Medication Administration and Medication Administration Self-Administration by Resident.</p> <p>DON and licensed staff will be in-serviced on self-administration of medication policy by June 12th. Any residents wanting to self-administer medications will have a self-administration assessment completed to see if they have the ability and follow the regulations. Self-administrations assessments will be completed initially, quarterly, annually and with significant changes. The protocol for self-administration will be followed. These assessments will be provided to the Medical Director for evaluation and signature if appropriate.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>IDT committee will review and discuss</p> |  |                                                        |



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| F 554                                                                 | Continued From page 2<br><br>and a provider order to leave the medication at<br>bedside. The ADON stated there are currently no<br>residents who require a SAM assessment. The<br>ADON stated narcotics are not allowed to be<br>administered independently however all other<br>medications are evaluated on a "case by case<br>basis". The ADON stated medications cannot be<br>left with residents unless a SAM is performed to<br>ensure residents are deemed safe to administer<br>the medication properly. Self-administration<br>assessments are reviewed every 3 months for<br>safety and is documented .<br><br>Facility policy titled Medication Administration<br>General-Guidelines dated 1/2023, included<br>Residents are allowed to self -administer<br>medications when specifically authorized by the<br>prescriber, the nursing care center's<br>Interdisciplinary Team (IDT), and in accordance<br>with procedures for self-administration of<br>medications and state regulations. |                                                                            |  | F 554                                                                                     | residents that wish to self-administer<br>medications. The residents who have<br>demonstrated the ability and desire to<br>self-administer meds in a safe manner will<br>be observed by the DON/Designee doing<br>this self-administration. DON/Designee<br>will complete 2 random medication pass<br>audits weekly for 6 weeks. All audits will<br>be brought to QAPI for review and<br>analysis with the Medical Director. |                                                        |                            |
| F 577<br>SS=C                                                         | Right to Survey Results/Advocate Agency Info<br>CFR(s): 483.10(g)(10)(11)<br><br>§483.10(g)(10) The resident has the right to-<br>(i) Examine the results of the most recent survey<br>of the facility conducted by Federal or State<br>surveyors and any plan of correction in effect with<br>respect to the facility; and<br>(ii) Receive information from agencies acting as<br>client advocates, and be afforded the opportunity<br>to contact these agencies.<br><br>§483.10(g)(11) The facility must--<br>(i) Post in a place readily accessible to residents,<br>and family members and legal representatives of<br>residents, the results of the most recent survey of<br>the facility.                                                                                                                                                                                                                                                                                                        |                                                                            |  | F 577                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                        | 6/12/25                    |



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| F 577                                                                 | <p>Continued From page 3</p> <p>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and</p> <p>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.</p> <p>(iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to ensure the facility's state survey results were kept in a location readily accessible to all residents and/or visitors. This had the potential to affect all 22 residents and/or visitors who could wish to review the information.</p> <p>Findings include:</p> <p>R16's quarterly Minimum Data Set (MDS) assessment dated 4/12/25, indicated R16 had intact cognition.</p> <p>During resident council meeting on 5/12/25 at 10:50 a.m., R16 (resident council president) stated she did not know the state survey results were available to be read and confirmed she would be interested in seeing them.</p> <p>During observation and interview on 5/12/25 at 11:21 a.m., social worker (SW) said the facility had a survey binder and was unsure where the binder was located. SW walked out to main atrium and could not readily find the survey results binder.</p> | F 577                                                                      | <p>F577 Right to Survey Results/Advocate Agency Info</p> <p>Corrective Action taken for those residents alleged to have been affected by the deficient practice are:</p> <p>Survey binder was moved to the wired stand at the front entrance. It was updated and placed on 5/12/25. R16 was informed and shown where survey binder is located on 5/12/25. R16 is no longer a resident at facility.</p> <p>Actions taken to identify other residents that may have been affected by the deficient practice are:</p> <p>Residents wishing to review survey results have the potential to be affected by the alleged practice.</p> <p>The measures the facility will take to ensure the problem will be corrected and will not reoccur:</p> <p>Social Services/designee will remind residents during Resident Council of the location of the survey binders at least once a quarter. ED and Social Services re-inserviced immediately by VPS on</p> |  |                                                        |



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| F 577                                                                 | Continued From page 4<br><br>During observation and interview on 5/12/25 at 12:00 p.m., assistant director of nursing (ADON) and corporate vice president of success (VP) had located the survey binder stacked amongst other facility binders, out of sight of residents and others who may want to review. ADON confirmed the survey binder should be in a visible location and easily accessible .<br><br>A policy regarding posting survey results was requested and not received.                                                                                                                                                                                                                                                                                                                                  | F 577                                                                      | updating survey binders with respect to 3 preceding years annual and complaint surveys and to ensure placement where it is easily accessible to residents, family members and legal representatives<br>Quality Assurance plan to monitor facility performance to make sure corrections are achieved:<br>Social Services / designee will audit the clear and easily located survey binders twice weekly x 6 weeks to ensure compliance. The results of these audits will be brought to QAPI monthly x 2 months for review and recommendations. |                            |                                                        |
| F 655<br>SS=D                                                         | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable. | F 655                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6/12/25                    |                                                        |



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| F 655                                                                 | <p>Continued From page 5</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission.</p> <p>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident.</p> <p>(ii) A summary of the resident's medications and dietary instructions.</p> <p>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to complete and implement a baseline care plan within 48 hours of admission for 1 of 2 residents (R125) reviewed for new admissions.</p> <p>Findings include:</p> <p>R125's face sheet, indicated R125 admitted on 5/7/25; diagnosis include, heart failure, respiratory disease, right lower leg pressure ulcer (reduce blood pressure to body area, leading to skin and tissue damage), left lower leg pressure ulcer, right hip pressure ulcer, perineum (area of sensitive skin between genitals and anus) wound, spinal vertebrae pain, lumbar pain, adult failure to</p> | F 655                                                                      | <p>F655 Baseline Care Plan</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice:</p> <p>1.</p> <p>R125 baseline care plan was completed on 6/9/25</p> <p>Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken:</p> <p>All new admission residents could have the potential to be affected by deficient practice. An audit of all new and readmissions in the last 3 months was</p> |  |                                                        |



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

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| F 655                                                                 | <p>Continued From page 6</p> <p>thrive and a new diagnosis of urinary retention requiring a urinary catheter to drain bladder.</p> <p>R125's resident admission Minimum Data Set (MDS) assessment was not completed at time of survey. R125's cognitive function was intact.</p> <p>R125's a baseline care plan had not been initiated at time of survey; pain management treatment and goals had not been assessed.</p> <p>During interview on 5/12/25 at 10:39 a.m., R125 stated she has been in pain all morning, stated she was given Tylenol (used to help relieve pain) and some other medication this morning but the medications are not helping her with her pain. R125 stated her pain is where the urinary catheter is, she described it as a burning pain. R125 stated she is miserable here and just wants the pain to subside even for just a little bit. R125 stated no one at the facility had asked her what her pain goals were; she stated her goal would be a pain score of less than 2/10.</p> <p>During interview on 5/13/25 at 11:43 a.m., assistant director of nursing (ADON) and director of nursing (DON) stated R125 experiences pain frequently, and her pain has been high since arriving to the facility. ADON stated the initial goal was to try non-pharmacological options first. DON stated facility staff would be able to locate resident-specific needs in the resident care plan. Upon review, ADON confirmed a resident-specific care plan focus on pain had not been completed at the time of this interview.</p> <p>A facility care plan policy was requested and not received.</p> | F 655                                                                      | <p>completed 6/9/25 to verify a Baseline Care Plan was completed. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur:</p> <p>The nursing staff, MDS/Care Plan Coordinator and IDT will be in-serviced on the policy and procedure for baseline care plans. Baseline care plans are to be implemented on admission and readmission for all residents within 48 hours. In-service will be held by 6/12/25. Monitoring of corrective action to ensure the deficient practice will not reoccur: Director of Nursing or designee will audit new resident's charts for Baseline Care Plan being completed within 48 hours of admission. Audits will occur 2 x weekly for 6 weeks to review the need for continued intervention or amendment of plan. All audits will be brought to QAPI for review and analysis.</p> |  |                                                        |



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| F 697<br>F 697<br>SS=D                                                | <p>Continued From page 7</p> <p>Pain Management<br/>CFR(s): 483.25(k)</p> <p>§483.25(k) Pain Management.<br/>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and document review, the facility failed to identify, treat, follow up on pain and offer non-pharmacological interventions for 1 of 1 resident (R125) reviewed for pain management who was newly admitted.</p> <p>Findings include:</p> <p>R125's resident admission Minimum Data Set (MDS) assessment was not completed at time of survey. R125's had intact cognitive.</p> <p>R125 was admitted on 5/7/25 following a hospital stay, R125's diagnosis include, heart failure, respiratory disease, right lower leg pressure ulcer (reduce blood pressure to body area, leading to skin and tissue damage), left lower leg pressure ulcer, right hip pressure ulcer, perineum (area of sensitive skin between genitals and anus) wound, spinal vertebrae pain, lumbar pain, adult failure to thrive and a new diagnosis of urinary retention requiring a urinary catheter to drain bladder.</p> <p>R125's record lacked a baseline care plan. R125's pain management, treatment and goals was not assessed upon admission.</p> <p>R125's orders included Lyrica (Pregabalin-an</p> |                                                                            |  | F 697<br>F 697                                                                            | <p>F697 Pain Management<br/>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br/>R125's Lyrica order was amended to include pain assessment on administration. All current active pain medication orders have been updated to include pain scale pre and post administration, as well as non-pharmacological pain interventions attempted prior to pain medications being administered.<br/>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;<br/>Director of Nursing/Designee reviewed all in house residents active pain medication orders to ensure all ordered pain medications included a pain rating scale and non-pharmacological interventions.<br/>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;<br/>Licensed Nurses to be in-serviced by DON/designee on the Pain Management</p> |                                                        | 6/12/25                    |



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| F 697                                                                 | <p>Continued From page 8</p> <p>anticonvulsant that can be used for nerve pain) 50 milligrams (mg) two times a day for pain, acetaminophen (a pain medication) 1000 mg every 6 hours for pain. Pain level was to be assessed each time the scheduled acetaminophen medication was administered.</p> <p>R125's May treatment administration record (TAR), included document any non-pharmacological pain interventions attempted. Interventions-ice, relaxation/distraction, repositioning, re-medication, notify MD, diversional activities, music, re-repositioning, warm blanket, stretching, massage, rest, reduce stimuli, and other. R125's TAR included, Resident pain level every shift, use PAINAD (is a five-item observational tool to measure pain in people with dementia. It evaluates breathing, vocalization, facial expression, body language, and consolability) if resident unable to verbalize pain.</p> <p>R125's TAR lacked non-pharmacological pain interventions attempted for the following dates 5/8/25, 5/9/25, 5/10/25, and 5/11/25. R125's Pain Interview with Pain Management Review dated 5/12/25, indicated R125 had pain almost constantly over the past five days with an intensity rating as high as nine out of ten at times. The review of progress notes indicated staff had noticed vocal complaints of pain from R125 daily. The review indicated R125 received scheduled pain medication, but pain assessment was not completed for one of the two pain medications.</p> <p>R125's record included:<br/>-5/10/25 at 6:00 p.m., 1000mg acetaminophen was administered with pain rated 8/10.<br/>-5/10/25 at 8:00 p.m., 50mg Lyrica</p> | F 697                                                                      | <p>Policy and Procedure. This includes pain assessments, pain control, non-pharmacological interventions, following care plans on resident's pain control, and notification to primary providers if current measures ineffective on uncontrolled pain on 6/12/25. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Director of Nursing/Designee will conduct audits on all residents ordered pain medications and non-pharmacological interventions had been administered, pain ratings documented, and nonpharmacological interventions attempted as per physician order with adequate pain control. Audits will be conducted twice weekly for 6 weeks. Any discrepancies noted on weekly audits will be reported to Attending Physician for affected resident by Director of Nursing/Designee. Results of all audits will be reviewed in the next scheduled monthly Quality Assurance Performance Improvement Committee meeting. The Quality Assurance Committee will assess and modify the action plan as needed and evaluate any ongoing need to ensure continued compliance.</p> |                            |                                                        |



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| F 697                                                                 | <p>Continued From page 9</p> <p>-5/10/25 at 10:29 p.m., R125 was calling out in pain, stating her pain is 8/10.</p> <p>-5/11/25 at 12:00 a.m., 1000mg acetaminophen was administered with pain rated 6/10.</p> <p>-5/11/25 at 6:00 a.m., 1000mg acetaminophen was administered with pain rated 5/10.</p> <p>-5/11/25 at 6:09 a.m., resident calling out in pain, stating to staff her pain is 8/10.</p> <p>-5/11/25 at 8:00 a.m., 50mg Lyrica</p> <p>-5/11/25 at 9:47 p.m., resident calling out in pain, stating to staff her pain is unbearable</p> <p>-5/11/25 at 12:00 p.m., 1000mg acetaminophen was administered with pain rated 5/10.</p> <p>-5/11/25 at 2:09 p.m., resident calling out in pain, stating to staff her pain is 8/10.</p> <p>-5/11/25 at 6:00 p.m., 1000mg acetaminophen was administered with pain rated 8/10.</p> <p>-05/11/25 6:32 p.m., resident stated the catheter is unbearable pain</p> <p>-5/11/25 at 8:00 p.m., 50mg Lyrica</p> <p>-5/11/25 at 11:37 p.m., resident calling out in pain</p> <p>-5/12/25 at 12:00 a.m., 1000mg acetaminophen was administered with pain rated 2/10.</p> <p>-5/12/25 at 3:27 a.m., pain is rated 2/10 (bilateral lower extremities, urinary catheter pain (noted to be draining clear yellow urine)</p> <p>-5/12/25 at 6:00 a.m., 1000mg acetaminophen was administered with pain rated 2/10.</p> <p>-5/12/25 at 8:00 a.m., 50mg Lyrica</p> <p>During observation on 5/11/25 at 6:20 p.m.,R125's call was on, nursing assistant (NA)-C entered the room and, told R125 the registered nurse (RN) would be in shortly to help her. R125 could be heard crying out in pain, stated she can't take this pain much longer, shouting out she doesn't understand why her pain isn't being treated.</p> | F 697                                                                      |                                                                                                                          |                            |                                                        |



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| F 697                                                                 | <p>Continued From page 10</p> <p>During observation on 5/12/25 at 9:25 a.m., R125 crying out, "oh, oh this pain is terrible" and "ahh, ahh, make it stop"</p> <p>During observation on 5/12/25 at 10:02 a.m., R125 called out in pain, "ahh, oh , oh , someone help me" "owww, help it hurts so bad"</p> <p>During observation on 5/12/25 at 10:29 a.m., R125 calling out in pain "ahh, this hurts so bad, oh, please help me"</p> <p>During interview on 5/12/25 at 10:39 a.m., R125 stated she has been in pain all morning, stated she was given acetaminophen and some other medication this morning but the medications are not helping her with her pain. R125 stated her pain is where the urinary catheter is, she described it as a burning pain. R125 stated she is miserable here and just wants the pain to subside even for just a little bit.</p> <p>During interview on 5/13/25 at 10:22 a.m., NA-C stated she will check on each resident as often as she is able. NA-C stated she will update the nurse right away when a resident complains of pain or sounds like the resident is in pain. NA-C stated if she answers the same resident call light again and the resident had not been seen by the nurse NA-C stated she would remind the nurse. In addition, NA-C would assist the resident with anything while waiting for the nurse to give pain medications. NA-C stated she would expect pain to be treated within 10-15 minutes of staff notification.</p> <p>During interview on 5/13/25 at 7:55 a.m., RN-A stated she was unsure how long R125 had her light on and knew R125 was having pain. RN-A</p> | F 697                                                                      |                                                                                                                          |  |                                                        |



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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245270</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/14/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE<br/>ST CHARLES, MN 55972</b>                                |  |                                                        |
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| F 697                                                                 | <p>Continued From page 11</p> <p>stated pain should be treated within 15 minutes of the time the resident tells staff they are experiencing pain. RN-A stated if it was too soon to give pain medications, staff should offer things like ice or heat or other non-pharmacological options to manage the pain. RN-A confirmed if staff offered non-pharmacological options they were to chart and document in the residents record and said sometimes non-pharmacological interventions work better than giving medications.</p> <p>During interview on 5/13/25 at 11:43 a.m., assistant director of nursing (ADON) stated R125 experiences pain frequently, and her pain has been high since arriving to the facility. ADON stated the initial goal was to try non-pharmacological options first. ADON stated it is an expectation if the resident is offered a non-pharmacological option, it is charted, and a follow up assessment completed. ADON confirmed R125 did not have any non-pharmacological options charted as given since her arrival. ADON stated resident pain should be treated with 15-20 minutes of staff notification.</p> <p>Per facility policy titled Pain Management dated 8/9/22, stated staff will recognize when the resident is experiencing pain, evaluate the resident for pain and the cause, manage or prevent pain.</p> | F 697                                                                      |                                                                                                                          |  |                                                        |
| F 880<br>SS=D                                                         | <p>Infection Prevention &amp; Control<br/>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control<br/>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | F 880                                                                      |                                                                                                                          |  | 6/12/25                                                |



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| F 880                                                                 | <p>Continued From page 12</p> <p>comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program.<br/>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the</p> | F 880                                                                      |                                                                                                                          |                            |                                                        |



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| F 880                                                                 | <p>Continued From page 13</p> <p>circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.<br/>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.<br/>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, and record review, the facility failed to ensure staff followed proper infection control practices for 1 of 1 resident (R11) reviewed for urinary catheter. Staff failed to ensure a mechanical transfer lift was cleaned and disinfected after resident use for 1 of 1 resident (R125) observed for infection control. Furthermore, staff failed to ensure proper personal protective equipment (PPE) was used for 2 of 2 residents (R125, R126) observed for proper PPE.</p> <p>Findings include:</p> <p>R11</p> |                                                                            |  | F 880                                                                                     | <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br/>R11, facility obtained urinary drainage bags from suppliers that resident feels drain the best for him. In servicing to nursing staff on catheter drainage bag coverage or shielded at all times when in use will be held on 6/12/25.<br/>R125, R126<br/>Director of Nursing re-educated NA-D and NA-C on sanitization of lifts after each use. Nursing staff to be in serviced on sanitizing of equipment, lifts after each resident use prior to utilizing on another</p> |                                                        |                            |



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| F 880                                                                 | <p>Continued From page 14</p> <p>R11's quarterly Minimum Data Set (MDS) assessment dated 1/28/25, indicated R11 was cognitively intact with no behaviors, had range of motion limitations to both lower extremities, and was dependent on staff for lower body cares, bed mobility, and transfers. It also indicated R11 had a urinary catheter and colostomy, history of spina bifida (genetic neurologic condition), history of UTI, paraplegia (paralysis of lower extremities due to disorder of the nerves).</p> <p>R11's physician orders indicated R11 required enhanced barrier precautions, provide catheter care every shift, and change catheter system as needed.</p> <p>R11's diagnoses included spina bifida, paraplegia, heart failure, Ileal conduit (surgical opening in the abdomen to allow urine to drain from the kidneys), artificial opening of urinary tract status.</p> <p>R11's urostomy care plan indicated "empty when half full, monitor skin around stoma for breakdown, provide ostomy care and change appliance as needed, report any changes in amount and color/odor of urine, use 2 ¼ inch ostomy supplies". R11's infection care plan indicated R11 was at risk for infection related to indwelling catheter and wounds requiring enhanced barrier precautions when performing high-contact care activities.</p> <p>R11's nursing assistant Kardex instructed staff to empty urostomy when half full, use enhanced barrier precautions when performing high contact care activities.</p> <p>During observation and interview on 5/11/25 at</p> |                                                                            |  | F 880                                                                                     | <p>resident on 6/12/25.</p> <p>R125, R126<br/>Director of Nursing will be providing re-education on discarding of PPE before exiting each room that is on Transmission Based Precautions. Staff will also be provided re-education on isolation precautions, transmission-based precautions including donning PPE upon room entry and doffing before exiting the room is done. Staff in-service will be held on 6/12/25</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:<br/>All residents have the potential to be affected by this finding. Facility wide resident assessment completed specifically for other residents on isolation precautions; residents with urinary or suprapubic catheters. The Infection Control Surveillance Log is being kept updated each day with changes in resident status and is monitored daily by the DON/ADON/ICP/Designee.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:<br/>A Nursing In-service will be conducted on 6/12/25 by the DON/ICP/designee. The training to address infection policy and procedures on standard precautions with sanitation of equipment, urinary catheter</p> |                                                        |                            |



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| F 880                                                                 | <p>Continued From page 15</p> <p>2:07 p.m., R11 was lying in bed connected to a urinary drainage bag that was laying directly on the floor without a barrier preventing contact with the floor. A blue cloth privacy bag was attached to the bedframe next to the drainage bag. R11 indicated he has had a urostomy for a long time and has a history of recurrent "kidney issues" including infections.</p> <p>During observation on 5/11/25 at 4:47 p.m., R11's drainage bag was observed directly on the floor.</p> <p>R11's progress notes dated 5/13/25 at 1:15 a.m., indicated R11 was sent to the emergency room for an elevated temperature and swelling/redness to left hip. On 5/13/25 at 12:50 p.m., R11 returned from the emergency room with a diagnosis of cellulitis (infection under the surface of the skin) to the left hip and urinary tract infection and was started on a 7 day course of antibiotics.</p> <p>During observation 5/14/25 at 8:45 a.m., R11's catheter bag was observed directly on the floor without a barrier beneath it. Blue cloth privacy bag was tied to the bedframe next to the catheter bag.</p> <p>During interview on 5/14/25 at 9:20 a.m., nursing assistant (NA)-B stated urinary drainage bags should be placed in the cloth privacy bag and hung on the bedframe. NA-B stated placing the catheter bag directly on the floor would be an infection control issue and risk the bag getting run over and damaged.</p> <p>During interview on 5/14/25 at 9:22 a.m., NA-A stated urinary drainage bags should be placed in the cloth bag on the side of the bed and hung</p> | F 880                                                                      | <p>drainage bag care, and transmission based/isolation precaution PPE donning/doffing .</p> <p>DON/Designee will conduct audits to ensure proper Isolation practices are in place, PPE is properly being utilized and Infection Control practices are in place. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DON/designee will be responsible for completing the audit twice weekly x 6 weeks. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.</p> |  |                                                        |



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| F 880                                                                 | <p>Continued From page 16</p> <p>from the frame. NA-A stated catheter bags should not be placed directly on the floor due to risk for infection.</p> <p>During interview on 5/14/25 at 9:30 a.m., registered nurse (RN)-A stated catheter bags should be hung below the level of the bladder and in a blue bag on the frame, not directly on the floor. RN-A asked, "are you referring to the gentleman in the middle room?" and immediately went to R11's room to remove the catheter from the floor.</p> <p>During interview on 5/14/25 at 10:08 a.m., the infection preventionist (IP) stated R11 "has a habit of pulling on the tubing of the catheter bag to remove it from the dignity bag and place the catheter bag directly on the floor." The IP stated R11's care plan was updated instructing staff to double check the room and make sure the catheter bag is protected.</p> <p>During interview on 5/14/25 at 10:27 a.m., the director of nursing (DON) and assistant director of nursing (ADON) stated R11 gets very angry when the catheter bag hanging from the bedframe stating he doesn't feel it drains properly unless it is on the floor. The ADON stated staff did compromise with R11 by at least placing the catheter bag in the cloth bag prior to it being placed on the floor. The next morning R11 was upset stating the catheter bag didn't drain properly in the dignity bag and the urine backed up.</p> <p>During observation and interview on 5/14/25 at 11:01 a.m., R11's catheter bag was in the cloth dignity bag attached to the bedframe. R11 stated his preference for the location of the catheter bag</p> |                                                                            |  | F 880                                                                                     |                                                                                                                          |                                                        |                            |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE<br/>ST CHARLES, MN 55972</b>                                |  |                                                        |
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| F 880                                                                 | <p>Continued From page 17</p> <p>depends on the type of bag the facility uses. R11 stated some of the catheter bags the facility uses do not drain as well as he would like unless they are hanging low. R11 stated his catheter bag does not have to be directly on the floor, he just prefers it hang as low as possible. He does not like to use the dignity bag because he feels it doesn't allow proper drainage. R11 observed his catheter bag hanging from the bedframe in the dignity bag at the time of the interview and stated the current bag is draining well and he doesn't have an issue with it hanging from the bedframe.</p> <p>During interview on 5/14/25 at 12:45 p.m., the DON and ADON reiterated R11's wishes keeping the catheter bag on the floor. The corporate vice president of success (VP) stressed the need to have a barrier between the catheter bag and the floor.</p> <p>A policy titled "Catheter Care" dated 3/15/23 indicated "privacy/dignity bags will be available and a catheter drainage bag should be covered or shielded at all times when in use."</p> <p>Disinfecting Equipment</p> <p>R125's resident admission MDS assessment was not completed at time of survey. R125's cognition was intact.</p> <p>R125 was admitted on 5/7/25 following hospital admission for acute respiratory failure with hypercapnia (too much carbon dioxide in the blood). R125's admission diagnosis include, heart failure, respiratory disease, right lower leg pressure ulcer (reduce blood pressure to body area, leading to skin and tissue damage), left lower leg pressure ulcer, right hip pressure ulcer,</p> | F 880                                                                      |                                                                                                                          |  |                                                        |



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| F 880                                                                 | <p>Continued From page 18</p> <p>perineum (area of sensitive skin between genitals and anus) wound, spinal vertebrae pain, lumbar pain, adult failure to thrive and a new diagnosis of urinary retention requiring a urinary catheter to drain bladder.</p> <p>During an observation on 5/12/25 at 8:55 a.m., nursing assistant (NA)-D and NA-C answered R125's call light, taking mechanical transfer lift from the hallway without wiping it down, assisted resident to commode, then back to chair. NA-D placed the mechanical transfer lift into the hall without wiping it down or sanitizing.</p> <p>During observation on 5/12/25 at 9:23 a.m., NA-D and NA-C answered call light for another room, the same mechanical transfer lift was used for the 2nd resident without being wiped down or sanitized before or after the 2nd use.</p> <p>During interview on 5/12/25 at 9:33 a.m., NA-D stated facility equipment should be cleaned between residents, this is done to help prevent the spread of infection from resident to resident. NA-D confirmed she had not wiped the lift after using it with R125 and before using it with the 2nd resident.</p> <p>During interview on 5/13/25 at 11:43 a.m., director of nursing (DON) and assistant director of nursing (ADON) stated it is an expectation mechanical lifts are sanitized after use with each resident.</p> <p>Per facility policy titled Standard Precautions Infection Control dated 3/24/23, reusable resident equipment, such as mechanical lifts, should be cleaned and disinfected between residents.</p> |                                                                            |  | F 880                                                                                     |                                                                                                                          |                                                        |                            |



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| F 880                                                                 | <p>Continued From page 19</p> <p>Appropriate PPE Donning/Doffing</p> <p>R125's resident admission MDS assessment was not completed at time of survey. R125's cognitive function was intact.</p> <p>R125 was admitted on 5/7/25 following hospital admission for acute respiratory failure with hypercapnia (too much carbon dioxide in the blood). R125's admission diagnosis include, heart failure, respiratory disease, right lower leg pressure ulcer (reduce blood pressure to body area, leading to skin and tissue damage), left lower leg pressure ulcer, right hip pressure ulcer, perineum (area of sensitive skin between genitals and anus) wound, spinal vertebrae pain, lumbar pain, adult failure to thrive, new diagnosis of urinary retention requiring a urinary catheter to drain bladder, and c-difficile (contagious pathogen in stool).</p> <p>R125 had an order to be placed in a room designated with contact precautions (used for residents with known or suspected infections that pose an increased risk for infection transmission). R125 was placed in a room with contact precautions implemented.</p> <p>R126's resident admission MDS assessment was not completed at time of survey. R126's cognitive function was intact.</p> <p>R126 was admitted on 5/16/25 following hospital admission after left knee surgery. R126's admission diagnosis includes, type 2 diabetes, chronic kidney disease requiring dialysis, heart failure, irregular heart rate, history of long-term antibiotic use, and known infection of left knee surgical site.</p> | F 880                                                                      |                                                                                                                          |                            |                                                        |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE<br/>ST CHARLES, MN 55972</b>                                |                            |                                                        |
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| F 880                                                                 | <p>Continued From page 20</p> <p>R126 had an order to be placed in a room designated with contact precautions . R126 was placed in a room with contact precautions implemented.</p> <p>During observation on 5/12/25 at 1:09 p.m., housekeeping (H)-A donned gown and gloves upon entering room 304. Upon exiting 304, H-A removed gloves, did not take off gown. H-A applied new gloves to clean room 306 and did not change gown from the previous room. Upon exiting 306, H-A removed gloves but did not take off gown before moving to clean the 3rd room. H-A applied new gloves to clean room 308 but did not change his gown from the previous 2 rooms. Upon exiting 308, H-A removed gown and gloves.</p> <p>During interview on 5/12/25 at 1:27 p.m., H-A stated the process for cleaning each room is the same when you are in the room (wipe stuff down, mop the floor, clean bathroom, empty trash, etc.). H-A stated the process for cleaning contact isolation rooms depends on the specific type of isolation pathogen, generally you need an isolation gown and gloves for cleaning these types of isolation rooms. H-A stated it is an acceptable practice to wear the same gown to clean multiple rooms; would just need to change gloves between rooms.</p> <p>During interview on 5/12/25 at 2:00 p.m., housekeeping supervisor (H)-B stated it is an expectation for housekeepers to change isolation gowns and gloves each time they enter a room to clean. Wearing the same gown for each room could spread different infections to residents.</p> <p>During interview on 5/12/25 at 2:09 p.m.,</p> | F 880                                                                      |                                                                                                                          |                            |                                                        |



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| F 880                                                                 | <p>Continued From page 21</p> <p>assistant director of nursing (ADON) and corporate vice president of success (VP) stated it is and expectation and facility policy to remove gown and gloves after cleaning each room. This process is done to prevent the spread of infection between residents during the cleaning process.</p> <p>Per facility policy titled Transmission-Based (Isolation) Precautions, dated 9/24/24, donning PPE upon room entry and discarding before exiting the room is done to contain pathogens.</p> | F 880                                                                      |                                                                                                                          |                            |                                                        |



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| K 000                                                                 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/13/2025. 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.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION |                                                                            |  | K 000                                                                                       |                                                                                                                          |                                                        |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
  
Electronically Signed

TITLE

(X6) DATE  
  
06/09/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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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| K 000                                                                 | <p>Continued From page 1<br/>IS NOT REQUIRED.</p> <p>Healthcare Fire Inspections<br/>State Fire Marshal Division<br/>445 Minnesota St., Suite 145<br/>St. Paul, MN 55101-5145, OR</p> <p>By email to:<br/>FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH<br/>DEFICIENCY MUST INCLUDE ALL OF THE<br/>FOLLOWING INFORMATION:</p> <p>1. A detailed description of the corrective action<br/>taken or planned to correct the deficiency.</p> <p>2. Address the measures that will be put in<br/>place to ensure the deficiency does not reoccur.</p> <p>3. Indicate how the facility plans to monitor<br/>future performance to ensure solutions are<br/>sustained.</p> <p>4. Identify who is responsible for the corrective<br/>actions and monitoring of compliance.</p> <p>5. The actual or proposed date for completion of<br/>the remedy.</p> <p>WHITEWATER HEALTH SERVICES is a 1 story<br/>building with partial basements.</p> <p>The building was constructed at 2 different times.<br/>The original building was constructed in 1967 and<br/>is a 1 structure with partial basement and was<br/>determined to be Type II ( 111 ) construction. In</p> |                                                                            |  | K 000                                                                                       |                                                                                                                          |                                                        |                            |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE</b><br><b>ST CHARLES, MN 55972</b> |                                                                                                                          |                                                        |                            |
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| K 000                                                                 | Continued From page 2<br>1969 a 1 story addition with partial basement was constructed and determined to be of Type II ( 111 ) construction.<br><br>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.<br><br>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.<br><br>The facility has a capacity of 45 beds and had a census of 25 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by: |                                                                            |  | K 000                                                                                           |                                                                                                                          |                                                        |                            |
| K 346<br>SS=C                                                         | Fire Alarm System - Out of Service<br>CFR(s): NFPA 101<br><br>Fire Alarm - Out of Service<br>Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.<br>9.6.1.6<br>This REQUIREMENT is not met as evidenced by:<br>Based on available documentation and staff                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |  | K 346                                                                                           |                                                                                                                          |                                                        | 6/6/25                     |
|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |  |                                                                                                 | K346 Fire Alarm System – Out of Service                                                                                  |                                                        |                            |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE</b><br><b>ST CHARLES, MN 55972</b>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                        |
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| K 346                                                                 | Continued From page 3<br>interview, the facility failed to maintain a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 05/13/2025 between 10:30 AM and 2:30 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy did not include in the notification and correct listing of the AHJ - Deputy State Fire Marshal Inspector assigned to the area in which the facility is located ( point of contact and phone # ).<br><br>2. On 05/13/2025 between 10:30 AM and 2:30 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy did not include in the notification and correct listing of the AHJ - MN Department of Health ( point of contact and phone # ).<br><br>An interview with the Regional Maintenance Director verified these deficient findings at the time of discovery. | K 346                                                                      | Executive Director corrected the white emergency binder to include the AHJ Deputy State Fire Marshal Inspector listed by the state fire Marshall for the St. Charles MN area. Included the AHJ Minnesota Department of Health point of contact telephone number.<br>No other Emergency Binders.<br>Executive director or designee will monitor and update emergency contacts within the Emergency Operations Binder on a monthly basis. All corrections were completed on 6/6/25.<br>Completion Date: 6/6/25 |  |                                                        |
| K 353<br>SS=F                                                         | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | K 353                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 6/13/25                                                |



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| K 353                                                                 | <p>Continued From page 4<br/>available.</p> <p>a) Date sprinkler system last checked<br/>_____</p> <p>b) Who provided system test<br/>_____</p> <p>c) Water system supply source<br/>_____</p> <p>Provide in REMARKS information on coverage for<br/>any non-required or partial automatic sprinkler<br/>system.<br/>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br/>This REQUIREMENT is not met as evidenced<br/>by:<br/>Based on documentation review, and staff<br/>interview the facility failed to inspect and maintain<br/>the sprinkler system in accordance with NFPA<br/>101 (2012 edition), Life Safety Code, sections<br/>4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition)<br/>Standard for the Inspection, Testing, and<br/>Maintenance of Water-Based Fire Protection<br/>Systems, section(s), 5.1, 5.2, 5.2.1.1.2(2)(5).<br/>These deficient findings could have a widespread<br/>impact on the residents within the facility.</p> <p>Findings include:</p> <p>1. On 05/13/2025 between 10:30 AM and 2:30<br/>PM, it was revealed by observation that sprinkler<br/>head(s) located in the Shower Room in Wing 300<br/>exited signs of debris loading / oxidation.</p> <p>2. On 05/13/2025 between 10:30 AM and 2:30<br/>PM, it was revealed by a review of available<br/>documentation that no documentation was<br/>presented to confirm that the deficiency finding<br/>cite by fire sprinkler system testing vendor ( Fire<br/>Department Connection ) had been resolved /<br/>corrected.</p> |                                                                            |  | K 353                                                                                       | <p>K353 Sprinkler System - Maintenance<br/>and Testing<br/>The sprinkler head located in the shower<br/>room in the 300 wing that exhibits signs of<br/>debris loading/oxidation will be replaced<br/>by Ahern on 6/13/25.<br/>The Maintenance Director has contacted<br/>Ahern to correct all documented<br/>deficiencies reported in the sprinkler<br/>system testing. This is part of the current<br/>repair/install order along with sprinkler<br/>head. Ahern will correct on 6/13/25<br/>The Maintenance Director inspected all<br/>sprinkler heads throughout the facility and<br/>no additional issues were identified.<br/>The Maintenance Director will inspect all<br/>sprinkler heads monthly to keep sprinkler<br/>heads free from debris loading. If<br/>oxidation is noticed the Maintenance<br/>Director will contact Sprinkler System<br/>Vendor for inspection and replacement.<br/>Completion Date: 6/13/25</p> |                                                        |                            |



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| K 353                                                                 | Continued From page 5<br>An interview with the Regional Maintenance Director verified these deficient findings at the time of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  | K 353                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                        |                            |
| K 354<br>SS=C                                                         | Sprinkler System - Out of Service<br>CFR(s): NFPA 101<br><br>Sprinkler System - Out of Service<br>Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service.<br>18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)<br>This REQUIREMENT is not met as evidenced by:<br>Based on available documentation and staff interview, the facility failed to maintain a sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1, 9.7.5, 9.7.6 and NFPA 25 ( 2011 edition ) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2(6). These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>1. On 05/13/2025 between 10:30 AM and 2:30 PM, it was revealed by a review of available |                                                                            |  | K 354                                                                                       | K354 Sprinkler System - Out of Service<br>Executive Director corrected documentation in the white emergency binder to provide for the fire sprinkler system out-of-service policy to include the notification and correct listing of the AHJ – Deputy State Fire Marshal Inspector assigned to the area in which the facility is located (point of contact and phone number) and correct listing of AHJ Minnesota Department of Health (point of contact and phone number).<br>No other Emergency Binders<br>Executive director or designee will monitor and update emergency contacts within the |                                                        | 6/6/25                     |



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| K 354                                                                 | Continued From page 6<br>documentation that the fire sprinkler system out-of-service policy did not include in the notification and correct listing of the AHJ - Deputy State Fire Marshal Inspector assigned to the area in which the facility is located ( point of contact and phone # ).<br><br>2. On 05/13/2025 between 10:30 AM and 2:30 PM, it was revealed by a review of available documentation that the fire sprinkler system out-of-service policy did not include in the notification and correct listing of the AHJ - MN Department of Health ( point of contact and phone # ).<br><br>An interview with the Regional Maintenance Director verified these deficient findings at the time of discovery.                                    |                                                                            |  | K 354                                                                                       | Emergency Operations Binder on a monthly basis. All corrections were completed on 6/6/25.<br>Completion Date 6/6/25                                                                                                                                                                                                    |                                                        |                            |
| K 355<br>SS=D                                                         | Portable Fire Extinguishers<br>CFR(s): NFPA 101<br><br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1, 7.2.4.5, 7.3.2.1, This deficient findings could have a |                                                                            |  | K 355                                                                                       | K 355 Portable Fire Extinguishers<br>Maintenance Director inspected all in house fire extinguishers<br>Maintenance Director created a spreadsheet to document inspection and service of fire extinguishers for monthly inspections.<br>Maintenance Director will audit monthly that the spreadsheet has been completed |                                                        | 6/2/25                     |



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| K 355                                                                 | Continued From page 7<br>widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 05/13/2025 between 10:30 AM and 2:30 PM, it was revealed by observation and a review of available documentation, that no monthly inspection log / ledger was presented for review to demonstrate that at least the last 12 monthly inspections have been performed.<br><br>An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.                                                                                                                                                                                                                 | K 355                                                                      | and all extinguishers have been inspected and or serviced.<br>Completion Date 6/2/25                                                                                                                              |                            |                                                        |
| K 511<br>SS=F                                                         | Utilities - Gas and Electric<br>CFR(s): NFPA 101<br><br>Utilities - Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to secure electrical boxes in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.1, NFPA 70 (2011 edition), National Electrical Code, section | K 511                                                                      | K511 Utilities - Gas and Electric<br>Maintenance Director secured lock for electrical panel.<br>Maintenance Director inspected all electrical panels for secure locks<br>Maintenance Director/Designee will audit | 6/2/25                     |                                                        |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE<br/>ST CHARLES, MN 55972</b>   |                                                                                                                          |                                                        |                            |
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| K 511                                                                 | Continued From page 8<br>110.26(F). This deficient finding could have a<br>widespread impact on the residents within the<br>facility.<br><br>Findings include:<br><br>On 05/13/2025 between 10:30 AM and 2:30 PM,<br>it was revealed by observation that an electrical<br>panel located in the corridor adjacent to the<br>Dining Room was found unsecured and readily<br>accessible to unauthorized individuals.<br><br>An interview with the Regional Maintenance<br>Director verified this deficient finding at the time<br>of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |  | K 511                                                                                       | monthly that all electrical panels are<br>secured and have working locking<br>mechanisms.<br>Completion Date 6/2/25      |                                                        |                            |
| K 541<br>SS=D                                                         | Rubbish Chutes, Incinerators, and Laundry Chu<br>CFR(s): NFPA 101<br><br>Rubbish Chutes, Incinerators, and Laundry<br>Chutes<br>2012 EXISTING<br>(1) Any existing linen and trash chute, including<br>pneumatic rubbish and linen systems, that opens<br>directly onto any corridor shall be sealed by fire<br>resistive construction to prevent further use or<br>shall be provided with a fire door assembly having<br>a fire protection rating of 1-hour. All new chutes<br>shall comply with 9.5.<br>(2) Any rubbish chute or linen chute, including<br>pneumatic rubbish and linen systems, shall be<br>provided with automatic extinguishing protection<br>in accordance with 9.7.<br>(3) Any trash chute shall discharge into a trash<br>collection room used for no other purpose and<br>protected in accordance with 8.4. (Existing<br>laundry chutes permitted to discharge into same<br>room are protected by automatic sprinklers in<br>accordance with 19.3.5.9 or 19.3.5.7.) |                                                                            |  | K 541                                                                                       |                                                                                                                          |                                                        | 6/3/25                     |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE<br/>ST CHARLES, MN 55972</b>                                                                                                                                                                                                                                                                                                                                                                                |                            |                                                        |
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| K 541                                                                 | Continued From page 9<br><br>(4) Existing fuel-fed incinerators shall be sealed<br>by fire resistive construction to prevent further<br>use.<br>19.5.4, 9.5, 8.4, NFPA 82<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on observation and staff interview, the<br>facility failed to maintain chute doors and safety<br>measures of the laundry and bio-hazard chute<br>systems per NFPA 101 (2012 edition), section<br>19.5.4, 9.5, 9.5.2 and NFPA 82 (2009 edition),<br>section 5.2.3.3. This deficient finding could have<br>an isolated impact on the residents within the<br>facility.<br><br>Findings include:<br><br>On 05/13/2025 between 10:30 AM and 2:30 PM,<br>it was revealed by observation in the Laundry<br>Chute Room - Wing 100, that the chute intake<br>door, upon testing, did not properly close and<br>seal the vertical shaft opening. The door did<br>have gasketing and staff did not confirm the cute<br>door was 1-hour fire rating.<br><br>An interview with the Regional Maintenance<br>Director verified this deficient finding at the time<br>of discovery. | K 541                                                                      | K 541 Rubbish Chutes, Incinerators, and<br>Laundry Chutes<br>Maintenance Director fixed the laundry<br>chute door by tightening the door closer<br>and adjusting the hinge on 6/3/25<br>Maintenance Director will inspect all doors<br>to ensure proper closing<br>Maintenance Director added the laundry<br>chute door onto the monthly task check<br>list<br>Maintenance Director will audit monthly<br>that door inspections as completed.<br>Completion date: 6/3/25 |                            |                                                        |
| K 712<br>SS=F                                                         | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm<br>signal and simulation of emergency fire<br>conditions. Fire drills are held at expected and<br>unexpected times under varying conditions, at<br>least quarterly on each shift. The staff is familiar<br>with procedures and is aware that drills are part of                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | K 712                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5/31/25                    |                                                        |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE</b><br><b>ST CHARLES, MN 55972</b>                                                                                                                                                                                                                                                                                  |  |                                                        |
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| K 712                                                                 | Continued From page 10<br>established routine. Where drills are conducted<br>between 9:00 PM and 6:00 AM, a coded<br>announcement may be used instead of audible<br>alarms.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on a review of available documentation<br>and staff interview, the facility failed to conduct<br>fire drills per NFPA 101 (2012 edition), Life Safety<br>Code, sections 19.7.1. These deficient findings<br>could have a widespread impact on the residents<br>within the facility.<br><br>Findings include:<br><br>1. On 05/13/2025 between 10:30 AM and 2:30<br>PM, it was revealed by review of available<br>documentation that documentation presented for<br>review did not confirm that fire drills were<br>conducted: 1st shift - 1st Quarter; 2nd shift - 1st,<br>2nd and 3rd Quarter; 3rd shift - 1st, 2nd, 3rd, 4th<br>Quarters.<br><br>2. On 05/13/2025 between 10:30 AM and 2:30<br>PM, it was revealed by review of available<br>documentation that completed Fire Drills did not<br>have complete documentation - no signature<br>sheets to identify or confirm participating staff.<br><br>An interview with the Regional Maintenance<br>Director verified these deficient findings at the<br>time of discovery. | K 712                                                                      | K712 Fire Drills<br>Maintenance Director completed fire drill<br>for the month of May<br>Maintenance Director added a sign in<br>sheet to the Fire Drill checklist<br>Maintenance Director will be using TELS<br>to document and Track fire drills monthly<br>ED/Designee will audit to ensure Fire<br>Drills are completed on all shifts each<br>quarter.<br>Completed: 5/31/25 |  |                                                        |
| K 761<br>SS=F                                                         | Maintenance, Inspection & Testing - Doors<br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | K 761                                                                      |                                                                                                                                                                                                                                                                                                                                                                                  |  | 6/9/25                                                 |



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| K 761                                                                 | <p>Continued From page 11</p> <p>annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:</p> <p>Based on a review of available documentation and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. These deficient findings could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>1. On 05/13/2025 between 10:30 AM and 2:30 PM, it was revealed by a review of available documentation that most current annual door inspection was last completed 04/08/2024.</p> <p>2. On 05/13/2025 between 10:30 AM and 2:30 PM, it was revealed by observation that Kitchen fire rated door was in disrepair, such that upon test did not self-close and seal the opening.</p> <p>3. On 05/13/2025 between 10:30 AM and 2:30 PM, it was revealed by observation that Janitorial Room adjacent to the Dining Room, the door and hinges had been modified to non-manufacture</p> | K 761                                                                      | <p>K761 Maintenance, Inspection &amp; Testing Maintenance Director completed the annual door inspection and documentation. Maintenance Director repaired the lower hinge on the Kitchen fire rated door by tightening screws. Maintenance Director repaired hinges on the Janitorial Room adjacent to the dining room. Maintenance Director will complete Monthly Inspections on all door functions and make repairs as needed. ED/Designee will audit the completion of door inspections by the Maintenance Director Completion Date: 6/9/25</p> |                            |                                                        |



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| K 761                                                                 | Continued From page 12<br>standard(s).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |  | K 761                                                                                       |                                                                                                                                                                                                                         |                                                        |                            |
| K 914<br>SS=F                                                         | <p>An interview with the Regional Maintenance Director verified these deficient findings at the time of discovery.</p> <p>Electrical Systems - Maintenance and Testing CFR(s): NFPA 101</p> <p>Electrical Systems - Maintenance and Testing 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 6.3.3.3.2 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)<br/>This REQUIREMENT is not met as evidenced by:<br/>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, 6.3.4.1.3, 6.3.4.2. This deficient finding could</p> |                                                                            |  | K 914                                                                                       |                                                                                                                                                                                                                         |                                                        | 6/4/25                     |
|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |  |                                                                                             | K914 Electrical Systems - Maintenance and Testing.<br>Maintenance Director performed the outlet testing on all the resident rooms finding 2 errors and 2 problems on June 3.<br>Electricians from Don's Electric in St. |                                                        |                            |



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| K 914                                                                 | Continued From page 13<br>have a widespread impact on the residents within<br>the facility.<br><br>Findings include:<br><br>On 05/13/2025 between 10:30 AM and 2:30 PM,<br>it was revealed by a review of available<br>documentation that the most current annual<br>electrical outlet inspection was last completed -<br>05/09/2024.<br><br>An interview with the Regional Maintenance<br>Director verified this deficient finding at the time<br>of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |  | K 914                                                                                       | Charles MN corrected and repaired the<br>outlets that were found faulty by the<br>Maintenance Director on June 4.<br>Maintenance Director will complete annual<br>inspections of Electrical Outlets and<br>record and fixes needed into a yearly<br>spreadsheet.<br>ED/Designee will monitor that Electrical<br>Outlet testing is performed annually<br>Completion Date 6/4/25 |                                                        |                            |
| K 918<br>SS=F                                                         | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System<br>Maintenance and Testing<br>The generator or other alternate power source<br>and associated equipment is capable of supplying<br>service within 10 seconds. If the 10-second<br>criterion is not met during the monthly test, a<br>process shall be provided to annually confirm this<br>capability for the life safety and critical branches.<br>Maintenance and testing of the generator and<br>transfer switches are performed in accordance<br>with NFPA 110.<br>Generator sets are inspected weekly, exercised<br>under load 30 minutes 12 times a year in 20-40<br>day intervals, and exercised once every 36<br>months for 4 continuous hours. Scheduled test<br>under load conditions include a complete<br>simulated cold start and automatic or manual<br>transfer of all EES loads, and are conducted by<br>competent personnel. Maintenance and testing of<br>stored energy power sources (Type 3 EES) are in<br>accordance with NFPA 111. Main and feeder |                                                                            |  | K 918                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                |                                                        | 5/31/25                    |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE<br/>ST CHARLES, MN 55972</b>                                                                                                                                                                                                                                                                                                                                                                  |                            |                                                        |
| (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 APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                   | (X5)<br>COMPLETION<br>DATE |                                                        |
| K 918                                                                 | <p>Continued From page 14</p> <p>circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on documentation review and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 ( 2010 edition ), Standard for Emergency and Standby Power Systems, section, 8.3, 8.4. These deficient findings could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>1. On 05/13/2025 between 10:30 AM and 2:30 PM, it was revealed by a review of available documentation that the most recent documented weekly inspection of the generator was completed - February 2025.</p> <p>2. On 05/13/2025 between 10:30 AM and 2:30 PM, it was revealed by a review of available documentation that the most recent documented monthly inspection and run-test of the generator was completed - February 2025.</p> | K 918                                                                      | <p>K918 Electrical Systems - Essential Electric Systems</p> <p>Maintenance Director completed weekly inspections starting 5/19/25. Monthly inspections were completed 5/31/25. Maintenance Director will complete weekly and monthly inspections and record the results in TELS for tracking. ED/designee will audit generator inspections to verify weekly and monthly inspections are completed in a timely manner.</p> <p>Completion date 5/31/2025</p> |                            |                                                        |



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

PRINTED: 06/11/2025  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245270</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____     |                                                                                                                                                                                                                             | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/13/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE</b><br><b>ST CHARLES, MN 55972</b> |                                                                                                                                                                                                                             |                                                        |                            |
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| K 918                                                                 | Continued From page 15<br>An interview with the Regional Maintenance<br>Director verified these deficient findings at the<br>time of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |  | K 918                                                                                           |                                                                                                                                                                                                                             |                                                        |                            |
| K 920<br>SS=F                                                         | Electrical Equipment - Power Cords and Extens<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Power Cords and<br>Extension Cords<br>Power strips in a patient care vicinity are only<br>used for components of movable<br>patient-care-related electrical equipment<br>(PCREE) assemblies that have been assembled<br>by qualified personnel and meet the conditions of<br>10.2.3.6. Power strips in the patient care vicinity<br>may not be used for non-PCREE (e.g., personal<br>electronics), except in long-term care resident<br>rooms that do not use PCREE. Power strips for<br>PCREE meet UL 1363A or UL 60601-1. Power<br>strips for non-PCREE in the patient care rooms<br>(outside of vicinity) meet UL 1363. In non-patient<br>care rooms, power strips meet other UL<br>standards. All power strips are used with general<br>precautions. Extension cords are not used as a<br>substitute for fixed wiring of a structure.<br>Extension cords used temporarily are removed<br>immediately upon completion of the purpose for<br>which it was installed and meets the conditions of<br>10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8<br>(NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on observation and staff interview, the<br>facility failed to manage usage electrical devices<br>in accordance with NFPA 99 (2012 edition),<br>Health Care Facilities Code, section 10.2.3.6,<br>10.2.4, 10.5.2.3 and NFPA 70, (2011 edition),<br>National Electrical Code, sections 110.3(B), 400.8 |                                                                            |  | K 920                                                                                           | K920 Electrical Equipment - Power Cords<br>and Extension Cords<br>Maintenance Director removed<br>daisy-chained power strips in the dietary<br>office. The extension cord connected to<br>the appliance and the 200 Hallway |                                                        | 6/5/25                     |



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

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE<br/>ST CHARLES, MN 55972</b>   |                                                                                                                                                                                                                                                                                                                 |                                                        |                            |
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| K 920                                                                 | Continued From page 16<br>(1) and UL 1363. These deficient findings could<br>have a isolated impact on the residents within the<br>facility.<br><br>Findings include:<br><br>1. On 05/13/2025 between 10:30 AM and 2:30<br>PM, it was revealed by observation that in the<br>Dietary Office, relocatable power taps were<br>daisy-chained together and in use.<br><br>2. On 05/13/2025 between 10:30 AM and 2:30<br>PM, it was revealed by observation that in the 200<br>Hallway - Utility / Janitorial Room, an extension<br>cord was connected to an appliance.<br><br>An interview with the Regional Maintenance<br>Director verified these deficient findings at the<br>time of discovery.                                                                     |                                                                            |  | K 920                                                                                       | Utility/Janitorial Room was removed June<br>5.<br>The Maintenance Director inspected all<br>facility rooms and no other extension<br>cords were identified<br>Maintenance Director will audit monthly<br>that facility rooms are not using extension<br>cords for main power supply.<br>Completion Date: 6/5/25 |                                                        |                            |
| K 926<br>SS=F                                                         | Gas Equipment - Qualifications and Training<br>CFR(s): NFPA 101<br><br>Gas Equipment - Qualifications and Training of<br>Personnel<br>Personnel concerned with the application,<br>maintenance and handling of medical gases and<br>cylinders are trained on the risk. Facilities<br>provide continuing education, including safety<br>guidelines and usage requirements. Equipment is<br>serviced only by personnel trained in the<br>maintenance and operation of equipment.<br>11.5.2.1 (NFPA 99)<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on review of available documentation and<br>staff interview, the facility failed to provide<br>documentation of education and staff training per<br>NFPA 99 (2012 edition), Health Care Facilities |                                                                            |  | K 926                                                                                       | K926 Gas Equipment - Qualifications and<br>Training<br>We provide training for staff during<br>orientation upon hire and annually via                                                                                                                                                                           |                                                        | 6/12/25                    |



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE</b><br><b>ST CHARLES, MN 55972</b>                                                                                                                                                                                                                                                                                                                                  |                            |                                                        |
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| K 926                                                                 | <p>Continued From page 17</p> <p>Code, sections 11.5.2.1, 11.5.2.1.1, 11.5.2.1.2, 11.5.2.1.3 This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 05/13/2025 between 10:30 AM and 2:30 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that staff are receiving initial and continuing education on risks associated with the handling of Med Gas ( O2 ) and cylinders.</p> <p>An interview with the Regional Maintenance Director verified this deficient finding at the time of discovery.</p> | K 926                                                                      | <p>Relias computer based training currently "Using Oxygen Safely Self Paced". Facility Staff will receive re-education on Oxygen Safety Policy and procedure 6/12/25</p> <p>Maintenance Director will ensure that Oxygen Safety is reviewed Annually with all staff and a sign in sheet will be kept in binder.</p> <p>ED/Designee will audit staff compliance for oxygen training annually.</p> <p>Completion date: 6/12/25</p> |                            |                                                        |





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

Electronically delivered  
May 30, 2025

Administrator  
Whitewater Health Services  
525 Bluff Avenue  
St Charles, MN 55972

Re: State Nursing Home Licensing Orders  
Event ID: HSOX11

Dear Administrator:

The above facility was surveyed on May 11, 2025, through May 14, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html). The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.



PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



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)



Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>00942 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>05/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>525 BLUFF AVENUE<br>ST CHARLES, MN 55972                                        |  |                                              |
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| 2 000                                                          | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:<br/>On 5/11/25 to 5/14/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and</p> | 2 000                                                           |                                                                                                                          |  |                                              |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/09/25



Minnesota Department of Health

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                           |                                                                                                                          |  |                                                     |
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| 2 000                                                                 | <p>Continued From page 1</p> <p>identify the date when they will be completed.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin<br/>&lt;<a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a>&gt; The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.</p> | 2 000                                                                                     |                                                                                                                          |  |                                                     |
| 21375                                                                 | <p>MN Rule 4658.0800 Subp. 1 Infection Control; Program</p> <p>Subpart 1. Infection control program. A nursing</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 21375                                                                                     |                                                                                                                          |  | 6/12/25                                             |



Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>525 BLUFF AVENUE<br>ST CHARLES, MN 55972 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                              |
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| 21375                                                          | <p>Continued From page 2</p> <p>home must establish and maintain an infection control program designed to provide a safe and sanitary environment.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the facility failed to ensure staff followed proper infection control practices for 1 of 1 resident (R11) reviewed for urinary catheter. Staff failed to ensure a mechanical transfer lift was cleaned and disinfected after resident use for 1 of 1 resident (R125) observed for infection control. Furthermore, staff failed to ensure proper personal protective equipment (PPE) was used for 2 of 2 residents (R125, R126) observed for proper PPE.</p> <p>Findings include:</p> <p>R11</p> <p>R11's quarterly Minimum Data Set (MDS) assessment dated 1/28/25, indicated R11 was cognitively intact with no behaviors, had range of motion limitations to both lower extremities, and was dependent on staff for lower body cares, bed mobility, and transfers. It also indicated R11 had a urinary catheter and colostomy, history of spina bifida (genetic neurologic condition), history of UTI, paraplegia (paralysis of lower extremities due to disorder of the nerves).</p> <p>R11's physician orders indicated R11 required enhanced barrier precautions, provide catheter care every shift, and change catheter system as needed.</p> <p>R11's diagnoses included spina bifida,</p> | 21375                                                                             | <p>MN Rule 4658.00 Subp 1 Infection Control Program<br/>Subpart 1. Infection Control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:<br/>R11, facility obtained urinary drainage bags from suppliers that resident feels drain the best for him. In servicing to nursing staff on catheter drainage bag coverage or shielded at all times when in use will be held on 6/12/25.<br/>R125, R126<br/>Director of Nursing re-educated NA-D and NA-C on sanitization of lifts after each use. Nursing staff to be in serviced on sanitizing of equipment, lifts after each resident use prior to utilizing on another resident on 6/12/25.</p> <p>R125, R126<br/>Director of Nursing will be providing re-education on discarding of PPE before exiting each room that is on Transmission Based Precautions. Staff will also be provided re-education on isolation precautions, transmission-based precautions including donning PPE upon</p> |  |                                              |



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| 21375                                                                 | <p>Continued From page 3</p> <p>paraplegia, heart failure, ileal conduit (surgical opening in the abdomen to allow urine to drain from the kidneys), artificial opening of urinary tract status.</p> <p>R11's urostomy care plan indicated "empty when half full, monitor skin around stoma for breakdown, provide ostomy care and change appliance as needed, report any changes in amount and color/odor of urine, use 2 ¼ inch ostomy supplies". R11's infection care plan indicated R11 was at risk for infection related to indwelling catheter and wounds requiring enhanced barrier precautions when performing high-contact care activities.</p> <p>R11's nursing assistant Kardex instructed staff to empty urostomy when half full, use enhanced barrier precautions when performing high contact care activities.</p> <p>During observation and interview on 5/11/25 at 2:07 p.m., R11 was lying in bed connected to a urinary drainage bag that was laying directly on the floor without a barrier preventing contact with the floor. A blue cloth privacy bag was attached to the bedframe next to the drainage bag. R11 indicated he has had a urostomy for a long time and has a history of recurrent "kidney issues" including infections.</p> <p>During observation on 5/11/25 at 4:47 p.m., R11's drainage bag was observed directly on the floor.</p> <p>R11's progress notes dated 5/13/25 at 1:15 a.m., indicated R11 was sent to the emergency room for an elevated temperature and swelling/redness to left hip. On 5/13/25 at 12:50 p.m., R11 returned from the emergency room with a diagnosis of cellulitis (infection under the surface</p> | 21375                                                                  | <p>room entry and doffing before exiting the room is done. Staff in-service will be held on 6/12/25</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:<br/>All residents have the potential to be affected by this finding. Facility wide resident assessment completed specifically for other residents on isolation precautions; residents with urinary or suprapubic catheters. The Infection Control Surveillance Log is being kept updated each day with changes in resident status and is monitored daily by the DON/ADON/ICP/Designee.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:<br/>A Nursing In-service will be conducted on 6/12/25 by the DON/ICP/designee. The training to address infection policy and procedures on standard precautions with sanitation of equipment, urinary catheter drainage bag care, and transmission based/isolation precaution PPE donning/doffing .<br/>DON/Designee will conduct audits to ensure proper Isolation practices are in place, PPE is properly being utilized and Infection Control practices are in place. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> |  |                                                     |



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| 21375                                                          | <p>Continued From page 4</p> <p>of the skin) to the left hip and urinary tract infection and was started on a 7 day course of antibiotics.</p> <p>During observation 5/14/25 at 8:45 a.m., R11's catheter bag was observed directly on the floor without a barrier beneath it. Blue cloth privacy bag was tied to the bedframe next to the catheter bag.</p> <p>During interview on 5/14/25 at 9:20 a.m., nursing assistant (NA)-B stated urinary drainage bags should be placed in the cloth privacy bag and hung on the bedframe. NA-B stated placing the catheter bag directly on the floor would be an infection control issue and risk the bag getting run over and damaged.</p> <p>During interview on 5/14/25 at 9:22 a.m., NA-A stated urinary drainage bags should be placed in the cloth bag on the side of the bed and hung from the frame. NA-A stated catheter bags should not be placed directly on the floor due to risk for infection.</p> <p>During interview on 5/14/25 at 9:30 a.m., registered nurse (RN)-A stated catheter bags should be hung below the level of the bladder and in a blue bag on the frame, not directly on the floor. RN-A asked, "are you referring to the gentleman in the middle room?" and immediately went to R11's room to remove the catheter from the floor.</p> <p>During interview on 5/14/25 at 10:08 a.m., the infection preventionist (IP) stated R11 "has a habit of pulling on the tubing of the catheter bag to remove it from the dignity bag and place the catheter bag directly on the floor." The IP stated R11's care plan was updated instructing staff to</p> | 21375                                                           | <p>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program. The DON/designee will be responsible for completing the audit twice weekly x 6 weeks. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.</p> |  |                                              |



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| 21375                                                                 | <p>Continued From page 5</p> <p>double check the room and make sure the catheter bag is protected.</p> <p>During interview on 5/14/25 at 10:27 a.m., the director of nursing (DON) and assistant director of nursing (ADON) stated R11 gets very angry when the catheter bag hanging from the bedframe stating he doesn't feel it drains properly unless it is on the floor. The ADON stated staff did compromise with R11 by at least placing the catheter bag in the cloth bag prior to it being placed on the floor. The next morning R11 was upset stating the catheter bag didn't drain properly in the dignity bag and the urine backed up.</p> <p>During observation and interview on 5/14/25 at 11:01 a.m., R11's catheter bag was in the cloth dignity bag attached to the bedframe. R11 stated his preference for the location of the catheter bag depends on the type of bag the facility uses. R11 stated some of the catheter bags the facility uses do not drain as well as he would like unless they are hanging low. R11 stated his catheter bag does not have to be directly on the floor, he just prefers it hang as low as possible. He does not like to use the dignity bag because he feels it doesn't allow proper drainage. R11 observed his catheter bag hanging from the bedframe in the dignity bag at the time of the interview and stated the current bag is draining well and he doesn't have an issue with it hanging from the bedframe.</p> <p>During interview on 5/14/25 at 12:45 p.m., the DON and ADON reiterated R11's wishes keeping the catheter bag on the floor. The corporate vice president of success (VP) stressed the need to have a barrier between the catheter bag and the floor.</p> | 21375                                                                  |                                                                                                                          |  |                                                     |



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| 21375                                                                 | <p>Continued From page 6</p> <p>A policy titled "Catheter Care" dated 3/15/23 indicated "privacy/dignity bags will be available and a catheter drainage bag should be covered or shielded at all times when in use."<br/>Disinfecting Equipment</p> <p>R125's resident admission MDS assessment was not completed at time of survey. R125's cognition was intact.</p> <p>R125 was admitted on 5/7/25 following hospital admission for acute respiratory failure with hypercapnia (too much carbon dioxide in the blood). R125's admission diagnosis include, heart failure, respiratory disease, right lower leg pressure ulcer (reduce blood pressure to body area, leading to skin and tissue damage), left lower leg pressure ulcer, right hip pressure ulcer, perineum (area of sensitive skin between genitals and anus) wound, spinal vertebrae pain, lumbar pain, adult failure to thrive and a new diagnosis of urinary retention requiring a urinary catheter to drain bladder.</p> <p>During an observation on 5/12/25 at 8:55 a.m., nursing assistant (NA)-D and NA-C answered R125's call light, taking mechanical transfer lift from the hallway without wiping it down, assisted resident to commode, then back to chair. NA-D placed the mechanical transfer lift into the hall without wiping it down or sanitizing.</p> <p>During observation on 5/12/25 at 9:23 a.m., NA-D and NA-C answered call light for another room, the same mechanical transfer lift was used for the 2nd resident without being wiped down or sanitized before or after the 2nd use.</p> <p>During interview on 5/12/25 at 9:33 a.m., NA-D stated facility equipment should be cleaned</p> | 21375                                                                  |                                                                                                                          |  |                                                     |



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| 21375                                                          | <p>Continued From page 7</p> <p>between residents, this is done to help prevent the spread of infection from resident to resident. NA-D confirmed she had not wiped the lift after using it with R125 and before using it with the 2nd resident.</p> <p>During interview on 5/13/25 at 11:43 a.m., director of nursing (DON) and assistant director of nursing (ADON) stated it is an expectation mechanical lifts are sanitized after use with each resident.</p> <p>Per facility policy titled Standard Precautions Infection Control dated 3/24/23, reusable resident equipment, such as mechanical lifts, should be cleaned and disinfected between residents.</p> <p>Appropriate PPE Donning/Doffing</p> <p>R125's resident admission MDS assessment was not completed at time of survey. R125's cognitive function was intact.</p> <p>R125 was admitted on 5/7/25 following hospital admission for acute respiratory failure with hypercapnia (too much carbon dioxide in the blood). R125's admission diagnosis include, heart failure, respiratory disease, right lower leg pressure ulcer (reduce blood pressure to body area, leading to skin and tissue damage), left lower leg pressure ulcer, right hip pressure ulcer, perineum (area of sensitive skin between genitals and anus) wound, spinal vertebrae pain, lumbar pain, adult failure to thrive, new diagnosis of urinary retention requiring a urinary catheter to drain bladder, and c-difficile (contagious pathogen in stool).</p> <p>R125 had an order to be placed in a room designated with contact precautions (used for</p> | 21375                                                                             |                                                                                                                          |  |                                              |



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| 21375                                                                 | <p>Continued From page 8</p> <p>residents with known or suspected infections that pose an increased risk for infection transmission). R125 was placed in a room with contact precautions implemented.</p> <p>R126's resident admission MDS assessment was not completed at time of survey. R126's cognitive function was intact.</p> <p>R126 was admitted on 5/16/25 following hospital admission after left knee surgery. R126's admission diagnosis includes, type 2 diabetes, chronic kidney disease requiring dialysis, heart failure, irregular heart rate, history of long-term antibiotic use, and known infection of left knee surgical site.</p> <p>R126 had an order to be placed in a room designated with contact precautions . R126 was placed in a room with contact precautions implemented.</p> <p>During observation on 5/12/25 at 1:09 p.m., housekeeping (H)-A donned gown and gloves upon entering room 304. Upon exiting 304, H-A removed gloves, did not take off gown. H-A applied new gloves to clean room 306 and did not change gown from the previous room. Upon exiting 306, H-A removed gloves but did not take off gown before moving to clean the 3rd room. H-A applied new gloves to clean room 308 but did not change his gown from the previous 2 rooms. Upon exiting 308, H-A removed gown and gloves.</p> <p>During interview on 5/12/25 at 1:27 p.m., H-A stated the process for cleaning each room is the same when you are in the room (wipe stuff down, mop the floor, clean bathroom, empty trash, etc.). H-A stated the process for cleaning contact isolation rooms depends on the specific type of</p> | 21375                                                                  |                                                                                                                          |  |                                                     |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WHITEWATER HEALTH SERVICES</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>525 BLUFF AVENUE<br/>ST CHARLES, MN 55972</b>                                |  |                                                     |
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| 21375                                                                 | <p>Continued From page 9</p> <p>isolation pathogen, generally you need an isolation gown and gloves for cleaning these types of isolation rooms. H-A stated it is an acceptable practice to wear the same gown to clean multiple rooms; would just need to change gloves between rooms.</p> <p>During interview on 5/12/25 at 2:00 p.m., housekeeping supervisor (H)-B stated it is an expectation for housekeepers to change isolation gowns and gloves each time they enter a room to clean. Wearing the same gown for each room could spread different infections to residents.</p> <p>During interview on 5/12/25 at 2:09 p.m., assistant director of nursing (ADON) and corporate vice president of success (VP) stated it is an expectation and facility policy to remove gown and gloves after cleaning each room. This process is done to prevent the spread of infection between residents during the cleaning process.</p> <p>Per facility policy titled Transmission-Based (Isolation) Precautions, dated 9/24/24, donning PPE upon room entry and discarding before exiting the room is done to contain pathogens.</p> <p>SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policies/procedures regarding isolation precautions for the resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They could also do environmental rounds, audits, and re-education anytime isolation precautions are placed. The ICP should have formal training to be completed according to regulation and head the above measures. The ICP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI)</p> | 21375                                                                  |                                                                                                                          |  |                                                     |



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| 21375                                                                 | Continued From page 10<br><br>committee for a determined amount of time, until<br>the QAPI committee determines successful<br>compliance or the need for ongoing monitoring.<br><br>TIME PERIOD FOR CORRECTION: 21<br>(twenty-one) DAYS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 21375                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                        |
| 21565                                                                 | MN Rule 4658.1325 Subp. 4 Administration of<br>Medications Self Admin<br><br>Subp. 4. Self-administration. A resident may<br>self-administer medications if the comprehensive<br>resident assessment and comprehensive plan of<br>care as required in parts 4658.0400 and<br>4658.0405 indicate this practice is safe and there<br>is a written order from the attending physician.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview and record<br>review, the facility failed to ensure a<br>self-administration of medication (SAM)<br>assessment was completed for 1 of 1 resident's<br>(R16) reviewed for medication administration.<br><br>Findings include:<br><br>R16's quarterly Minimum Data Set (MDS)<br>assessment dated 4/12/25 indicated R16 was<br>cognitively intact.<br><br>R16's provider orders, included an order for<br>Nystatin antifungal powder to both breasts and<br>groin folds every 12 hours as needed .<br><br>During observation on 5/14/25 at 7:17 a.m.,<br>registered nurse (RN)-A dispensed antifungal<br>powder in a medication cup, walked to R16's<br>room, and handed the medication cup to the | 21565                                                                                     | 21565 Self Administration of Medication<br>What Corrective actions will be<br>accomplished for those residents found to<br>have been affected by the deficient<br>practice.<br>R16's POA/family does not want resident<br>self-administering medications. Licensed<br>staff were re-educated by reviewing the<br>policies of Medication Administration and<br>Medication Administration<br>Self-Administration by Resident.<br><br>How other residents having the potential<br>to be affected by the same deficient<br>practice will be identified and what<br>corrective actions will be taken:<br>No other residents were affected. All in<br>house residents had the potential to be<br>affected. |  | 6/12/25                                                |



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| NAME OF PROVIDER OR SUPPLIER<br><br>WHITEWATER HEALTH SERVICES |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>525 BLUFF AVENUE<br>ST CHARLES, MN 55972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                              |
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| 21565                                                          | <p>Continued From page 11</p> <p>director of nursing (DON) who was already in the room. The DON then placed the cup of powder on R16's bedside table and left the room. The DON stated R16 was getting ready for the day and would apply the powder herself when she is ready.</p> <p>During interview on 5/14/25 at 10:55 a.m., RN-A stated she did not think any current residents had a SAM assessment. RN-A stated a SAM assessment is needed to determine if a resident is safe to administer prescribed medications. Once a resident is deemed safe, a provider order is required for medications to be left at bedside. RN-A stated the SAM assessment is important to make sure the resident does not forget to take the medication. RN-A indicate all prescribed medications required a SAM assessment prior to leaving the medication at the bedside. RN-A confirmed R16 did not have a SAM assessment on file.</p> <p>During an interview on 5/14/25 at 11:20 a.m., the assistant director of nursing (ADON) stated residents who chose to have medications left at bedside would require an assessment for safety and a provider order to leave the medication at bedside. The ADON stated there are currently no residents who require a SAM assessment. The ADON stated narcotics are not allowed to be administered independently however all other medications are evaluated on a "case by case basis". The ADON stated medications cannot be left with residents unless a SAM is performed to ensure residents are deemed safe to administer the medication properly. Self-administration assessments are reviewed every 3 months for safety and is documented .</p> | 21565                                                           | <p>What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Licensed staff were re-educated by reviewing the policies of Medication Administration and Medication Administration Self-Administration by Resident. DON and licensed staff will be in-serviced on self-administration of medication policy by June 12th. Any residents wanting to self-administer medications will have a self-administration assessment completed to see if they have the ability to follow the safety guidelines. Self-administration assessments will be completed initially, quarterly, annually and with significant changes. If deemed safe to self-administer, licensed nursing staff will obtain order from the provider.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:<br/>IDT committee will review and discuss residents that wish to self-administer medications. The residents who have demonstrated the ability and desire to self-administer meds in a safe manner will be observed by the DON/Designee doing this self-administration. DON/Designee will complete 2 random medication pass audits weekly for 6 weeks. Completed audits will be brought to QAPI for review, analysis, and further recommendations (if needed).</p> |  |                                              |



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| 21565                                                                 | <p>Continued From page 12</p> <p>Facility policy titled Medication Administration General-Guidelines dated 1/2023, included Residents are allowed to self-administer medications when specifically authorized by the prescriber, the nursing care center's Interdisciplinary Team (IDT), and in accordance with procedures for self-administration of medications and state regulations.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty one (21) days.</p> | 21565                                                                  |                                                                                                                          |  |                                                     |