CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAI **PART**

CICARE/MEDICALD CERTIFICATION AND TRANSMITTAL	ID: MKWH
I - TO BE COMPLETED BY THE STATE SURVEY AGENCY	Facility ID: 00942

MEDICARE/MEDICAID PROVIDER N	NO.	3. NAME AND AD	DDRESS OF FACI	LITY		4. TYPE OF ACTION: 2 (L8)
(L1) 245270		(L3) WHITEWAT		SERVICES	S	1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO. (L2) 823957600		(L4) 525 BLUFF (L5) ST CHARLE			(L6) 55972	3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9) 03/01/2017	NERSHIP	7. PROVIDER/SU.		RY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 12/07/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	021 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 45 (L37) (L38)	19 SNF (L39)	B. Not in Cor Requirements:	mce With Requirements ce Based On: Acceptable POC mpliance with Prog and/or Applied Wa IID (L43)	ram ivers:	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: A* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
	to (ii 7ii i Elentei	SESSION ETC CANCE	DEDATION DATE). 		
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17. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGENCY	APPROVAL Date:
17. SURVEYOR SIGNATURE Karen Aldinger, Unit Sup	ervisor		01/05/2022	(L19)	Melissa Poepping, Enfo	
Karen Aldinger, Unit Sup				` ′		orcement Specialist 01/05/2022 (L20)
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 5, 2022

CMS Certification Number (CCN): 245270

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 16, 2021 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Mighing

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 5, 2022

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

RE: CCN: 245270

Cycle Start Date: October 18, 2021

Dear Administrator:

On November 10, 2021, we notified you a remedy was imposed. On December 7, 2021 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 December 16, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective November 25, 2021 be discontinued as of December 16, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of November 10, 2021, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 25, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

Mighing

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CE	RITFICATION AN	ND TRANSMITTAL
PART I - TO RE COMPLETE	D BV THE STATE	SUBVEV ACENCY

Facility ID: 00942

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16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
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	(L32)			(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted November 10, 2021

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

RE: CCN: 245270

Cycle Start Date: October 18, 2021

Dear Administrator:

On October 18, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On October 13, 2021, the situation of immediate jeopardy to potential health and safety cited at F0578 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 25, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 25, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 25, 2021, (42 CFR 488.417 (b)).

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.

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 \$11,160; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 25, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor St. Cloud A District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: karen.aldinger@state.mn.us

Office: (651) 201-3794 Mobile: (320) 249-2805

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 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 April 18, 2022 (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 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

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.

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:

William Abderhalden, Fire Safety Supervisor Deputy State Fire Marshal Health Care/Corrections Supervisor – Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145

Cell: (507) 361-6204

Email: william.abderhalden@state.mn.us

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

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Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 12/21/2021 FORM APPROVED OMB NO. 0938-0391

		L IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION NG	()	(X3) DATE SURVEY COMPLETED	
	245270		B. WING				C 18/2021
	PROVIDER OR SUPPLIER	1 1		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972	DE		10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
E 000	Initial Comments On 10/11/21, 10/12 10/15/21 and 10/18 with Appendix Z, Er Requirements, §48 during a standard re facility was NOT in The facility's plan of as your allegation of Department's accelenrolled in ePOC, y at the bottom of the form. Upon receipt of an onsite revisit of you validate substantial regulation has been EP Program Patien CFR(s): 483.73(a)(3) §403.748(a)(3), §47	2/21, 10/13/21, 10/14/21, /21, a survey for compliance mergency Preparedness 3.73(b)(6) was conducted ecertification survey. The compliance. If correction (POC) will serve of compliance upon the otance. Because you are four signature is not required effirst page of the CMS-2567 Cacceptable electronic POC, and are facility may be conducted to compliance with the fattained. If Population 3.	E 0	DEFICIENCY)	PROPRI		12/1/21
ADODATOR	§483.73(a)(3), §483 §485.68(a)(3), §483 §485.920(a)(3), §483 [(a) Emergency Pla and maintain an emergency Pla and maintain an emergency and maintain an emergency; and including delegation	160.84(a)(3), §482.15(a)(3), 3.475(a)(3), §484.102(a)(3), 5.625(a)(3), §485.727(a)(3), 91.12(a)(3), §494.62(a)(3). In The [facility] must develop hergency preparedness plan red, and updated at least every must do the following:] It/client] population, including, ersons at-risk; the type of resons at-risk; the type of resonation in continuity of operations, as of authority and succession	JATUDE.	TITLE			(X6) DATE

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

,

Electronically Signed

11/19/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		l'	(X3) DATE SURVEY COMPLETED		
		245270	B. WING			C 10/18/2021	
	PROVIDER OR SUPPLIER	/ICES		52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BLUFF AVENUE T CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Plan. The LTC facian emergency prepreviewed, and updaplan must do all of (3) Address reside limited to, persons LTC facility has the emergency; and coincluding delegation plans. *NOTE: ["Persons hospice, PACE, HRRHC/FQHC, or ESThis REQUIREME by: Based on interview facility failed to addincluding the person operations plan. Tall 34 residents residents residents residents include: The facility's Emergundated, failed to inpopulation to include During interview or executive directors plan did not addresserved. Subsistence Needs	at §483.73(a):] Emergency lity must develop and maintain paredness plan that must be ated at least annually. The the following: In the population, including, but not at-risk; the type of services the eability to provide in an ontinuity of operations, ans of authority and succession at risk" does not apply to: ASC, HA, CORF, CMCH, RD facilities.] NT is not met as evidenced and document review, the dress their resident population at risk, in their emergency his had the potential to affect siding at the facility. In 10/18/21, at 10:04 a.m. the verified the facility emergency as the population of persons as for Staff and Patients	ΕO		Assessment of current resident population conducted on 11/19/2021 Assessment tool placed in emergence evacuation kit at each nurse's station use by staff in the event of an emerge Assessment will be updated weekly. Audits will be conducted weekly to ercompliance. Audit findings will be reviewed at QAPI meeting.	oy n for ency.	12/1/21
	CFR(s): 483.73(b)						

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED C		
		245270	B. WING _			/18/2021		
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP COD 525 BLUFF AVENUE ST CHARLES, MN 55972				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
E 015	Continued From pa	ge 2	E 0′	15				
		18.113(b)(6)(iii), §441.184(b) §482.15(b)(1), §483.73(b)(1), 35.625(b)(1)						
	develop and implem policies and proced plan set forth in par assessment at para and the communica this section. The policy be reviewed and up for LTC facilities].	ocedures. [Facilities] must nent emergency preparedness lures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must odated every 2 years [annually At a minimum, the policies and ddress the following:						
	and patients whether place, include, but a (i) Food, water, measupplies (ii) Alternate source following: (A) Temperatures to safety and for the seprovisions. (B) Emergency light	extinguishing, and alarm						
	Policies and proced (6) The following ar hospice-operated in The policies and pr following:	pice at §418.113(b)(6)(iii):] dures. The additional requirements for apatient care facilities only. The occurrence of the subsistence needs for						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	245270 B. WING			1	C 18/2021	
	PROVIDER OR SUPPLIER ATER HEALTH SERV	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
E 015	evacuate or shelter limited to the follow (A) Food, water, me supplies. (B) Alternate source following: (1) Temperatures to safety and for the sprovisions. (2) Emergency light (3) Fire detection, esystems. (C) Sewage and water This REQUIREMENT by: Based on interview facility failed to inclusive facility failed to inclusive facility failed to inclusive sewage and waster emergency. This has residents at the facility failed: Review of the facility would obtain pharm they would maintain during an emergen	and patients, whether they in place, include, but are not ing: edical, and pharmaceutical es of energy to maintain the protect patient health and afe and sanitary storage of ting. Extinguishing, and alarm este disposal. Nor is not met as evidenced and document review, the ude in their emergency (DP) how to obtain explies and how to maintain disposal during an ed the potential to affect 34 elility. Extinguishing and alarm extended and document review, the ude in their emergency (DP) how to obtain explies and how to maintain disposal during an ed the potential to affect 34 elility.	E 018	Shelter in place and evacuation procedures updated in emergency preparedness plan to reflect how would ensure delivery of medical either situation. Agreement with lobtained in the event our sewage fails. In this situation, Kimo's wou portable bathrooms and we woul commodes and sewage into the bathrooms, keeping a few design staff use. Agreement has been a emergency preparedness plan. Vensure compliance upon annual emergency preparedness plan.	we we we we we we we system ald bring dempty portable nated for dded to Will	
	executive director v Policies/Procedures CFR(s): 483.73(b)(10/18/21, at 10:22 a.m., the rerified this information. s for Medical Documentation 5) 16.54(b)(4), §418.113(b)(3),	E 023	3		12/1/21

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245270	B. WING			1	C 18/2021		
	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	1 10/	10/2021		
(X4) ID PREFIX TAG			ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
E 023	§483.73(b)(5), §483 §485.68(b)(3), §485	ge 4 60.84(b)(6), §482.15(b)(5), 3.475(b)(5), §484.102(b)(4), 5.625(b)(5), §485.727(b)(3), 36.360(b)(2), §491.12(b)(3),	ΕO	23					
	develop and implen policies and proced plan set forth in par assessment at para and the communicathis section. The pobe reviewed and up [annually for LTC fa	pocedures. The [facilities] must ment emergency preparedness dures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must odated at least every 2 years acilities]. At a minimum, the dures must address the							
	protects confidentia	system of medical preserves patient information, lity of patient information, and availability of records.							
	procedures. (5) As that does the follow (i) Preserves patien (ii) Protects confide								
	procedures. (2) As documentation that donor information, potential and actual	6.360(b):] Policies and system of medical preserves potential and actual protects confidentiality of I donor information, and ains the availability of records.							

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245270	B. WING		C 10/18/2021	
	PROVIDER OR SUPPLIER ATER HEALTH SERV	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	This REQUIREMENT by: Based on interview facility failed to develop and implement of the executive director. The facility's emerging 10/18/21, was revied director. The facility would preserve patronfidentiality of parand maintain availar an emergency. During an interview the executive director or procedure documents. Roles Under a Wair CFR(s): 483.73(b)(8), §441.184(b)(8), §441.184(b)(8), §483.73(b)(6), §403.748(b) (8), §485.920(b)(7). [(b) Policies and procedure documents of the communication of the communication. The policies and the communication of the communication of the communication of the communication. The policies and the communication of the communication of the communication of the communication.	And document review, the elop a policy and procedure medical documents. This had ct all 34 residents residing in ency operations plan reviewed when we will be executive and no system in place that itent information, protect tient information, and secure bility of records in the event of ency operations plan reviewed when he will be executive and no system in place that itent information, and secure bility of records in the event of ency operation on 10/18/21, at 10:32 a.m. for verified there was not a to preserve medical ever Declared by Secretary (8) (6.54(b)(6), §418.113(b)(6)(C), §460.84(b)(9), §482.15(b) §483.475(b)(8), §485.625(b)	E 026	Resident demographic pages, physician and contact information in the center's emergency evact by 12/1/2021 and will be update weekly basis. Audits will be conweekly to ensure compliance. A findings will be reviewed at QAF	on, placed uation kit ed on a ducted	12/1/21

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245270		` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C 10/18/2021	
			B. WING		_ 1		
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STA 525 BLUFF AVENUE ST CHARLES, MN 55972	TE, ZIP CODE	0,10,2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
E 026	policies and proced following:] (8) [(6), (6)(C)(iv), ([facility] under a wain accordance with provision of care arcare site identified officials. *[For RNHCIs at §4 procedures. (8) The waiver declared by with section 1135 of at an alternative camanagement official This REQUIREMED by: Based on document facility failed to devin its emergency plain providing care arsites under section potential to affect a residing in the facility Findings Include: The facility emerged did not contain infoothe facility's role in at alternate care sit During an interview the executive direct policy and procedure the facility's role in a contain infoothe facility in a contain infoothe f	rocilities]. At a minimum, the lures must address the 7), or (9)] The role of the iver declared by the Secretary, section 1135 of the Act, in the nd treatment at an alternate by emergency management 03.748(b):] Policies and erole of the RNHCI under a the Secretary, in accordance of Act, in the provision of care are site identified by emergency als. NT is not met as evidenced and treview and interview, the elop policies and procedures an describing the facility's role and treatment at alternate care 1135 act waiver. This had the li 34 residents currently	EO	Information regardin placed in emergency on 11/17/2021. Will e upon annual review o preparedness plan.	preparedness plan ensure compliance		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C		
		245270	B. WING		10)/18/2021	
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972		710/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	§441.184(c)(1), §48; §483.73(c)(1), §48; §485.68(c)(1), §48; §485.920(c)(1). [(c) The [facility mu emergency prepare that complies with I and must be review 2 years [annually for communication pla following: [i) Staff. (ii) Entities providin (iii) Patients' physic (iv) Other [facilities] (v) Volunteers. *[For Hospitals at § §485.625(c)] The coinclude all of the fol (1) Names and confollowing: (i) Staff. (ii) Entities providin (iii) Patients' physic (iv) Other [hospitals (v) Volunteers. *[For RNHCIs at §485.625(c)] The coinclude all of the fol (1) Names and confollowing: (ii) Staff. (iii) Entities providin (iiii) Patients' physic (iv) Other [hospitals (v) Volunteers.	1) 16.54(c)(1), §418.113(c)(1), 60.84(c)(1), §482.15(c)(1), 3.475(c)(1), §484.102(c)(1), 85.625(c)(1), §485.727(c)(1), 86.360(c)(1), §491.12(c)(1), 8491.12(c)(1), 8491.12	E 03	30		12/1/21	
		n must include all of the					

NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	` '	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES IX CAN IDENTIFY IN STATEMENT OF DEFICIENCIES SEE BLUFF AWENUE IX CHAPTER STATEMENT OF DEFICIENCIES ST CHARLES, IN 55972 IX CHAPTERS, IN 55972 PROVIDER'S PLAN DE CORRECTION INCESTOR PRECIDED BY BLL REGULATION OF LEGICIENCIES (CACH DEFICIENCY MUST DE PRECIDED BY BLL REGULATION OF LEGICIENCY) E 030 Continued From page 8 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCLs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (i) Names and contact information for the following: (ii) Patients' physicians. (iv) Other Physicians. (iv) Other Physicians. (iv) Definition plan must include all of the following: (i) Hospice employees. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hypsicians. (iv) Definition providing services under arrangement. (iii) Patients' physicians. (iv) Definition providing services under arrangement. (iii) Patients' physicians. (iv) Definition providing services under arrangement. (iii) Patients' physicians.			245270					
S25 BLUFF AVENUE ST CHARLES, MN 55972	NAME OF F	DDOV/IDED OD SLIDDLIED	245270	D. WING		TREET ADDRESS CITY STATE ZID CODE	10/	18/2021
ECAH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG CROSR-CTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 030 Continued From page 8 (1) Names and contact information for the following: (i) Starf. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (i) Starf. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (1) Names and contact information for the following: (1) Starf. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (v) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (1) Names and contact information for the following: (1) Patients' physicians. (1) Patients' physicians.			ICES		5	25 BLUFF AVENUE		
(1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCls. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (1) Names and contact information for the following: (1) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
*[For OPOs at §486.360(c):] The communication plan must include all of the following:	E 030	(1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Next of kin, gua (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416 plan must include a (1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Patients' physic (iv) Volunteers. *[For Hospices at § communication plan following: (1) Names and confollowing: (i) Hospice employe (ii) Entities providing (iii) Patients' physic (iv) Other hospices. *[For HHAs at §484 plan must include a (1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Patients' physic (iv) Volunteers. *[For OPOs at §486 *[For OPOs at §486 *[For OPOs at §486	g services under arrangement. rdian, or custodian. .45(c):] The communication and the following: tact information for the g services under arrangement. ians. 418.113(c):] The must include all of the tact information for the ses. g services under arrangement. ians. 4.102(c):] The communication and of the following: tact information for the g services under arrangement. ians. 6.360(c):] The communication and of the following: tact information for the g services under arrangement. ians.	E	030			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	PLE CONSTRUCTION IG	COM	E SURVEY IPLETED
		245270	B. WING _		1	C 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	1 10/	10/2021
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E 030	following: (i) Staff. (ii) Entities providing (iii) Volunteers. (iv) Other OPOs. (v) Transplant and of Donation Service A This REQUIREMEN by: Based on interview	g services under arrangement. donor hospitals in the OPO's rea (DSA). NT is not met as evidenced and document review, the	E 03	Physician information and conta		
	required information and contact numbe information for physic affect all 34 resident Findings include: During interview on executive director a list of physicians and staff names and the information in the e	10/18/21, at 10:46 a.m. the acknowledged there was not a ad their contact numbers or eir contact numbers mergency operations plan. as Contact Information	E 03	information is included on reside demographic sheets which were the nurses stations in the evacua by 12/1/2021. Audits will be concuevely to ensure compliance. Fit will be reviewed at QAPI meeting	placed at ition kits lucted ndings	12/1/21
	§441.184(c)(2), §46 §483.73(c)(2), §485 §485.68(c)(2), §485 §485.920(c)(2), §485 §494.62(c)(2). [(c) The [facility] mule mergency prepare that complies with F	16.54(c)(2), §418.113(c)(2), 60.84(c)(2), §482.15(c)(2), 8.475(c)(2), §484.102(c)(2), 6.625(c)(2), §485.727(c)(2), 86.360(c)(2), §491.12(c)(2), set develop and maintain an edness communication plan Federal, State and local laws yed and updated at least every				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	(X3) DATE SURVEY COMPLETED C	
		245270	B. WING		10/18/2021
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E 031	2 years [annually for communication plan following: (2) Contact information Federal, State, the emergency prepared (ii) Other sources on the following: *[For LTC Facilities information for the folion formation for folion formation for federal fand contact in this had the potent currently residing in Findings include:	or LTC facilities]. The n must include all of the n must include all ocal edness staff. If assistance. If assistance, at §483.73(c):] (2) Contact following: and Certification Agency, and all ocal edness staff. If assistance, asing and Certification Agency, are tipled, regional, and local edness staff. If assistance, asing and Certification Agency, are tipled and Advocacy Agency. The not met as evidenced and document review, the are their Emergency OP) included contact formation for the Ombudsman, and to affect all 34 residents in the facility.	E 031	Ombudsman contact information at to emergency preparedness plan of 11/17/2021. Will ensure compliance annual review of emergency preparedness plan.	n
	The facility's EOP v	vas reviewed with the			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION IG	COMPLETED
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E 031	lacked documentat federal emergency contact information On 10/18/21, at 10:	ommunication plan however, ion of contact information for preparedness staff and for the Ombudsman. 50 a.m. the executive director	E 03	31	
E 035 SS=C	CFR(s): 483.73(c)(naring Plan with Patients B)	E 03	95	12/1/21
	an emergency prep that complies with I and must be review	at §483.73(c):] must develop and maintain aredness communication planederal, State and local laws and updated at least munication plan must include			
	emergency prepare that complies with I and must be review	st develop and maintain an edness communication plan Federal, State and local laws red and updated at least every nunication plan must include			
	emergency plan, th is appropriate, with families or represer This REQUIREMET by: Based on interview facility failed to ens Plan (EOP) was co	aring information from the at the facility has determined residents [or clients] and their ntatives. NT is not met as evidenced and document review, the the Emergency Operations mmunicated to residents wes. This had the potential to		Emergency preparedness informations shared with residents and represe by 12/1/2021 including information to obtain additional details. New residents	ntatives on how

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
		0.45050					c
		245270	B. WING			10/	18/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WHITEW	ATER HEALTH SERV	ICES			25 BLUFF AVENUE		
				S	T CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	Findings include: The facility's EOP procumentation of a information from the had determined appropriate families or representation of a information from the had determined appropriate families or representation of the emergency plant families. EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §43 §441.184(d)(1), §43 §485.68(d)(1), §48 §485.68(d)(1), §48 *[For RNCHIs at §4 Hospitals at §482.1 at §484.102, "Organ OPOs at §486.360, (1) Training program the following: (i) Initial training in expolicies and proceed staff, individuals program arrangement, and expected roles. (ii) Provide emergeleast every 2 years.	plan reviewed 10/18/21, lacked method for sharing e emergency plan the facility propriate with residents and resentatives. on 10/19/21, at 2:20 p.m. the confirmed the facility had not d for sharing information from with residents and their match the facility had not d for sharing information from with residents and their match the facility had not do for sharing information from the with residents and their match the facility had not do for sharing information from the with residents and their match the facility had not do for sharing information from the facility had not do for sharing information from the facility had not do for sharing at had all of the facility had not do for sharing the facility had	E		and representatives will be provided emergency preparedness informati upon admission via the new admission packet. Training provided to social services director regarding the requirement to include in the admission packet.	ion sion	12/1/21
		entation of all emergency					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	CON	TE SURVEY MPLETED
		245270	B. WING _		1	C / 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP COE 525 BLUFF AVENUE ST CHARLES, MN 55972	•	10,2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 037	procedures. (v) If the emergency procedures are signated to all (i) Initial training in policies and procedures are expected roles. (ii) Demonstrate staprocedures. (iii) Provide emergency prepare employees (including special emphasis procedures necess others. (v) Maintain docum preparedness training (vi) If the emergency preparedness are signated to all (vi) If the emergency preparedness training procedures are signated to all (vi) If the emergency	ing. aff knowledge of emergency y preparedness policies and nificantly updated, the [facility] ng on the updated policies and 418.113(d):] (1) Training. The l of the following: emergency preparedness lures to all new and existing and individuals providing ungement, consistent with their aff knowledge of emergency ency preparedness training at iew and rehearse its edness plan with hospice ng nonemployee staff), with laced on carrying out the ary to protect patients and entation of all emergency	E 03	37		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	COM	E SURVEY MPLETED
		245270	B. WING _			C 1 8/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		10,2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 037	preparedness train (iii) Demonstrate st procedures. (iv) Maintain docum preparedness train (v) If the emergenc procedures are sign must conduct traini procedures. *[For PACE at §460 organization must of (i) Initial training in policies and proced staff, individuals pre arrangement, contr volunteers, consiste (ii) Provide emerge least every 2 years (iii) Demonstrate st procedures, includi what to do, where t case of an emerge (iv) Maintain docum (v) If the emergency procedures are sign must conduct traini procedures. *[For LTC Facilities Program. The LTC following: (i) Initial training in policies and proced staff, individuals procedures are staff, individuals procedures.	ing, provide emergency ing every 2 years. aff knowledge of emergency mentation of all emergency ing. by preparedness policies and nificantly updated, the PRTF ing on the updated policies and 0.84(d):] (1) The PACE do all of the following: emergency preparedness lures to all new and existing eviding on-site services under actors, participants, and ent with their expected roles. Incy preparedness training at aff knowledge of emergency ing informing participants of o go, and whom to contact in	E 03	7		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 037	least annually. (iii) Maintain documpreparedness training (iv) Demonstrate st procedures. *[For CORFs at §48 CORF must do all of (i) Provide initial trapreparedness policing and existing staff, in under arrangement with their expected (ii) Provide emerge least every 2 years (iii) Maintain docum (iv) Demonstrate st procedures. All new and assigned specific the CORF's emergentheir first workday, include instruction in alarm systems and equipment. (v) If the emergentheir first workday include instruction in alarm systems and equipment. (v) If the emergentheir first workday include instruction in alarm systems and equipment. (v) If the emergentheir first workday include instruction in alarm systems and equipment. (v) If the emergentheir first workday include instruction in alarm systems and equipment. (v) If the emergentheir first workday include instruction in alarm systems and equipment. (v) If the emergentheir first workday include instruction in alarm systems and equipment. (v) If the emergentheir first workday include instruction in alarm systems and equipment. (v) If the emergentheir first workday include instruction in alarm systems and equipment. (v) If the emergentheir first workday include instruction in alarm systems and equipment. (v) If the emergentheir first workday include instruction in alarm systems and equipment. (v) If the emergentheir first workday include instruction in alarm systems and equipment. (v) If the emergentheir first workday include instruction in alarm systems and equipment.	ncy preparedness training at lentation of all emergency ng. aff knowledge of emergency 35.68(d):](1) Training. The of the following: ining in emergency ies and procedures to all new individuals providing services, and volunteers, consistent roles. Incy preparedness training at lentation of the training. aff knowledge of emergency or personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of The training program must in the location and use of signals and firefighting cy preparedness policies and inficantly updated, the CORF ing on the updated policies and inficantly (1) Training program.	E 03	37		

	JRVEY TED
245270 B. WING 10/18/2	2021
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) DMPLETION DATE
E 037 Continued From page 16 cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct annual training of the Emergency Operations Plan (EOP) plan with staff. This had the potential to affect all 34 residents and staff. Findings include: During an interview on 10/18/21, at 11:09 a.m. the executive director confirmed EOP training was completed upon hire however, lacked	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .		CONSTRUCTION	СОМ	E SURVEY IPLETED
		245270	B. WING			1	C 18/2021
	PROVIDER OR SUPPLIER	ICES		525	EET ADDRESS, CITY, STATE, ZIP CODE BLUFF AVENUE CHARLES, MN 55972	107	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 037	documentation to in training based on the assessment comple executive director v completing annual	dicate the facility had annual ne emergency plan and risk eted by the facility. The rerified the facility was not training on the EOP.	EC				
F 000	On 10/11/21, 10/12 10/15/21 and 10/18 survey was conduction investigations were was found to be NO requirements of 42 Requirements for L The following comp SUBSTANTIATED: H5270031C (MN73 F661 and F622.	2/21, 10/13/21, 10/14/21 //21, a standard recertification ted at your facility. Complaint also conducted. Your facility OT in compliance with the CFR 483, Subpart B, ong Term Care Facilities. plaints were found to be (537), with a deficiency cited at	FC				
	UNSUBSTANTIATE H5270033 (MN541 (MN53307), H5270 (MN48867). The IJ began on 8/1 to the facility and the code status, therefore Code status, when resuscitated if his he returned from the he both Full Code and directions in the med directions for Full Corders for life susta 4/20/21, a physician	plaints were found to be ED: H5270032 (MN55823), 34), and H5270034 (035 (MN53097), H5270036 (MN53097), H5270070, H5270070, H5270070, H5270070, H5270070, H5270070, H52					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245270	B. WING		10	C / 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972	•	110/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL PROPERTY OF THE ADDITIONAL PROPERTY OF THE ADDITIONAL PROVIDER OF THE ADDI	SHOULD BE	(X5) COMPLETION DATE
F 000	administrator and d notified of the IJ on was removed on 10 noncompliance rem severity of an E- pa which indicated no more than minimal jeopardy.	ge 18 status was on hold. The irector of nursing (DON) were 10/12/21, at 2:35 p.m. The IJ 0/13/21, at 4:30 p.m. but nained at the lower scope and attern scope and severity level, actual harm with potential for harm that is not immediate constituted substandard	F 0	00		
F 561 SS=D	quality of care and a conducted 10/18/21 The facility's plan or as your allegation of Departments accept enrolled in ePOC, yat the bottom of the form. Your electronic be used as verificated. Upon receipt of an onsite revisit of you validate that substate regulations has been self-Determination CFR(s): 483.10(f)(1) §483.10(f) Self-determination certainly support of incomplete and facilitate through support of incomplete the region of the region	an extended survey was l. f correction (POC) will serve of compliance upon the stance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will cion of compliance. acceptable electronic POC, an of facility may be conducted to notial compliance with the en attained. (a)-(3)(8) Description of the facility must after resident self-determination resident choice, including but ghts specified in paragraphs (f)	F 5	61		12/1/21

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C		` ′	PLE CONSTRUCTION G		
		245270	B. WING _			18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 561	waking times), hear care services constants and applicable provisions. \$483.10(f)(2) The rechoices about asperfacility that are signs \$483.10(f)(3) The rewith members of the community activities facility. \$483.10(f)(8) The reparticipate in other religious, and communiterfere with the rigitality. This REQUIREMED by: Based on interview facility failed to ensure preferences for free for 1 of 1 resident (Finding include: During an interview stated he got one shave two and they even interviewed medical would like, and I to week."	Ith care and providers of health istent with his or her interests, plan of care and other	F 56	R86 interviewed and care planeflect bathing preferences. Facility residents have the posificated. Residents interviewed for bather preferences; care plans updathose preferences. Residents will be interviewed admission and as requested preferences which will be reflicate plan, and bath schedule Interdisciplinary team and nurwere educated by Director of	tential to be hing ted to reflect on for bathing ected in the .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245270	B. WING			10/1	C 18/2021
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES				52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BLUFF AVENUE T CHARLES, MN 55972		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 561	indicated resident's shower and indicate acceptable. During an interview nursing assistant (Non Mondays, and ha week. NA-A show that indicated room the bath schedule for the stated she would first surveyor. LPN-B resident how often type of bath and the schedule. During a p.m. LPN-B verified completed R86's be stated she did not form after she com LPN-B stated she will be placed in the bo (DON) door for the schedule. During an interview the DON stated the by LPN-A or hersel preference sheet won their door, then	erence form dated 9/27/21, a preference for a morning ed twice a week would be of on 10/13/21, at 12:45 p.m. NA)-A stated R86 had a bath he was just scheduled for once wed surveyor the bath schedule (R86's room number) was on for Monday only. If on 10/13/21, at 12:51 p.m. have (LPN)-B stated she was process was to determine how a resident wanted a bath and and out and get back to eturned to surveyor and stated and admitting nurse asked the they would like a bath, what hey were to put it on the bath subsequent interview at 1:04 deshe was the nurse who had athing preference form and know where she placed the pleted it upon admission. Was unaware the form was to be a control of the placed in the mailbox of the placed in the mailbox they update the bath sheet, designed in the resident chart. This	F 5	561	Resident Rights Policy which included bathing preferences, and showers, and nail care education. Task was added to the revised Admission/Re-admission checklist. Director of Nursing/Designee will at care plans once weekly x 8 weeks ensure bathing preferences are hor and care plans are up to date. The results of the audits will be reviby the QAPI committee for trends at needs for adjustment of audit schedor content, as well as any further educational needs. The Executive Director is responsible to ensure the action occurs.	udit to nored iewed and any dules	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	COMPLETED		
		245270	B. WING _		l l	C / 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		
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	A policy was request preferences and was Resident/Family Gr	eting on resident bathing as not provided. oup and Response	F 56			12/1/21
SS=E	and participate in re (i) The facility must group, if one exists reasonable steps, verification to make residents a upcoming meetings (ii) Staff, visitors, or resident group or fathe respective grou (iii) The facility must person who is appr group and the facility providing assistance requests that result (iv) The facility must resident or family groups concerning in the facility. (A) The facility must response and ration (B) This should not facility must implement request of the resident	esident has a right to organize esident groups in the facility. provide a resident or family, with private space; and take with the approval of the group, and family members aware of a in a timely manner. To other guests may attend amily group meetings only at p's invitation. To the provide a designated staff oved by the resident or family try and who is responsible for e and responding to written from group meetings. To consider the views of a group and act promptly upon recommendations of such issues of resident care and life to the able to demonstrate their hale for such response. The beconstrued to mean that the ment as recommended every lent or family group. The sident has a right to have				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	` ´COM	E SURVEY PLETED
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WHILEW	ATER HEALTH SERV	ICES		ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETION DATE	
F 565 Continued From page 22		age 22	F 56	5		
	by:	NT is not met as evidenced		Resident Council meeting held	on	
	Based on interview and document review, the facility failed to ensure concerns raised at the resident council meetings were documented and presented back to the council, for 5 of 5 resident (R26, R21, R4, R23, and R186) who were present during the resident council meeting with survey team.			10/28/21 R26, R21, R4, R23 in attendance. R186 discharged. Concerns documented appropria followed up on with resolution. Resolutions will be shared with i involved with specific concerns a	Grievances ately and andividuals and will be	
	Findings include:			shared with resident council gro meeting in November.	up at next	
	reviewed for the mo	cil meeting minutes were onths of 7/23/21, 8/27/21 and ng minutes revealed the		Facility residents have the poter affected.	tial to be	
	meeting held 7/23/2	were shared. es from the resident council 21, included concerns with food being cold, the attitude of		Activity Director, Executive Director, executi	m ces from and	
	the nursing assista communication bet would like to be inti	nts, the need for better ween staff and residents roduced to new staff. ced housekeeping concerns		Current staff educated by Execu Director starting on 11/12/21 to t Grievance policy and procedure Resident Council policy and procedure	tive he and the	
	meeting held on 8/2 housekeeping resid need better ramps	es from the resident council 27/21, included concerns with dent room and bathroom dirty, for going inside and outside he social work office is small		Executive Director/Designee will Grievance binder weekly x 8 we ensure all grievances were addrand complete.	eks to	
	and is hard for resi- office to talk to her, resident meal ticke preferences, short shower days seem outside of resident	dents to get wheelchairs in her if need be, making sure ts are accurate with staffed on weekends and to be the worst. Staff talking rooms about stuff they do not etimes snacks and ice water		The results of the audits will be by the QAPI committee for trend needs for adjustment of audit so or content, as well as any furthe educational needs. The Executive Director is responsible to ensure action occurs.	ls and any hedules r /e	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JULTIPLE CONSTRUCTION ILDING			(X3) DATE SURVEY COMPLETED C	
		245270	B. WING				18/2021	
	NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES			525	REET ADDRESS, CITY, STATE, ZIP CODE BLUFF AVENUE CHARLES, MN 55972	1 10/	10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 565	are not being passed between staff all stapage and if you do The meeting minute meeting held 9/30/2 of large furniture in completed, request cleaned. Would like On 10/13/21, at 10: meeting was held vR186 and one surv following questions views of the resider promptly upon griev recommendations? respond to the residen promptly upon griev recommendations? responded no. The had concerns, does the rationale for the residencerns with they had shared the council meetings in the time her food wher room. The residence of the residence o	ed, lack of communication aff should be on the same not know find out. es from the resident council 21, included concerns dusting common areas needs to be for all windowsills to be all activities to last an hour. 00 a.m. a resident council with R26, R21, R4, R23 and eyor. When asked the Does the facility consider the not or family groups and act		665				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED C
		245270	B. WING _		1	18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
	minute concerns. L residents have the resolved." During an interview executive director is shared in the reside documented in the worker to share the responsible and that to follow up to addr with the resident. T would expect the form the residents to be A policy and proced grievances was reconstructed and proced grievances was reconstructed by the residents to be a policy and proced grievances was reconstructed by the residents to be a policy and proced grievances was reconstructed by the residents to be a policy and proced grievances was reconstructed by the resident to Facility the facility where converheard. This includes a cellular phone expense. §483.10(g)(7) The facilitate that reside individuals and entificated individuals and entificated individuals and entificated in the internet, to facility; and	SW-A stated, "Its like the same concerns that do not get on 10/14/21, at 11:05 a.m. the stated he expected concern ent council meeting to be meeting minutes, the social concern with the department at it was that staff members job less the concern and follow up he executive director stated he ollow-up and the resolution with documented. Sommunication w/ Privacy 6)-(9) Tesident has the right to have to the use of a telephone, TDD services, and a place in alls can be made without being sludes the right to retain and the at the resident's own facility must protect and ent's right to communicate with ties within and external to the asonable access to: uding TTY and TDD services; the extent available to the large, writing implements and	F 56			12/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245270	B. WING				18/2021	
				525	REET ADDRESS, CITY, STATE, ZIP CODE 5 BLUFF AVENUE CHARLES, MN 55972			
(X4) ID PREFIX TAG			ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 576	PROVIDER OR SUPPLIER WATER HEALTH SERVICES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 5	76	Facility residents have the potential affected. Weekend manager task list update include delivery of mail on Saturday manager is not available, nursing sideliver mail. Interdisciplinary team and nursing educated by the Director of Clinical Services starting on 11/12/21 on the Residents Rights policy and proced which includes the right to send an receive mail and the Mail policy and procedures. Executive Director/Designee will be	e to ys if a staff to staff l e dures d		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LDINGCOM		E SURVEY PLETED	
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	PROVIDER OR SUPPLIER ATER HEALTH SERV			52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BLUFF AVENUE T CHARLES, MN 55972	10/	16/2021
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F 576	shared the staff do The residents share when the activity dir During an interview activity director (AD member that delive Saturday, the mana deliver the mail. The to work on a Monda delivered and state. The AD was not sur during the week if s During an interview executive director s manager on duty or responsibility to pas A policy on resident provided. The Combined Fed revised 6/18/19 incl respect the residen	n Saturdays. The residents not deliver mail on Saturdays. ed they only received mail rector (AC) was working. on 10/14/21, at 4:24 p.m.) stated she was the staff red the mail. The AD stated on ager on duty was supposed to be AD stated she had come in any and the mail had not been do this has been frustrating. The if the mail was delivered the was not at work. on 10/14/21, at 4:29 p.m. the tated the facility had a saturdays and it was their	F 5	76	responsible to ensure manager on schedule is complete monthly for Saturdays with nursing staff back-uneeded. Executive Director/Designee will au Manager on duty task list for comple and check off of the mail pass task for 8 weeks. The results of the audits will be revely the QAPI committee for trends a needs for adjustment of audit schedor content, as well as any further educational needs. The Executive Director is responsible to ensure the action occurs.	ip as dit the etion weekly iewed and any dules	
	is, spoken), written communications, in promptly receive un packages and othe facility for the reside through a means of Request/Refuse/Ds CFR(s): 483.10(c)(6) The resident through a means of Request/Refuse/Ds CFR(s): 483.10(c)(6) The resident through a means of Request/Refuse/Ds CFR(s): 483.10(c)(6) The resident through a means of Reguest/Refuse/Ds CFR(s): 483.10(c)(6) The resident through the resident t	and electronic cluding the right to send and appended mail and other letters, r materials delivered to the ent, including those delivered ther than a postal service."	F 5	78			12/1/21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		TE SURVEY MPLETED C
		245270	B. WING _		10	/18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972	· · · · · · · · · · · · · · · · · · ·	
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F 578	to participate in exp formulate an advar §483.10(c)(8) Noth construed as the right the provision of me services deemed in inappropriate. §483.10(g)(12) The requirements specially requirements specially inform and provide residents concerning medical or surgical resident's option, for (ii) This includes a facility's policies to and applicable Stat (iii) Facilities are per entities to furnish the legally responsible requirements of thic (iv) If an adult indivitime of admission a information or artice has executed an admay give advance individual's resident with State Law. (v) The facility is not provide this information or she is able to reconstructions.	perimental research, and to acce directive. Ing in this paragraph should be ght of the resident to receive dical treatment or medical nedically unnecessary or It facility must comply with the fied in 42 CFR part 489, Directives). In the information to all adult not the right to accept or refuse treatment and, at the formulate an advance directive. In written description of the implement advance directives are law. It is mistration but are still for ensuring that the	F 57	78		

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S25 BLUFF AVENUE S25 BLUFF AVENUE ST CHARLES, MN 55972		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION (X3	COMF	SURVEY
WHITEWATER HEALTH SERVICES SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972 (X4) ID PREFEIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO THE APPROPRIATE DEFICIENCY PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO THE APPROPRIATE DEFICIENCY PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO THE APPROPRIATE DEFICIENCY PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO THE APPROPRIATE DEFICIENCY PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO THE APPROPRIATE DEFICIENCY PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO THE APPROPRIATE DEFICIENCY PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO HAPPROPRIATE DEFICIENCY PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO HAPPROPRIATE DEFICIENCY PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO HAPPROPRIATE DEFICIENCY PREFIX TAG PROVIDER'S PLAN OF CROSS-REFERNDED TO HAPPROPRIATE DEFICIENCY PREFIX TAG PROVIDER TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERNDED TO HAPPROPRIATE DEFICIENCY PREFIX TAG PROVIDED TO HAPPROPRIATE DEFICIENCY PREFIX TAG PROVIDED TO HAPPROPRIATE DEFICIENCY PROVIDED TO HAPPROPRIATE DEFICIENCY PROVIDED TO HAPPROPRIA			245270	B. WING				
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 578 Continued From page 28 Based on interview and document review, the facility failed to ensure a system was in place to clearly identify resident wishes for code status, cardiopulmonary resuscitation (CPR), for 6 of 34 residents (R13, R10, R10, R18, R18, R18, R10, R18, R18, R18, R18, R18, R18, R18, R18	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0.202.
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION) F 578 Continued From page 28 Based on interview and document review, the facility failed to ensure a system was in place to clearly identify resident wishes for code status, cardiopulmonary resuscitation (CPR), for 6 of 34 residents (R13, R10, R32, R184, R26 and R86) reviewed for advanced directives. This failure resulted in an immediate leopardy (LI) for R13, R10, and R32, when their medical records failed to identify the residents in immediate jeopardy, the facility failed to ensure R184, R26, and R86's code status wishes were addressed with the resident or ordered by the physician. The IJ began on 8/11/21, when R13 was admitted to the facility and the facility failed to address code status, therefore considering him to be Full Code status, when R13 wished not to be resuscitated if his heart were to stop. R10 had returned from the hospital on 9/30/21, and had both Full Code and DNR (Do Not Resuscitate) directions for Full Code and DNR (Do Not Resuscitate) directions for Full Code and DNR (Do Not Resuscitate) directions for Full Code and DNR (Do Not Resuscitate) and directions for Full Code and DNR (Do Not Resuscitate) and directions for Full Code and DNR (Do Not Resuscitate) and directions for Full Code and DNR (Do Not Resuscitate) and directions for Full Code and DNR (Do Not Resuscitate) and directions for Full Code and DNR (Do Not Resuscitate) and directions for Full Code on a POLST (provider orders for life sustaining treatment) dated 4/20/21, a physician order dated 9/7/21 indicating DNR, a care plan dated 9/7/21 indicating the code status was on hold. The			W0=0		5	25 BLUFF AVENUE		
F578 Continued From page 28 Based on interview and document review, the facility failed to ensure a system was in place to clearly identify resident wishes for code status, cardiopulmonary resuscitation (CPR), for 6 of 34 residents (R13, R10, R32, R184, R26 and R86) reviewed for advanced directives. This failure resulted in an immediate jeopardy (IJ) for R13, R10, and R32, when their medical records failed to identify the residents wishes accurately. In addition to the residents wishes accurately. In addition to the residents in immediate jeopardy, the facility failed to ensure R184, R26, and R86's code status wishes were addressed with the resident or ordered by the physician. The IJ began on 8/11/21, when R13 was admitted to the facility and the facility failed to address code status, therefore considering him to be Full Code status, when R13 wished not to be resuscitated if his heart were to stop. R10 had returned from the hospital on 9/30/21, and had both Full Code and DNR (Do Not Resuscitate) directions in the medical record, R32 had directions for Full Code on a POLST (provider orders for life sustaining treatment) dated 4/20/21, a physician order dated 9/7/21 indicating DNR, a care plan dated 9/7/21	WHITEW	AIER HEALIH SERV	ICES		S	T CHARLES, MN 55972		
Based on interview and document review, the facility failed to ensure a system was in place to clearly identify resident wishes for code status, cardiopulmonary resuscitation (CPR), for 6 of 34 residents (R13, R10, R32, R184, R26 and R86) reviewed for advanced directives. This failure resulted in an immediate jeopardy (IJ) for R13, R10, and R32, when their medical records failed to identify the residents wishes accurately. In addition to the residents in immediate jeopardy, the facility failed to ensure R184, R26, and R86's code status wishes were addressed with the resident or ordered by the physician. The IJ began on 8/11/21, when R13 was admitted to the facility and the facility failed to address code status, therefore considering him to be Full Code status, when R13 wished not to be resuscitated if his heart were to stop. R10 had returned from the hospital on 9/30/21, and had both Full Code and DNR (Do Not Resuscitate) directions in the medical record. R32 had directions for Full Code on a POLST (provider orders for life sustaining treatment) dated 4/20/21, a physician order dated 9/21/21 indicating DNR, a care plan adated 9/7/21 indicating the code status was on hold. The	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
notified of the IJ on 10/12/21, at 2:35 p.m. The IJ was removed on 10/13/21, at 4:30 p.m. but noncompliance remained at the lower scope and severity of an E- pattern scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. (Physician Orders for Life-Sustaining Treatment). The admitting nurse will be responsible to enter this information into the resident's chart, resident's orders in PCC, and care plan. The admitting nurse will verify upon admission that Advanced Directive wishes are current prior to processing. Clear identification will be available for staff regarding CPR/code status and POLST in PCC (resident orders), in residents' hard chart, and in	F 578	Based on interview facility failed to ensiclearly identify residents (R13, R1 reviewed for advances lead in an immer R10, and R32, who to identify the resident of addition to the resident of addition to the resident or ordered. The IJ began on 8/ to the facility failed to code status wishes resident or ordered. The IJ began on 8/ to the facility and the code status, therefore Code status, when resuscitated if his hard returned from the hard both Full Code and directions for Full Corders for life susta 4/20/21, a physicial indicating DNR, a indicating the code administrator and contified of the IJ or was removed on 1/2 noncompliance reseverity of an E-pushich indicated no more than minimal jeopardy.	and document review, the sure a system was in place to dent wishes for code status, esuscitation (CPR), for 6 of 34 0, R32, R184, R26 and R86) aced directives. This failure ediate jeopardy (IJ) for R13, en their medical records failed ents wishes accurately. In dents in immediate jeopardy, ensure R184, R26, and R86's were addressed with the I by the physician. 11/21, when R13 was admitted the facility failed to address one considering him to be Full R13 wished not to be the facility failed to address one considering him to be Full R13 wished not to be the facility failed to address one considering him to be Full R13 wished not to be the facility failed to address one considering him to be Full R13 wished not to be the facility failed to address one considering him to be Full R13 wished not to be the facility failed to address one considering him to be Full R13 wished not to be the facility failed to address one considering him to be Full R13 wished not to be the facility failed to address one considering him to be Full R13 wished not to be the facility failed to address one considering him to be Full R13 wished not to be the facility failed to address one considering him to be Full R13 wished not to be the facility failed to address one considering him to be Full R13 wished not to be the facility failed to address one considering him to be Full R13 wished not to be facility failed to address one considering him to be Full R13 wished not to be facility failed to address one considering him to be Full R13 wished not to be facility failed to address one considering him to be Full R13 wished not to be facility failed to address one considering him to be Full R13 wished not to be facility failed to address one considering him to be Full R13 wished not to be facility failed to address one considering him to be Full R13 wished not to be failed to address one considering him to be Full R13 wished not to be failed to address one considering him to be failed to address one considering him to be failed to address one con	F 5	578	Directives reviewed and updated, to reflect accurate information. Physiciar updated. R184, R26, and R86 Advance Directiva addressed with the resident, Physiciar updated, and care plan updated. Facility residents have the potential to affected. Resident orders in electronic charting system, care plans and hard charts audited and updated with accurate, complete, signed, and dated CPR/coostatus and POLST for each resident (10/11/2021 and 10/12/2021). Any error conflicting information detected on forms were corrected and sent to Physician for review and signature on 10/12/2021. If not already completed prior to admission and provided to facility, residents will be asked to complete ar Advance Directive. Residents will be gethe opportunity to complete the POLS (Physician Orders for Life-Sustaining Treatment). The admitting nurse will be responsible to enter this information in the resident's chart, resident's orders PCC, and care plan. The admitting nurse will verify upon admission that Advance Directive wishes are current prior to processing. Clear identification will be available for staff regarding CPR/codestatus and POLST in PCC (resident	n ves n be de rors the n given in urse ced e e	

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NAME OF F	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
WHITEW	ATER HEALTH SER	VICES		525 BLUFF AVENUE		
				ST CHARLES, MN 55972		
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F 578		age 29 I/DS dated 8/11/21, included vith diagnoses of lung disease	F 57	Interdisciplinary team and licen educated by the Director of Clin Services starting on 11/12/21 or	nical	
	R13's physician's of failed to include ar or code status. The	orders in the EHR on 10/11/21 ny order for advanced directives e code status banner in the ate a wish for CPR or DNR.		Will/Advance Directives/Life-su treatment orders policy and pro including CPR/code status and Policy and procedure, and defa status of "full code" if POLST documentation is undecided.	staining cedure, POLST	
	which was signed (MD)-A on 8/5/21,	cal chart contained a POLST by the facility's medical director but the form was blank and not shes were not expressed on ed form.		Director of Nursing/Designee wadmission checklist for comple admission tasks during next dameeting. If advance directive/C documentation is absent, incorcontains conflicting instructions	tion of ys clinical PR/POLST nplete, or	
	stated, nobody at t	on 10/11/21, at 2:35 p.m. R13 the facility has asked about 13 would want to be		of Nursing/designee will follow determine status of documenta resident's wishes. If resident had make decisions as to advance planning, the default status of "	up to tion and/or as yet to d care	
	7/30/21, included a with diagnoses included heart failure. R10 anticipated MDS wunplanned dischar 9/23/21. An entry to	nimum Data Set (MDS) dated moderate cognitive impairment cluding Alzheimer's disease and had a discharge, return which indicated he had an acute care hospital on cracking MDS indicated he had cility from the hospital on		will be entered/verified and follobe completed with resident untare made. Advance Directives reviewed with resident/represe during care plan meetings, with in resident condition, and as reresident/representative. Executive Director/Designee warandom audits of Advance Director/DeST documentation three x	ow up will I decisions will be ntative changes quested by II complete ctive,	
	initiated of 2/3/18, advanced directive nutrition, IV/IM [int antibiotics." The go wishes will be hon Code [CPR] Long antibiotics. Follow	ated 5/24/21, with a date identified, "[R10] has an e. Full Code, Long term artificial ravenous/intramuscular] oal was listed as, "Resident ored." Staff were directed, "Full term artificial nutrition, IV/IM facility protocol for identification view code status at least		12 weeks. The results of the audits will be by the QAPI committee for tren needs for adjustment of audit s or content, as well as any furth educational needs. The Execut Director is responsible to ensuraction occurs.	reviewed ds and any chedules er ive	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		TE SURVEY MPLETED C
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	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP COD 525 BLUFF AVENUE ST CHARLES, MN 55972	•	710/2021
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F 578	quarterly and as dir resident's/responsi R10's physician ord record (EHR) did not status when review the EHR also did not for full code (cardio DNR (do not resus) When interviewed elicensed practical notes are residents desired of paper medical record (Provider Orders for LPN-B retrieved Ratiocated a POLST in POLST was dated wished to have carreficial nutrition by antibiotic treatment discussion was hele agent and was sign family member (FN this form on 1/31/11 located, this one was (SW)-B and R10 or a note scribbled neresuscitation (CPR "Discussed with PT 12/1/202 [unknown "Attempt Resuscitation/DNR an X in it and was desired to the resuscitation/DNR an X in it and was desired to the resuscitation (DNR an X in	ders in the electronic health of include any order for code red on 10/11/21. The banner in ot identify if R10's wishes were pulmonary resuscitation) or for	F 5	78		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	. ,	TE SURVEY MPLETED C
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	PROVIDER OR SUPPLIER	/ICES		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972		
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F 578	treatment and Oral had an X in them. were conflicting an do in the event of cogoing to happen, we are not suppose noted any conflicting the director of nurse 2:35 p.m. R10's meand remained unch	antibiotics only (no IV/IM) both LPN-B stated the POLST's d staff would not know what to cardiac arrest, "A mistake is to are going to do CPR when ed to." LPN-B stated if she ng orders, she would report it to ing (DON). On 10/12/21, at edical record was reviewed nanged with the conflicting hysician order addressing code	F 57	'8		
	cognitive impairment heart failure and luck R32's order summan order for DNR/E 9/7/21. On 10/12/21, R32's contained a POLS indicated R32 wish R32's care plan da Status: Changed a DNR/DNI per MD a of 9/7/2021." Howe directed staff, "ON Cares, No artificial	ary dated 10/12/21, included DNI [do not intubate] dated DNI [do not intubate] dated spaper medical record T dated 4/20/21, which led to have CPR performed. Ited 9/7/21, included, "Code gain from Full CODE to lead POA [power of attorney] as ever, listed under interventions HOLD: DNR/DNI, Comfort nutrition, IV/IM ATB is unclear if the full code or				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG		TE SURVEY MPLETED C
		245270	B. WING _		10	/18/2021
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F 578	Continued From pa	ge 32	F 57	8		
		MDS dated 10/7/21, included impairment with diagnoses lung disease.				
		10/11/21, R184's EMR and rd failed to include any s or POLST.				
	stated, if was found	on 10/11/21, at 5:42 p.m. R184 I with no pulse and was not Id like CPR performed.				
	R184's family mem like to have CPR pe	on 10/11/21, at 7:22 p.m. ber (FM)-E stated R184 would erformed. The facility had not either R184 or FM-E.				
		DS dated 9/1/21, included th diagnosis including heart				
	included an order for dated 9/17/21. How	ders in the EHR on 10/11/21, or, "Full Code," which was vever, there was no apparent der from the physician.				
	dated 9/21/21. The out, however MD-A POLST and dated i	al record contained a POLST POLST was blank/not filled and LPN-B had signed the t with 9/21/21. Even though ned by the physician, R26's the form.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245270	B. WING_		10	C / 18/2021	
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP OF STATE AVENUE ST CHARLES, MN 55972			
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F 578	licensed practical news going around to of the POLST's and residents. LPN-C so of them (the POLS' important to have the time when the Echart they were not did her best to upde everybody. LPN-C her concerns with the and the social work anxiety because stain an emergency. It was found in a med expected to perform have no pulse and When interviewed of LPN-A stated, it was the resident's code record in point click became aware that orders" for code stated orders for code stated orders but was unsupply the physician and facility staff would reason as you can't ask at code status."	on 10/11/21, at 7:01 p.m. Jurse (LPN)-C she stated she rying to find the orders for all digetting information for the tated she had to fill out some T's) herself as it was so hose. LPN-C stated most of POLST's were in a resident's afilled out. LPN-C stated she atte them but could not get to stated she'd previously shared the DON, executive director, ster. LPN-C stated it caused her aff would not know what to do LPN-C stated if no code status dical record, the staff would be in CPR if they were found to	F 57	78			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245270	B. WING _		10	C / 18/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 525 BLUFF AVENUE ST CHARLES, MN 55972		110/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 578	status as the form would look in the h POLST and if the have needed to lothere was a verba LPN-B stated she EHR had indicated. When interviewed LPN-D stated she front of the resident's code stated POLST was blank you know their CP charge nurse comadmission. When interviewed DON stated, "In the do CPR if we don DON stated the Poresident or represedent or represedent or represedent or represedent or represedent wished back, and then rousignature. The phy POLST form prior the form. R86's baseline call and orientated and 9/24/21. R86's POLST in the 9/27/21, indicated	was blank. LPN-B stated she hard (paper) chart for the POLST was blank, she would ok in the computer and verified I order that indicated full code. would have started CPR as the It R26 was full code. on 10/11/21, at 4:12 p.m. would look at the POLST in the nt's medical record for a latus. LPN-D stated, if the pleted the POLST upon on 10/12/21, at 1:37 p.m. the e state of Minnesota, we would ot have a signed POLST." The DLST was reviewed with the entative upon admission and, a sure we are checking what e status." The DON stated the less the POLST document with s is supposed to sign it on the late it to the physician for visician should not sign a blank the resident wishes added to the paper medical record dated R86 wished to have an Attempt R) order in the case of cardiac	F 57	78		

NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		TE SURVEY MPLETED C
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972 ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 578 Continued From page 35 arrest with selective treatment. This form was			245270	B. WING _		10	
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 578 Continued From page 35 arrest with selective treatment. This form was					525 BLUFF AVENUE		71072021
arrest with selective treatment. This form was	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE
No signature from a physician. When interviewed on 10/12/21, at 8:53 a.m. DON stated the admitting nurse meets with the resident to discuss the POLST, educate the resident and determine what their wishes were. The DON stated once that was completed, "the physician has a book we put the POLST in for it to be signed." The DON stated the physician comes to the facility on Tuesdays and Thursday and will sign items placed in a book. The DON verified R86 was admitted on 9/24/21, and did not have the POLST signed as of yet. When interviewed on 10/13/21, at 1:15 p.m. the facility medical director (MD-A) and R10's physician, stated in the case of newly admitted residents, the facility should first review to see if the resident had come to the facility with a pre-existing POLST. If not, the facility should review any medical orders, or orders from a recent hospital stay for an indication of what has previously been ordered. MD-A stated an expectation for the facility to discuss any pre-existing POLST or pre-existing medical orders with the new resident to ensure their current wishes, and contact the provider of any new orders needed following admission. MD-A stated, she had been receiving a POLST for signature from a nurse or social worker, but thought it was usually the admitting nurse who would send it for review. MD-A stated she was in her office three days per week so any form coming to the office might take 24-48 hours to come to her attention, but said more recently, the	F 578	arrest with selective signed by LPN-B a no signature from a When interviewed stated the admitting to discuss the POL determine what the stated once that wa has a book we put signed." The DON the facility on Tues sign items placed i R86 was admitted the POLST signed When interviewed facility medical dire physician, stated in residents, the facilithe resident had copre-existing POLS review any medica recent hospital stay previously been ordered expectation for the pre-existing POLS orders with the new current wishes, and new orders needed stated, she had be signature from a nuthought it was usual would send it for reher office three day coming to the office	e treatment. This form was and R86 on 9/27/21. There was a physician. on 10/12/21, at 8:53 a.m. DON g nurse meets with the resident and a pir wishes were. The DON as completed, "the physician the POLST in for it to be stated the physician comes to days and Thursday and will a book. The DON verified on 9/24/21, and did not have as of yet. on 10/13/21, at 1:15 p.m. the actor (MD-A) and R10's and the case of newly admitted the ty should first review to see if the case of newly admitted the ty should first review to see if the tothe facility with a T. If not, the facility with a T. If not, the facility should I orders, or orders from a year for an indication of what has dered. MD-A stated an facility to discuss any T or pre-existing medical we resident to ensure their discontact the provider of any discontact the provider of an	F 57	8		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245270	B. WING		10	C / 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP 525 BLUFF AVENUE ST CHARLES, MN 55972		710/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 578	review until the nex MD-A confirmed the blank POLST and a it was signed. MD-A so and stated, "that The facility policy ti Directives/Life-Susdated 6/1/2017, ide offered an option of Advance Directive so, upon admission orders that are dev following a resident designated decision his/her physician. To communication to a tot he resident's wis The immediate jeon was removed on 10 determined that the appropriate removal correcting/clarifying R32, R86, R184 and signal and s	ould not be available for her at date she made rounds. At a physician may not sign a allow the facility to fill it in after A confirmed that she had done to is my error. That is on me." Ited, Living Will/Advance taining Treatment Orders entified residents would be for completing a Living Will or if they have not already done in A POLST is a set of medical eloped and documented its (or the resident's in-maker) conversation with the POLST form provides for all health care professionals as shes. Dearly that began on 8/11/21 in 20/13/21, when it could be a facility had implemented an	F 5			
	reviewed it's policy forward, code statu upon admission, bu or able to make a code status would case of cardiac arrobe reviewed again weekly until a decis facility reviewed all status wishes with parties and obtaine	and identified that going as orders would be reviewed at if a resident was not willing lecision upon admission, their default to perform CPR in the lest, but resident wishes would within 48-72 hours and then sion had been made. The current resident's codes residents or responsible d a physician's order which lesident charts, and ensured				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG		E SURVEY IPLETED
		245270	B. WING		1	C 1 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	•	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	any POLST form w signed. As well as a clarified and correct educated in the pol status and POLST, educate any staff p not available during system was design was instructed and Develop/Implement	as accurate, complete and any conflicting information was ted. Facility staff were icy and procedures for code and a plan was in place to rior to working their next shift if initial training. An audit ed and the medical director updated.	F 5			12/1/21
35=D	§483.12(b)(1) Prohneglect, and exploit misappropriation of §483.12(b)(2) Estato investigate any s §483.12(b)(3) Incluparagraph §483.95 This REQUIREMED by: Based on interview facility failed to enscheck was obtained employment for 1 or reviewed for employment for	ility must develop and policies and procedures that: ibit and prevent abuse, sation of residents and resident property, blish policies and procedures uch allegations, and de training as required at and document review, the ure a criminal background and verified prior to f 1 practical nurse (PN)-A		PN-A removed from schedule background check completed a license obtained. Facility residents have the pote affected. Audit of current employees to background check, license, an certification documentation cor 10/17/21	ential to be verify	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245270	B. WING			10/1	C 1 8/2021
NAME OF	PROVIDER OR SUPPLIER	\ \			TREET ADDRESS, CITY, STATE, ZIP CODE	107	.0,2021
WHITEV	VATER HEALTH SER	VICES			25 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	During an interview director of nursing brand-new nurse a license. The DON up by her criminal stated PN-A had n with her criminal because with the forminal background been working as a without a complete since her first date. During an interview executive director facility had an unlied building. The executive director facility had an unlied building. The executive director the loop if the DON member under any where the staff me executive director checks should be. The Background of dated August 2017 required, the B.O.I (or designee) will exill be completed and the completed of the complete o	w on 10/11/21, at 7:23 p.m. the (DON) stated PN-A was a and working under a temporary stated PN-A's license was held background check. The DON nade her aware of the concern	F6	607	Employees will have on file complet background check information, curr and validated license information, a credential documentation prior to with residents. Interdisciplinary team educated by Director of Clinical Services starting 10/18/21 on the Background Check and procedure, Abuse prevention pand procedure and state of Minnest regulations. Executive Director/Designee will aunew hires for 8 weeks for complete documentation. Audit tracking tool developed. The results of the audits will be reviby the QAPI committee for trends a needs for adjustment of audit schedor content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	ent ind orking g on a policy olicy ota dit ewed ind any dules	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C		
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	PROVIDER OR SUPPLIER ATER HEALTH SERV	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 607	2018 included: 1) Significance as a result of a resident. A crin conducted on all prother permanent and 5-y State and Federal resident and 5-y State and Federal residence is the screen employees.	ion Program dated March creening: Abuse Policy he policy of this facility to medical directors, contractors, dents (in nurse aide programs emic institutions, including ocial and activity programs) hour residents. Screening everification of references, ons and background checks. Everified as well as certifications, s, and criminal background will not employ or otherwise who have been found guilty of poloitation, misappropriation of atment by a Court of law. The oy or otherwise engage any in a finding entered into the eming abuse, neglect, propriation of residents. The facility or otherwise engage a hall who has a disciplinary inst his/her professional of a finding of abuse, neglect, lent property, or mistreatment of a finding will result in denied of the twith the policy, the ear bars to employment per regulations.	F 60			
	Transfer and Disch CFR(s): 483.15(c)(arge Requirements	F 62	22		12/1/21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245270	B. WING				C 18/2021
	PROVIDER OR SUPPLIER			525	REET ADDRESS, CITY, STATE, ZIP CODE 5 BLUFF AVENUE C CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	remain in the facilit discharge the reside (A) The transfer or resident's welfare a cannot be met in the (B) The transfer or because the reside sufficiently so the reservices provided (C) The safety of in endangered due to status of the reside (D) The health of in otherwise be enda (E) The resident has appropriate notice, under Medicare or Nonpayment applies ubmit the necessing payment or after the Medicare or Medicare or Medicare or Medicare or Medicare or Medicare in the submit the necessing payment or after the Medicare or Medicare or Medicare in the submit the necessing payment or after the Medicare or Medicare in the submit of the su	er and discharge- lity requirements- t permit each resident to ty, and not transfer or dent from the facility unless- discharge is necessary for the and the resident's needs ne facility; discharge is appropriate ent's health has improved esident no longer needs the by the facility; ndividuals in the facility is the clinical or behavioral ent; ndividuals in the facility would ngered; as failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. es if the resident does not ary paperwork for third party ne third party, including aid, denies the claim and the pay for his or her stay. For a mes eligible for Medicaid after lity, the facility may charge a able charges under Medicaid;	F6	522			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245270	B. WING	i			C 18/2021
	PROVIDER OR SUPPLIER			ST 52	REET ADDRESS, CITY, STATE, ZIP CODE 5 BLUFF AVENUE C CHARLES, MN 55972	1 10/	16/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 622	facility. The facility that failure to transfall that facility that resident under any in paragraphs (c)(1 section, the facility or discharge is doc medical record and communicated to the institution or provide (i) Documentation in must include: (A) The basis for that (ii) of this section. (B) In the case of posection, the specific be met, facility attendeds, and the serfacility to meet the facility to meet the facility to meet the facility to meet the facility for this section. (A) The resident's produced in the facility in the facility is necessary under pathis section. (iii) Information product information product include a minimal facility in the facility that facility is necessary under pathis section. (iii) Information product information product include a minimal facility in the facility that facility is necessary under pathis section. (iii) Information product informatic include a minimal facility is necessary under pathis section.	dent or other individuals in the must document the danger fer or discharge would pose. Imentation. Insfers or discharges a of the circumstances specified (i)(i)(A) through (F) of this must ensure that the transfer umented in the resident's appropriate information is a receiving health care er. In the resident's medical record the transfer per paragraph (c)(1) (i)(A) of this cresident need(s) that cannot mpts to meet the resident vice available at the receiving need(s). Ition required by paragraph (c) must be made byothysician when transfer or sary under paragraph (c) (1) ction; and en transfer or discharge is aragraph (c)(1)(i)(C) or (D) of wided to the receiving provider imum of the following: ation of the practitioner care of the resident. Sentative information including	F	622			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245270	B. WING			C 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP (525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 622	copy of the residen consistent with §48 any other document a safe and effective This REQUIREMEI by: Based on interview facility failed to ensincluding skin cond contact information health agency, for reviewed for dischabealth services. Findings include: R36's admission redate of 4/7/21 with sclerosis, mild cogrecontractures. R36's admission M4/16/21, indicated Fed mobility, transformstand fressing, toileting and skin issues. R36's discharge MI was an assist of on locomotion on/off upersonal hygiene. That a stage 3 pression 10/14/21 a revieperformed and the	opropriate. c care plan goals; sary information, including a t's discharge summary, 3.21(c)(2) as applicable, and tation, as applicable, to ensure	F 62.	R36 discharged Facility discharged resident potential to be affected. Transfer/Discharge checklic implemented for nursing statransfer/discharge is initiated. Interdisciplinary team and lieducated by the Director of Services starting on 11/12/2 Discharge-Transfer of Resi procedure including discharge documentation, required disinformation provided to resire representative, documentatic communication education, information and the Change of the Resident policy and procedure to discharged reside documentation weekly as the Weeks. The results of the audits will by the QAPI committee for needs for adjustment of audor content, as well as any find the potential to be a supplied to the	st and folder aff when a ed. icensed staff Clinical 21 on dent policy and rge scharge ident or tion and discharge care e of Condition procedure. ee will complete nt ney occur for 8 Il be reviewed trends and any dit schedules	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245270	B. WING		10	C / 18/2021	
	PROVIDER OR SUPPLIER	rices		STREET ADDRESS, CITY, STATE, ZI 525 BLUFF AVENUE ST CHARLES, MN 55972			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 622	medical record reverses and if that information is a SW stated, "I have the last few months and I am working 1 things fall through the record and discharge summa care form which shilst of medications. Includischarge care. Rerepresentative.	Daily Skilled Note. The ealed no evidence that R36 here R36 was discharged to, on was sent with resident or ecciving agency. You on 10/14/21, at 9:36 A.M. the (DON) stated the expectation worker to document in a discharge summary, recap of ersations with home care You on 10/14/21, at 9:52 A.M. the extra set up, including depending on cognition, a list of have other needs. SW stated ork is printed off from the extra would have admission info, at, prescriptions for controlled there is rehab or wound care also included. Furthermore, not been documenting as well as, but we have been really busy 0-12 hour days so some the cracks, I'll be honest." Discharge - Transfer of the 2017 indicated to complete ary and post discharge plan of with instructions in simple medical terms or unde instructions for post eview with the resident and/or	F 622	educational needs. The EDirector is responsible to action occurs.			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245270	B. WING				C 18/2021
	PROVIDER OR SUPPLIER	ICES		52	REET ADDRESS, CITY, STATE, ZIP CODE 5 BLUFF AVENUE CHARLES, MN 55972	100	10/2021
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F 622	Continued From pa	ge 44	F6	522			
	copy of form to the	release of medications. Give resident and/or representative asible for care. Place signed the medical record.					
	Comprehensive Ass CFR(s): 483.20(b)(sessments & Timing 1)(2)(i)(iii)	F 6	36			12/1/21
	a comprehensive, a	assessment Induct initially and periodically Induct initially and periodically Induction in the second in the seco					
	§483.20(b)(1) Resi A facility must make assessment of a re goals, life history ar resident assessment by CMS. The asse the following: (i) Identification and (ii) Customary routi (iii) Cognitive patter (iv) Communication (v) Vision. (vi) Mood and beha (vii) Psychological v (viii) Physical functi (ix) Continence. (x) Disease diagnos (xi) Dental and nutr (xii) Skin Conditions (xiii) Activity pursuit (xiv) Medications. (xv) Special treatme (xvi) Discharge plar	sident's needs, strengths, and preferences, using the ent instrument (RAI) specified assment must include at least demographic information ne. Ins. Vior patterns. Vell-being. In oning and structural problems. It is and health conditions. It is and procedures.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	\ ,	(X3) DATE SURVEY COMPLETED	
		245270	B. WING_			C / 18/2021	
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP 0 525 BLUFF AVENUE ST CHARLES, MN 55972	· · · · · · · · · · · · · · · · · · ·	10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 636	regarding the addition the care areas to the Minimum Data (xviii) Documentation assessment. The ainclude direct observith the resident, a licensed and nonlice members on all shifts \$483.20(b)(2) Whe timeframes prescrift chapter, a facility massessment of a restimeframes specification through (iii) of this sprescribed in §413. apply to CAHs. (i) Within 14 calence excluding readmissing in the capture of the rapeutic leaves (iii) Not less than on This REQUIREMED by: Based on interview facility failed to communication (R84 and admissions. Findings include: R84's admission residents (R84 and admissions)	onal assessment performed riggered by the completion of Set (MDS). On of participation in assessment process must rivation and communication is well as communication with ensed direct care staff fts. In required. Subject to the bed in §413.343(b) of this must conduct a comprehensive sident in accordance with the ed in paragraphs (b)(2)(i) is section. The timeframes 343(b) of this chapter do not all a days after admission, sions in which there is no in the resident's physical or for purposes of this section, as a return to the facility any absence for hospitalization	F 63	R84 and R86 admission Mand submitted. Facility residents have the affected. MDS schedule reviewed for resident to ensure MDS times submission. MDS schedule will be reviewed.	potential to be r current nely		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245270	B. WING			10/1	 8/2021
NAME OF I	PROVIDER OR SUPPLIER	ı		S	STREET ADDRESS, CITY, STATE, ZIP CODE	107	10/2021
				5	25 BLUFF AVENUE		
WHITEW	ATER HEALTH SER	/ICES		S	ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 636	Continued From pa	_	F 6	36			
	R84's admission M	IDS indicated, "in progress."			morning meeting.		
	lacked evidence of of an admission M R86's admission re identified an admis	ectronic health record (EHR) f a completion, or transmission, DS. ecord printed 10/13/21 esion date to facility of 9/24/21. ectronic health record (EHR)			MDS nurse educated by Regional Reimbursement Director on 10/18/2 The Centers for Medicare and Med Services (CMS) Long-Term Care F. Resident Assessment Instrument (I 3.0 user's manual completion dates requirements.	licaid acility RAI)	
	lacked evidence of of an admission M	f a completion, or transmission, DS.			Executive Director/Designee to aud completion and submission at morr meetings for 8 weeks.		
	licensed practical radmissions MDS's 14 days of admissions MDS's verified R84's and still in progress and LPN-A stated she was be stated she was be shared her concernstated she was to hours a day on MD to start last week a stated she had a lonot get any help. L 12 hours a day and anymore and now	v on 10/14/21, at 9:36 a.m. nurse (LPN)-A stated, were to be completed within ion to the facility. LPN-A R86's admission MDS were d had not been completed. was the only one that esessments in the building and hind. LPN-A stated she had n with the executive director, be going downstairs to work 4 DS assessments and that was and that did not happen. LPN-A of of work to do, and she did PN-A stated she was working d stated she wound not do it she was behind.			Regional Reimbursement Director of closing and submission of MDS assessments off-site weekly-on-going. The results of the audits will be reviewed by the QAPI committee for trends at needs for adjustment of audit schedor content, as well as any further educational needs. The Executive Director is responsible to ensure the action occurs.	ing. iewed and any dules	
	was not provided. The Centers for M (CMS) Long-Term Assessment Instru dated 10/2019, ide	edicare and Medicare Services Care Facility Resident Iment (RAI) 3.0 User's Manual entified the RAI MDS and CAA's ras to identify resident care					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING	CON	(X3) DATE SURVEY COMPLETED	
		245270	B. WING			C / 18/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972		110/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	problems which wo individualized care from MDS assessm Skilled Nursing Fac System (SNF PPS) system, many State systems, and for m provided to nursing identified comprehe completion is define process in addition that the RN [registe coordinator has sig (item Z0500) and Completion attestati instructed the MDS (comprehensive) co Z0500 and V0200B "14th calendar day (admission date + [Develop/Implement CFR(s): 483.21(b)(1) The fimplement a compre system of the system of the services and time medical, nursing, an needs that are iden assessment. The codescribe the followi (i) The services tha or maintain the resi physical, mental, ar	uld be addressed in an plan. Further, data collected nents was also used for the cility Prospective Payment Medicare reimbursement onitoring the quality of care home residents. The manual ensive "assessment ed as completion of the CAA to the MDS items, meaning and care and dated both the MDS (item V0200B) ions." In addition, the manual and CAA(s) admission ompletion date(s) (items 2) were to be no later than the of the resident's admission plus] 13 calendar days)." Comprehensive Care Plans facility must develop and ehensive person-centered resident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial tified in the comprehensive care plan must	F 6			12/1/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245270	B. WING_			C 18/2021	
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F 656	(ii) Any services that under §483.24, §48 provided due to the under §483.10, incl treatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resi (iv) In consultation versident's represent (A) The resident's gedesired outcomes. (B) The resident's gedesired outcomes. (B) The resident's gedesired outcomes. (C) Discharge plant plant, as appropriate requirements set for section. This REQUIREMED by: Based on observative with facility facility facility facility facility for anticoagulation for for anticoagulation. Findings include: R26's Admission R indicated R26 was 8/26/21 with diagnored.	at would otherwise be required 33.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)-goals for admission and oreference and potential for acilities must document acilities must document of sessed and any referrals to sees and/or other appropriate pose. In the comprehensive care es, in accordance with the orth in paragraph (c) of this of the sessed and document acility in the resident (c) of this orth in paragraph (c) of this orth in paragraph (c) or this orth in par	F 6	R26 anticoagulant care plate Facility residents prescribe medication have the potent affected. Residents with anticoagula audited for complete compilan. Care plan schedule will be each morning meeting.	d anticoagulant tial to be nt orders rehensive care		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245270	B. WING			1	C 18/2021
NAME OF I	PROVIDER OR SUPPLIER	\ \	l	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2021
				52	5 BLUFF AVENUE		
WHITEW	ATER HEALTH SER	VICES			CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 656	R26's admission M 9/1/21, indicated F medications. R26's care plan pr plan of care for R2 interventions for a R26's physician or (anticoagulant memouth at bedtime related to chronic 10/15/21. (Order some some and stated it shoul behind on complet admissions. LPN-2	age 49 Minimum Data Set (MDS) dated R26 required anticoagulant inted 10/14/21 did not identity a R26's risk for bleeding, goals, and inticoagulation management ders included: Coumadin dication) 4 milligram (mg) by for Chronic Atrial Fibrillation kidney disease stage 5 until start date 10/11/2021). W on 10/14/21, at 12:11 p.m. nurse (LPN)-A stated coumadinedication and if a resident was should have a care plan for eeding. LPN-A stated R26's are plan was not finished yet disease plans for new A stated R26's comprehensive have been complete on 9/15/21.	F6	656	Coumadin orders, PT/INR check calendar implemented. Interdisciplinary team and license educated by Director of Clinical Starting on 11/12/21 on the Comprehensive Care Planning p procedure, including baseline ca requirements, and comprehensive plan requirements. Licensed stafeducated on the Warfarin policy procedure. Director of Nursing/Designee to a coumadin calendar daily weekly weeks. Director of Nursing/Designee to a admissions for complete care plareceiving anticoagulant medication. The results of the audits will be results of the audits will be resulted.	ed staff Services olicy and re plan ve care f and audit for 8 audit an if ons. eviewed	
	During an interview director of nursing care plan was don comprehensive ca within 72 hours of she would expect was a risk medical monitoring for blee not aware LPN-A viplans. The Comprehensit 8/23/21 included, A	w on 10/18/21, at 8:43 a.m. the (DON) stated the baseline e for the first 72 hours and the re plan should be completed admission. The DON stated a care plan for coumadin as it tion and residents need to be eding. The DON stated she was was behind in completing care ve care Planning Policy dated A comprehensive care plan for eveloped within seven (7) days			needs for adjustment of audit sol or content, as well as any further educational needs. The Executiv Director is responsible to ensure action occurs.	nedules	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	COMPLETED	
		245270	B. WING _		10/18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	10/10/2021
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F 656	Continued From pa	ge 50	F 65	6	
E 661	of completion of the assessments (MDS Discharge Summar	,	F 66	1	12/1/21
	CFR(s): 483.21(c)(2	•	F 00	I	12/1/21
	must have a dischabut is not limited to, (i) A recapitulation of includes, but is not of illness/treatment radiology, and considired items in particulate items in particulate items in particulate items in particulate items in the time of the discrelease to authorize the consent of the representative. (iii) Reconciliation of medications with the medications (both pover-the-counter). (iv) A post-discharge developed with the and, with the reside representative(s), vadjust to his or her post-discharge plarthe individual plans that have been mad care and any post-onon-medical service This REQUIREMENT.	nticipates discharge, a resident arge summary that includes, the following: of the resident's stay that limited to, diagnoses, course or therapy, and pertinent lab, sultation results. To of the resident's status to ragraph (b)(1) of §483.20, at harge that is available for ed persons and agencies, with resident or resident's of all pre-discharge e resident's post-discharge e resident's post-discharge erescribed and the plan of care that is participation of the resident which will assist the resident to new living environment. The nof care must indicate where to reside, any arrangements de for the resident's follow up discharge medical and es. NT is not met as evidenced			
	facility failed to com	s and record review the nplete a comprehensive including a recapitulation of		R36 discharged Facility discharged residents have	the

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\A/! !!TE\A	ATED HEALTH OED	4050			525 BLUFF AVENUE		
WHITEW	ATER HEALTH SERV	/ICES		;	ST CHARLES, MN 55972		
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F 661	Continued From pa	age 51	F 6	661			
	stay for 1 of 1 residuscharge.	dents (R36) reviewed for			potential to be affected.		
	Findings include:				Transfer/Discharge checklist and f implemented for nursing staff when transfer/discharge is initiated.		
	date of 4/7/21 with	ecord identified an admission diagnoses of multiple nitive impairment and muscle	admission tiple Interdisciplinary team and lice			rvices	
	4/16/21, indicated bed mobility, transf	ion Minimum Data Set (MDS) dated ated R36 was an assist of one with ransfers, locomotion on/off unit, ting and personal hygiene and had s.			Discharge Planning policy, the Cha Condition of the Resident policy al procedure including discharge documentation, required discharge information, discharge summary, a recapitulation of stay.	ange of nd	
	was an assist of or locomotion on/off upersonal hygiene.	DS dated 6/2/21 indicated R36 ne with bed mobility, transfers, unit, dressing, toileting and The MDS also indicated R36 sure ulcer in unknown location.			Director of Nursing/Designee will complete audits of discharged resi documentation weekly as they occ 12 weeks.		
	performed and the R36's medical reco A.M. and was titled medical record rev	ew of R36's record was last progress note entered in ord was dated 6/1/21 at 3:24 d Daily Skilled Note. The vealed no evidence that a ry or recapitulation of stay was			The results of the audits will be revelop the QAPI committee for trends an needs for adjustment of audit scheor content, as well as any further educational needs. The Executive Director is responsible to ensure the action occurs.	and any dules	
	DON stated the ex worker to documer discharge summar	or on 10/14/21 at 9:36 A.M., pectation was for the social at in a progress note the cy, recap of stay and any home care agency.					
	facility social worke	v on 10/14/21 at 9:52 A.M., er (SW) stated discharge d recapitulation of stay should					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 661	progress note. SW summary note in the completed by the state resident out the document out of the sum of the	ge 52 he medical record in a then stated that the discharge e medical record should be taff member that saw the or. SW then verified that there ote or recapitulation of stay for SW stated, "I have not been all the last few months, but we say and I am working 10-12 things fall through the cracks, Discharge - Transfer of e 2017 indicated to complete ary and post discharge plan of ould include the following: A	F6	61			
	list of medications of terms. Do not use in abbreviations. Includischarge care. Review representative. Have representative or pedischarge summary form. This includes copy of form to the or person(s) respondinal of form in the Treatment/Svcs to ICFR(s): 483.25(b)(s) \$483.25(b)(1) Press Based on the compresident, the facility (i) A resident receive professional standal pressure ulcers and	with instructions in simple medical terms or de instructions for post view with the resident and/or re resident and/or reson responsible for care sign and post discharge care release of medications. Give resident and/or representative asible for care. Place signed the medical record. Prevent/Heal Pressure Ulcer 1)(i)(ii) regrity sure ulcers. weehensive assessment of a	F 6	86		12/1/21	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245270	B. WING			C 10/18/2021	
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	10/2021
				52	25 BLUFF AVENUE		
WHITEW	ATER HEALTH SERV	ICES		S	T CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B		BE	(X5) COMPLETION DATE
F 686	demonstrates that (ii) A resident with professional st promote healing, promote and obtain 1 residents (R10) rehad developed a nefailed to transcribe provider for a newly failure resulted in a pressure ulcer becard deteriorated from a Findings include: Pressure Ulcer stag Data Set (MDS) per Services: Stage I pressure ul pressure ul pressure-related al indicators as comparea on the body merces.	they were unavoidable; and bressure ulcers receives at and services, consistent andards of practice, to revent infection and prevent veloping. NT is not met as evidenced ation, interview and document ailed to notify the medical awound care orders when 1 of eviewed for pressure ulcers, and and follow orders from a y developed heel ulcer. This ctual harm when R10's coccyx ame larger and the heel ulcer stage 2 to a stage 3 ulcer. ges defined by the Minimum r Center Medicare/Medicaid cer (An observable, teration of intact skin, whose ared to adjacent or opposite any include changes in one or	F 6	886	R10 wounds measured and assess MD updated, new treatment orders obtained and care plan updated. Facility residents have the potential affected. Skin assessments completed for curesidents on 10/13/21 and 10/14/21 checks will be completed weekly wibath/shower. Wound rounds will be completed every 7 days per policy, binder developed to assist with woutracking. Licensed staff educated by Director Clinical Services starting on 11/12/2 Skin Management policy and Press and Non-pressure Injury policy and procedures including identification conew wound requirements, assessm requirements, notification requirements.	to be urrent . Skin th wound and of 21 on ure of a ent	
	temperature (warm consistency (firm o itching); and/or a do redness in lightly pi darker skin tones, t persistent red, blue Stage II pressure u	ng parameters: skin th or coolness); tissue r boggy); sensation (pain, efined area of persistent gmented skin, whereas in the ulcer may appear with r, or purple hues.) Icers (Partial thickness loss of as a shallow open ulcer with a			and monitoring requirements. Licensed staff educated on Physicia orders policy and procedure. Director of Nursing/Designee to audresident consultation notes for new after appointments, hospital stays, a MD rounds 3 times weekly for 12 w.	ans dit orders and	

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		245270	B. WING			10/1	; 8/2021
	PROVIDER OR SUPPLIER			52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BLUFF AVENUE T CHARLES, MN 55972		
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F 686	red-pink wound be present as an intare loss. Subcutaneous tendon or muscle present but does reloss. May include the R10's quarterly Mi 7/30/21, included with diagnoses included and sease and periphediagnoses list included sease and periphediagnoses list included sease and periphediagnoses list included with diagnoses list included with diagnoses list included sease and periphediagnoses list included shin bones). Frequired extensive of daily living (ADL during the 7 day a risk for pressure uncurrent pressure uncurrent pressure uncurrent pressure uncurrent pressure uncontinence and agoal was, "Reside skin." Staff were in barrier lotion after to turn and reposit at times. Staff are reapproach. Chanafter voiding or a but times. Staff are to Increase out of be skin integrity every dry, and free of windry. Maintain adections are integrity every dry, and free of windry. Maintain adections are integrity every dry, and free of windry.	ed, without slough. May also ct or open/ ruptured blister.) ulcers (Full thickness tissue us fat may be visible but bone, is not exposed. Slough may be not obscure the depth of tissue undermining or tunneling.) nimum Data Set (MDS) dated moderate cognitive impairment cluding, diabetes, Alzheimer's heral vascular disease. R10's uded a recent nondisplaced re the bone breaks in 3 or more the right fibula and tibia (calf R10's MDS indicated he assistance with most activities c's) and rejected cares 1-3 days ssessment period. R10 was at lcers, but did not have any	F6	886	Director of Nursing/Designee to audit weekly wound rounds for measurem assessments, notifications, and treat orders for 12 weeks. The results of the audits will be reviet by the QAPI committee for trends an needs for adjustment of audit schedor content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	ents, tment ewed nd any ules	

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F 686	to skin: 1)pressure 2)pressure reduction plan lacked identificatual pressure ulder that the lacked identificatual pressure ulder the lacked identified R10 had cast and a call was return to cast room. According to a "wo R10's EHR dated pressure ulcer on I spine/tailbone). No medical record was measurements we with 0.1 cm depth, document indicate having both, "sloug (Slough is necrotic superficial wounds process generally Granulation tissue not generally seen form indicated R10 wound, but did not notified. R10's Cast Visit proposed in the Desurgery and was spractitioner (CNP)-cast on his right let the lower extremity	reduction mattress. on chair cushion." The care cation or staff direction for cers. te dated 10/5/21, identified R10 cast room," and was to continue ring on the right side and to ma control. The note also some loose stools soiling the s placed to advise if needs to	F 68	36			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED	
		245270	B. WING _		C — 10/18		
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP 525 BLUFF AVENUE ST CHARLES, MN 55972			
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F 686	last visit." The docudirections for care: a stockinette [dress provide skin protect Mepilex heel dress product that lifts the recommend that the immobilizer and stotwice daily. They are multi-Podus boot to The facility can character weekly. He is heel." R10's physician Or electronic health remot include any direct pressure ulcer on buttocks. R10's tree (TAR) and medicat (MAR) from 10/6/2	iment included the following "today patient was placed into sing similar to a thin sock to tion] and knee immobilizer, a ing with a multi-Podus boot [a heel to prevent pressure]. I ey remove the knee ockinette and check his skin re also to remove the vice daily to check his skin ange the Mepilex heel dressing to have no pressure on his der Summary Sheet from the cord (EHR) on 10/11/21, did ection or treatment for a neel, or pressure ulcer on atment administration records 1 to 10/11/21, failed to identify 110's pressure ulcers on heel	F 68	6			
	review," and directed identified to follow p	order for, "Weekly skin ed staff if new skin area is protocol and notify physician. s being completed on 10/4/21					
	R10's EHR dated 1 was measured at b depth of 0.2 cm, sti pressure ulcer, but "worsening." The d indication of the ca include, R10 should	und tracker document" in 0/12/21, the coccyx wound eing 2.2 cm by 2.5 cm with a II rated as a, "stage II" condition listed as, ocument did not provide any res being provided, but did d lay down after meals. The ndicate the medical provider					

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F 686	was notified of R10 During an observa 7:14 a.m. a nursing unidentified NA car morning cares. He bed. R10 had a so- large plastic leg im in place with straps covered his leg so visualized at that ti to prevent pressure the splint itself. NA was not to be remo NAs assisted R10 affected side, so th square foam dress 3 inches and 1/4 in R10's coccyx, but valong the edges ar bottom edge. Durin bowel movement vedge of the dressir removed the dressir removed the dressir removed the dressir removed after rem wound was situate the coccyx. The top and the wound bed dressing had a sm soaked into the foa washing R10's but previous position o NA threw away the said they would ne	tion of morning cares 10/13/21, g assistant (NA)-C and an me into R10's room to provide was laying on his back in his ab on his left shin, and had a mobilizer on his right leg, held s, and a stocking type dressing the skin could not be me. There was nothing in place to R10's right leg except for as both stated the immobilizer oved as he had a fractured leg. To turn towards his right, sey could wash his buttocks. A sing, approximately 3 inches by the chick was observed on was not adhered to the skin and was quite loose along the ag cares, R10 began to have a which oozed up under the loose ag and the unidentified NA ing. R10's entire left buttock to slightly pink and mottled. A to the size of a quarter was a loval of the foam dressing. The did between the left ischium and to layers of skin were missing it was a bright red color. The all amount of bloody drainage am. After the NAs finished tocks, they returned him to his in his back. The unidentified soiled dressing, and NA-C ed to report to the nurse that	F 68	36			
	Neither NA knew h	dressing on his wound. ow long he had had the wound beither one knew of any other					

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 686	wounds except for shin. When interviewed of licensed practical in had the long splint week or more, and the splint even thouby Velcro straps. Lifter skin breakdown splint and it was im condition, but said the skin that was not splint. LPN-B stated a wound on his but days before. LPN-E physician's order for stated they had beed dressing to R10's of (Mepilex is a trade of dressing types, the dressing meant to loother type of dressing occlusive foam drewhen a new wound getting worse, their director of nursing provider to get an order and new wound or a very dressing, the NA is LPN-B stated the remorning, and need reported to her and nurse it should hav. When interviewed or registered nurse con R10's physician or control or should hav.	the small scab on R10's left on 10/13/21, at 8:26 a.m. urse (LPN)-B stated R10 had on his leg for approximately a said they were not to remove ugh it was merely held in place PN-B stated R10 was at risk due to the application of the portant to monitor his they were only able to check of covered by the straps or d she was aware that R10 had tocks and had seen it several a said she was unable to find a or the care of the wound, but en applying a "Mepilex" upen wound near his coccyx name and can mean a variety the most common are a foam one held in place with some and, or a self-adhesive, assing). LPN-B stated that a is identified, or a wound is nurse should report it to the (DON) and call the medical order for care. If an NA notices wound that requires a new to report to the nurse on duty, emoval of R10's dressing that for wound care had not been she would have been the	F6	886			

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	PROVIDER OR SUPPLIER	/ICES		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972	· · · · · · · · · · · · · · · · · · ·		
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F 686	stated the expecter in the event of a newere to notify the newere to notify the newere to notify the newere to notify the newere deaded to the fact measurements showeekly measurement the treatment order recommendations provided by the ort 10/7/21, including nobservation and sk pressure ulcer and heel had not been note into R10's phyrecommendations communicated to rand could not be or provided. According to an int DON stated immediand NC had gone to "boot" and the dresstated she had not pressure ulcer prior the recommendation the recommendation of the work and was "healing" condition of the work and yound extends threst involving tendons, wound extends threst the subcutaneous and the subcutane	d process for nurses to follow ewly identified pressure ulcer nedical provider for wound dd new interventions to the n. The resident's name should cility "wound list" and initial ould be taken, followed by ents to monitor the efficacy or r. NC confirmed that for care of a right heel ulcer hopedic services cast room on removal of the splint for a right heel for no pressure to the right transcribed from the paper vician's orders and thus these for care had not been hursing staff through the EHR, confirmed to have been erview 10/13/21, 9:17 a.m. diately prior to interview DON to R10's room, removed his using applied on 10/7/21. DON known about the right heel r to 10/13/21 and had not read ons from CNP-A before that ed CNP-A's documentation d had been "just developing" on 10/7/21, but confirmed the und had deteriorated. DON II by now" (pressure ulcers are I, superficial redness that does ge IV, a deep tissue injury ligament and bone. A stage III ough all layers of the skin into tissue, but not to tendons or an expectation for nurses to	F 68	36			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		245270	B. WING			10/	18/2021
NAME OF	PROVIDER OR SUPPLIER	•		ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
\A/! !!TE\A	ATED HEALTH CEDY	UCEC		52	25 BLUFF AVENUE		
WHILEV	ATER HEALTH SERV	ICES		S	T CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)				BE	(X5) COMPLETION DATE
F 686	review any papers any medical appoir facility. DON was use recommendations but said the nurse their medical direct physician to verify appointment. DON then entered the oralso have reported DON, but said this she had replaced theel, but had not rethe stockinette due to be in touch with During the 10/13/2 described expectanew pressure ulcer DON said the nurse wound was found and measurements of the information and a compose some the progress note. DOI any standing order on duty would need in order to get treat DON said the nurse who was responsible wound weekly, and injury tracker." DOI aware of R10's word applied a Mepilex of confirmed she had did not have an order to stated she was the physician and MD-A stated she was the interviewed R10's physic	accompanying a resident from attment upon their return to the inable to confirm that CNP-A's for care were actual orders, on duty should have contacted for (MD)-A who is also R10's orders following the stated the nurse should have reders into the EHR and should to the nurse manager and the had not occurred. DON stated he soiled Mepilex on R10's emoved the brace or replaced to "pain", saying, "I am going (MD)-A about how to proceed." 1, 9:17 a.m. interview, DON tions of nursing staff when a ror wound were identified. The was responsible to take the wound and document this description of the wound in a N said the facility did not have so for wound care so the nurse of to notify the medical provider the should also notify the DON to be to monitor and assess the document in their "pressure N stated she had become und on his bottom and had dressing; however, DON not notified the physician and	F	686			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ICES		525 I	EET ADDRESS, CITY, STATE, ZIP CODE BLUFF AVENUE CHARLES, MN 55972		
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	Orthopedic Surgery been considered as should have been to orders. MD-A state the recommendation reason for the facilimedical director to orders. MD-A state wound, but said, and description on 10/7 on 10/13/21, the control orders and worsened since MD-A stated an exprostify the medical properties of the facility did not proving the medical properties of the facility did not proving the medical properties of the facility did not proving the facility	m CNP-A during the visit to the y Cast Room should have is medical provider orders, and transcribed and followed as different was no problems with ons written by CNP-A and no lity to contact the facility review or confirm those different she had not seen R10's heel coording to CNP-A's 1/21 and the DON's description or order of the pressure ulcer to he was seen by CNP-A. Spectation for the facility to provider if a resident's pressure in morning, were worsening or if the redeveloped. MD-A confirmed notified of R10's change in morning but had previously his 10/7/21 cast room visit hopedic Services. Indicate a policy related to hids to provider, or transcribing cian orders. Eazards/Supervision/Devices 1)(2)	F 6	686			12/1/21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	` ′сом	E SURVEY PLETED
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WHITEW	ATER HEALTH SERV	ICES			ST CHARLES, MN 55972		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI		(X5)
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F 689	Continued From pa	ge 62	F 6	889			
	Based on observat	tions, interviews and record			R10 wounds measured and asse	ssed,	
	review, facility failed	d to conduct a thorough			MD updated, new treatment order	'S	
	causative factors of a resident's fall that resulted				obtained and care plan updated.		
		y, or update the resident's			Facility residents have the potenti	al to be	
		opriate interventions to reduce nilar incidents for 1 of 2			affected.		
	residents (R10) rev				Skin assessments completed for	current	
	residents (IV10) lev	lewed for fails.			residents on 10/13/21 and 10/14/2		
	Findings include: checks will be completed weekly with bath/shower. Wound rounds will be						
	According to the ele	ectronic health record (EHR)			completed every 7 days per policy	, wound	
		diagnoses sheet, R10 had the			binder developed to assist with w	ound	
		s, among other co-morbidities,			tracking.		
		e, generalized muscle					
		walking, not elsewhere			Licensed staff educated by Direct		
	classified, and histo	ory or failing.			Clinical Services starting on 11/12 Skin Management policy and Pre-		
	R10's quarterly Min	imum Data Set (MDS) dated			and Non-pressure Injury policy ar		
		uired extensive assistance of			procedures including identification		
		and transfer. The MDS			new wound requirements, assess		
		unsteady and required			requirements, notification require		
		nce and turning. Furthermore,			and monitoring requirements.		
		ssistance of two persons to				_	
		ognitive status was marked as			Licensed staff educated on Physi	cians	
		d and R10 was assessed as			orders policy and procedure.		
		ng behaviors of rejecting care.			Director of Nursing/Designed to a	udit	
	K 10 Hau Ho Talls Sil	nce the prior assessment.			Director of Nursing/Designee to a resident consultation notes for ne		
	According to R10's	EHR care plan, R10 had a			after appointments, hospital stays		
		dated 4/4/2018 that indicated			MD rounds 3 times weekly for 12		
		e deficit related to difficulty in			,		
	walking. An interver	ntion dated 12/10/2019			Director of Nursing/Designee to a	udit	
		0] to direct cares. He may			weekly wound rounds for measur		
		move, etc. with minimal help.			assessments, notifications, and tr	eatment	
		st as he directs, but an			orders for 12 weeks.		
		1/20/20 indicated: transfers-			The manufacture of the control of th		
		ait belt and a walker. At times due to behaviors. Staff are to			The results of the audits will be reby the QAPI committee for trends		
	THE WILL HOLLIANSIEL	uue iu deliaviuis. Stall ale 10			- DV HE WALLCOHILINGS TO RENUS	anu anv	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIEF		,	STREET ADDRESS, CITY, STATE, Z 525 BLUFF AVENUE ST CHARLES, MN 55972			
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F 689	after a short while dated 2/06/2018 in has the potential funsteady gait, imp psychotropic med evidenced by his i without assistance for this focus probensure resident is shoes, gripper soc 2/6/2018 and revisof recliner, side of toilet (1/30/20); mensure adequate information on fascause of falls or rirevised 2/3/20). According to an instated he had recent broken hip follow to relate any other or the injury. According to a phenomen a certified number a serified number assisting herself on 9/22/21 stand lift rather thin his careplan. Win the bathroom, Noff the toilet, but on NA-D reported she bathroom to his begot R10 as far as would not fit under able to seat R10 certified number assisting the stand of the toilet and the seat R10 certified number assisting the seat R10 certified number assisting the seat R10 certified number as would not fit under able to seat R10 certified number as would not	lage 63 e environment and reapproach . An additional focus problem indicated the following: [R10] or injury-fall risk related to: paired safety awareness, use of ications, impaired mobility as inability to transfer/ambulate be. Corresponding interventions lem indicated staff should: wearing appropriate footwear cks, or slippers) (date initiated sed 10/25/20); grip strips in front bed, in bathroom in front of aintain room free of clutter and ighting (2/03/20);review t falls and attempt to determine sk factors as indicated (2/6/18, terview 10/11/21, 1:19 p.m. R10 ently been hospitalized with a wing a fall, but he was not able information regarding the fall one interview 10/14/21,1:52 rsing assistant NA-D stated she of R10 to the bathroom by using a mechanical "sit to the two assist as indicated then R10's cares were complete therwise seemed his usual self, the moved R10 from the ed, using the lift. When NA-D the bed, NA-D realized the lift of the bed and NA-D was only on the very edge of the bed, she and R10 were "scared" and	F6	needs for adjustment of or content, as well as an educational needs. The Director is responsible to action occurs.	y further Executive		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C	
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	PROVIDER OR SUPPLIER	/ICES		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972		
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F 689	she called for help, working nearby and she asked PN-A to Then they put a trahim to walk to the bed, and R10 said, he went down onto foot. NA-D was una have twisted his leg a Hoyer lift that did they lifted him into NA-D recalled that right leg, but she thruse of the Hoyer lift pain to PN-A, and I (RN-B) working the that later she notice like he couldn't strand I told [PN-A] throng with it. She wreported to the night and respond to a phorocollege in May of 2 a nurse before. PN nursing board exarran ursing license. 9/22/21, PN-A state time, and it was the respond to as a nursing assist should be done by vital signs, the nur and notify the DON.	A practical nurse (PN-A) was discame to assist. NA-D stated help move R10 to his recliner. Insfer belt on R10 and asked bed. They started towards the "I'm going to sit right now" and PN-D's knees and NA-D's able to say if R10 appeared to get that time. She went to get not require him to stand, and bed using that equipment. R10 stated he had pain in his hought it was caused by the t. NA-D said she reported this ater to the registered nurse exportingly shift. NA-D reported ed "his leg looked extended, aighten it, kind of to the right here was something really was going off duty so she int nurse who followed up." The interview with PN-A on and she had graduated from 021, and had never worked as labeled as he had taken her mis in July, but did not yet have when R10 suffered his fall on the did she was working at that the first fall that she had to be she was working at that the first fall that she had to had learned in nursing school a resident had fallen. PN-A the with falls was from when she stant, but said an assessment the nurse, including a set of se should document findings and the physician. PN-A could did written a progress note (no	F 68			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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F 689	progress note was called the DON and had to do, but said have to do anything to the floor" and did needed to call the psaid she "would tak found out the next felt horrible, and as PN-A said she was over-night nurse had in the progress note of the progress note	found). PN-A said she had d asked what paperwork she the DON told her she did not g because R10 was "lowered d not fall. PN-A asked if she physician, but said the DON as care of it." PN-A said "I day things were worse and I sked what I needed to do." told by the DON that the ad charted everything, and she anything else. Gress note in R10's EHR dated "Report from evening nurse owered to the floor while trying A notified nurse that resident ain around 23:15 [11:15 p.m.] at approx 23:30 [11:30 p.m.]. turned outward. Swelling and rox 1 inch below right knee continued to describe R10's el, notification to physician and of nursing/DON at 5:00 a.m. ansfer to hospital at 7:00 a.m.) not include information about I, what happened during the any immediate interventions to	F 6	39			

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F 689	specific to the inci indicated no injurinot go to the hosp consciousness we not documented. items of predisposincluding equipmer marked. The form predisposing physincluding a recent weakness, infectionly gait imbalanci included 47 check situation factors in assistive devices, provided and also "other" and descrifactors were check related to whether were present and sit to stand lift was R10's care plan. According to a profit of the root cause to undiagnosed resphave made him were to choose an interest assist for transfer. R10's care plan were discovered in the use of a Hoye a response to the infection." A review of R10's not indicate any not	dent initiated. The report es were observed and he did oital. No pain level, level of ere reported. Mental status was The form included 33 check list sing environmental factors, ent issues, but nothing was a provided a checklist of 48 siological factors to choose from change in condition, illness, on, various medications, but we was marked. The form clist items of predisposing including footwear, use of whether assistance was being the opportunity to choose be. No predisposing situation ked including any information or not care plan interventions followed, or why a mechanical a used when not indicated on or ethat R10 had an irratory infection which "may" eak. The response to this was evention of a Hoyer lift and two so. The progress note indicated as updated; however, a review d not reveal a change to include r lift. Care plan did not address "undiagnosed respiratory eral days prior to fall; however, eral days prior to fall; however,	F	889			

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F 689	A request was made summary for R10 f 9/23/21. Facility on radiology reports a physician progress diagnosis for hospifibula shaft committial right, and fraction nondisplaced closes sepsis was given the studies indicated a specimen collected detected antibodies on 9/27/21. Unknown present prior to hose According to an int DON explained the follow when a resignurse was to assess review a possible of based on those find with additional help bed, or call for emericulating transfer to fall, DON stated a in "risk manageme which triggers post documentation to be up-coming shifts. It done this, nor had DON confirmed shifts poor to the poor, but had not	e R10 cough syrup on several notation on his condition. de for the hospital discharge following his admission on ly provided R10's hospital labs, and diagnoses list, but no notes. R10's principle ital admission was "fracture nuted nondisplaced closed cture tibia shaft comminuted ed initial right." A diagnosis of a urinary tract infection with a di 9/26/21. A viral panel is to respiratory syncytial virus with either infection was spitalization. Berview 10/14/21, 10:42 a.m. is procedure for a nurse to dent falls. DON said first the iss the resident for injury, cause of the incident, and dings, either use a Hoyer lift of the hospital. Following the nurse is expected to document into eigency assistance up to and to the hospital. Following the nurse is expected to document int" (incident report) in the EHR incident progress on the DON confirmed PN-A had not PN-A written a progress note, e was the one to initiate the been present during the	F 68	39		
	done this, nor had DON confirmed sh report, but had not incident. Although the risk management	PN-A written a progress note. e was the one to initiate the				

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F 689	questions about the PN-A had tried to fi happened (root car appropriate interve it wasn't a fall, but considered a fall, but the management reporsisted the management reported for the fall out the best determine apprevent further incirisk management respectively fill out the second for the fall; did to environmental fact a equipment and with include the names provided only a verifall and no other indiconfirmed the reported and immediate intervention and manage and the policy stated the prevention and manage any risk famanage as much a falling and/or susta The policy statemerefers to unintention ground, floor or oth result of an overwhere.	e fall or his condition, or if gure out why the incident had use) to initiate any new and ntion. DON said, "(PN-A) said of course we know it is ut she said he looked fine." persons completing the risk of twere to get witness my staff who were present to cause of the fall, and were to the report so that the IDT could propriate interventions to dents, but DON confirmed the eport did not include any alluation of the R10's condition not contain information related actors or problems with the ess statements did not or titles of the staff, and y brief account of the actual formation or evaluation. DON rt did not contain evidence of rventions to provide for safety	F 68	39		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	` ´COM	E SURVEY PLETED
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F 689 F 698 SS=D	fall evaluation should physical assessme witness statement is environmental asset the fall, medication changes and any not the physician and reas an expectation. "upon initial review, assessment, nurse (1) any new interversevent additional finterventions deterrappropriate. The poshould review the fadetermine the potereview updates to the additional revisions Dialysis CFR(s): 483.25(l) Significant professional streamine dialysis received in the residents' goals This REQUIREMENT by: Based on observative review, facility failed comprehensively many post-treatment statireviewed for dialysis evaluate R11's fluid ev	Id be completed including a not with vital signs, resident and regarding the fall, resment, contributing factors to changes, mental status rew diagnoses. An update to responsible party was indicated and to update the care plan as to resting tion put in place to try to realls, and (2) removal of any resident and to be no longer reall the following morning to reall and resident. Sure that residents who reverse such services, consistent and and preferences. Note that residents who reverse such services and add and preferences. The policy also indicated the IDT residents who reverse that residents who reverse that residents who reverse such services, consistent and and preferences. The policy also indicated the IDT residents who reverse such services and add and resident that residents who reverse such services, consistent and and preferences. The policy also indicated the IDT residents who reverse that residents and reverse that residents and reverse that resident and reverse that reverse that reverse the reverse that reverse that reverse that reverse the reverse that reverse that reve	F 69		r each fluid	12/1/21

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F 698	Findings include: According to R11's Admission Record/following diagnoses hypertensive chronic chronic kidney dise disease, dependent on chronic diastolic hypertensive heart. According to a minital assessment dated have a 13/15 BIMS status) showing she at [site] every day status are listed to dependent 11/07/2020 directed catheter site every or warmth and notiff symptoms present. complete dialysis U dialysis every evenifor dialysis monitorior order for vital signs bath day, once were entered on 11/08/20 every day shift was order did not includ reporting vacillation 11/07/20 an order foliters per 24 hours were Recommended bre AM/PM shifts, 240c instruct on when to	electronic health record (EHR) diagnosis sheet, R11 has the samong other co-morbidities: c kidney disease with stage 5 ase or end stage renal ce on renal dialysis and acute (congestive) heart failure, and	F 6	698	Morning meeting form updated to review of residents on dialysis incliveight, fluid intake, and dialysis Ulticensed staff educated by the Dir Clinical Services starting on 11/12/1 the Hemodialysis Communication and procedure including the User Assessment communication tool a procedures and required monitoring dialysis residents. Director of Nursing/Designee to condialysis for completion of weigh Defined Assessment, and fluid monother the QAPI committee for trends needs for adjustment of audit scheor content, as well as any further educational needs. The Executive Director is responsible to ensure the action occurs	ector of (21 on policy Defined and any edules	

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F 698	liters daily, or how the fluid restriction 8/23/21 the order restriction 1.5 liter breakdown 240cd 180cc nights." The adaily total, asses A review of R11 tr (TAR) for August, showed that nurse completed the Diareview of the assefailed to show this R11's fluid intake totaled. No correstrelated to R11's in was within her de exceeded or had amount. A review showed a general vacillations, excel was 5.8 pounds how the second from the 9/10 not documented or weight remained done, and 9/3/21 pound from the 9/10 not documented. moved from the 7/2 administration recommended 9/5/2 on the MAR was day was 201 pour with no evidence or report. On 9/12 the next day 203. documented on 9/20 October 2021 MA	page 71 If to decide if R11 had exceeded in given the ordered range. On was updated to read "fluid rs per 24 hours. Recommended Imeal; 300 cc AM/PM shifts; e order still failed to instruct on assment or report to be made. Teatment administration record September and October 2021 as were documenting they had alysis UDA tool; however, a ressment portion of the EHR as form had been completed. Was documented, but not apponding assessment or note atake was found indicating if she signated fluid intake, or had not met her allotted fluid of R11's daily weights in August ally stable weight with slow but 8/29/21 when R11's weight igher than the day prior without other documentation. On 9/1/21 relevated, 9/2/21 weight was not weight had dropped only one and the following and the following and the following and the following and and the following and the following and a difference of 5.2 pounds, of reweigh, further assessment and for the first weight was 198. 6, 6, up 5lbs, and no weight /14/21. According to R11's R, R11's weight on 10/10/21 and no 10/11/21 it was 202lbs, or a	F6	988				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245270	B. WING				C 18/2021
	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE S25 BLUFF AVENUE ST CHARLES, MN 55972	1 10/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 698	Continued From pa	nge 72	F 6	98			
	assessment. On 10	out reweigh or other 0/12/21 weight was 196.8 and 202, an increase of 5.2 lbs.					
	and only one Dialys found to have been between August an document did not ir information except 9/13/21, two days psigns upon return.	HR assessment list was done sis Communication UDA was a completed (date 9/15/21) and October of 2021. The include pre-treatment for a set of vital signs from prior, and the same set of vital No other information was ing a nurse signature.					
	stated she went to She said the facility she left for dialysis port site to make so R11 also said staff monitoring how mu showed me she ha felt the staff were w	erview 10/11/21, 3:43 p.m. R11 dialysis three times weekly. It usually weighed her before and they were to check her there were no problems. Were supposed to be ch fluid she had to drink, and d soda cans in her room, but writing down how much she was unable to state her current					
	licensed practical nassess a dialysis patemperature and ox sending them to a contract information was LPN-B stated the factor R11's "face sheet" consult sheet," but who would send information on weight	erview 10/13/21, 12:10 p.m. a surse stated a nurse should atient's vital signs, including tygen saturation level before dialysis treatment, but stated s not sent with R11 to dialysis. acility nurse would send a copy of medication list and a t that dialysis was the ones formation on R11's condition to unable to confirm that ght changes or fluid intake is, and said information on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245270	B. WING _		10	C / 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 698	what to do with sign weight changes she physician orders. L notify a physician if to 5 pounds in a da a dialysis patient's access the venous assessed every shi swelling or leaking. During an interview director of nursing for nurses to monit to make sure the d were no signs of instate how often this stated an expectati dialysis patient's we three pounds in one physician by the nurses to document to amount consumprovided. The DON calculate what the foften went out of the because she was "consume what she know how much shoft the building; how R11 was their responding and they contain the amount total was overnight nurse and should be document according to the DO any dialysis patient.	inge 73 Ins of fluid overload, such as could be listed in a resident's PN-B said usually they were to a resident had a change of 3 y. LPN-B stated she believed cort (where dialysis would system) site should be fit for signs of redness, 10/13/21, 12:27 p.m. the (DON) stated an expectation for a dialysis patient's port site ressing was intact and there fection. DON was unable to should be done. DON also con for staff to be monitoring a eight and stated a change in the day should be reported to the rese working with that resident that an expectation for the R11's fluid intake, including the from what the kitchen it said they were able to facility offered R11, but R11 the building with family and ther own person" could wanted and they would not the had had when she was out rever, DON, confirmed that the considered and they were about her The documentation of the 24 the responsibility of the dany excess fluid intake and in a progress note DN. The DON confirmed that is considered at high risk for the risks include such things	F 69	8		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		TE SURVEY MPLETED C
		245270	B. WING _		10)/18/2021
	PROVIDER OR SUPPLIER	VICES		STREET ADDRESS, CITY, STATE, ZIP COD 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 698	as pulmonary compunable to state any DON explained the EHR called the Diacompleted prior to upon her return. The expected assessmination of the patients stability proposed before treatment, the sent with R11 treatment. DON could had rarely been could although the order signed by nurses a confirmed that the complete in the even dialysis with R11 experience.	polications, but DON was additional complications. The additional complications. The afacility had a document in the alysis UDA that was to be R11 leaving for dialysis and the Dialysis UDA contains all the ents for monitoring a dialysis for to and after hemodialysis. Completing in the morning the form could be printed out when she went for her dialysis infirmed that the Dialysis UDA in the morning had been shaving been done. DON also corder instructed nurses to be ening and then to send to wen though she was actually illity from dialysis in the end the facility had not provided aducation specific to dialysis, sed the care of a dialysis	F 69	8		
	R11's physician and (MD-A), complication fluid overload which conversely, problem electrolyte imbaland monitor R11's daily ensure stability. Fachanges could resuccomplications. MD-her blood pressure at least daily. MD-A often the facility was blood-pressure but	erview 10/13/21, 1:15 p.m. with d facility medical director ons of hemodialysis include h could result in heart failure or ms with dehydration and also ce. MD-A stated facility should weights and intake of fluids to ilure to monitor or reportult in a failure to identify -A also said R11 should have monitored on a regular basis, A said she was unsure how as checking R11's confirmed that once a week uate for a dialysis patient.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 698	Continued From pa	age 75	F 69	8			
	care of a dialysis p document titled He policy statement is designed and impli- strives to ensure the appropriate manag- resident regardless at the dialysis cent [facility] will utilize the UDA" for continuity and dialysis unit. Clinical responsibil assure daily asses fistula or graft site description of mon- post-dialysis (dry wonderer in the Dialysis each dialysis treaturesident and maint by Provider/dialysis not follow ordered resident/responsib- choice, document education and noti- center. Complete the electronic medical Further responsibilifluid restrictions as- center; manage sp dietary restrictions policy listed the fol- post-dialysis comp- but are not limited fatigue, signs/symp (low blood-pressur- electrolyte imbalant	de for a policy related to the atient. Facility provided a emodialysis dated 4/13/21. The as follows: The center has emented a process which he comfort, safety, and gement of a hemodialysis if the procedure is performed er or at the center. The center the "Dialysis Communication of care between the facility ities of the facility included: sment and documentation of (policy fails to include itoring of a port); document weight) obtained by the dialysis is Communication UDA afterment; monitor fluid status of ain fluid restriction as ordered as center. If resident chooses to fluid restrictions, educate le part on the risk of their this education and response to fluid restriction and dialysis he Risk vs Benefit UDA in the record. Ities listed include: manage ordered by provider/dialysis he cordered by provider/dialysis he cordered by provider/dialysis hecial dietary regime and as ordered. In addition, the lowing: assess and manage lications which may include, to, the following: bleeding, otoms of infection, hypotension e), chest pain, unsteady gait, ace, seizures, leg cramps, fluid adache. The policy instructs in					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	COMPLETED	
		245270	B. WING _		10/18/2021	
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION	
F 698	the use of the Dialy UDA for continuity of A request was made	sis Center Communication of care. e for a policy related to	F 69	98		
	<u> </u>		F 72	26	12/1/21	
	the appropriate con provide nursing and resident safety and practicable physica well-being of each resident assessme and considering the diagnoses of the fa	ervices live sufficient nursing staff with inpetencies and skills sets to direlated services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by ints and individual plans of care is number, acuity and cility's resident population in in a facility assessment required				
	licensed nurses had and skill sets neces needs, as identified	facility must ensure that we the specific competencies sary to care for residents' through resident described in the plan of care.				
	limited to assessing	iding care includes but is not g, evaluating, planning and ent care plans and responding				
	to demonstrate con	sure that nurse aides are able npetency in skills and ary to care for residents'				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		E SURVEY PLETED
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		245270	B. WING _		10/	18/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
WHITEW	ATER HEALTH SERV	ICES		525 BLUFF AVENUE		
******	AILK IILALIII SLKV	ICLS		ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 726	assessments, and This REQUIREMEI by: Based on interview facility failed to ensunlicensed practica adequate training a skills related to iderchanges in conditional assessment and not care specifically resident (R10) sufformatured fibula/tibiatimely response pocompetency training potential to affect a Findings include: According to educate the facility, PN-A reportentation on 8/10, with multiple substance to understanding facompleted. A test recompleted, but not test-outs for any sponthat date or any Facility reported PN computer training recompleted 14 didactotaling only 24 creprocess, disease k	described in the plan of care. NT is not met as evidenced wand document review, the ure a newly graduated, all nurse (PN-A) received and demonstrated competency ntifying and responding to on, and documenting resident ursing response for continuity related to falls and injury. A great a fall resulting in a a without a knowledgeable or st-fall by (PN-A). This lack of g and assessment had the II 34 residents in the facility. Attion documents provided by acceived general employee (2021. Eighteen general topics opics were covered in an 8 petency test for hand hygiene d a post-test for all staff related alls and infection control were elated to compliance was evidence of competency decific nursing skills completed other date were provided. N-A completed a half hour module on general (2021. Facility provided PN-A's howing that PN-A had otic and 10 clinical credit hours, dit hours specific to nursing nowledge, patient care and	F 72	Facility residents have the paffected. Current staff to have compecheckoff complete per policy. Director of Nursing/Designe a competency checklist for I certified staff per policy on hannually. Interdisciplinary team education of Clinical Services 11/12/21 to the MN Board of license requirements, the Enorientation policy and procedannual competency check of procedure. Executive Director/Designee hire documentation weekly a are hired and annually for coreviews. The results of the audits will by the QAPI committee for the needs for adjustment of audion or content, as well as any fureducational needs. The Execution occurs.	etency y annually. e to complete licensed and aire and eted by the starting on f Nursing mployee dure and the off policy and e to audit new as new staff complete I be reviewed crends and any lit schedules arther ecutive	
	documentation. Fa	nowledge, patient care and cility was unable to provide ng license for PN-A.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245270	B. WING _		10	C / 18/2021
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP C 525 BLUFF AVENUE ST CHARLES, MN 55972			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 726	According to docur health record (EHF 9/23/21, 6:54 a.m. (RN-B) writing the the evening nurse to the floor while transport of the floor was R10's condition and morning, notifying previous note was R10's condition or the incident on 9/22/responsible for R10 were found docum incident on 9/22/21 According to a doc related to the 9/22/by the director of nurse responsible did not document in the floor of the	mentation in R10's electronic R), a progress note dated indicated the registered nurse note, had received report from [PN-A] that R10 was "lowered ying to get into bed" [9/22/21]. 10's lower right leg was rotated len and bruised, and R10 was nificant pain. The progress note sessed and responded to d sent him to the hospital in the family and physician. No found in R10's EHR describing cares provided prior to or after 2/21 during the time PN-A was 0's care. No vital signs for R10 ented by PN-A following the	F 72	26		
	and of predisposing gait imbalance was According to an int DON explained the follow when a residurse was to assess review a possible obased on those find	erview 10/14/21, 10:42 a.m. er procedure for a nurse to dent falls. DON said first the set the resident for injury, cause of the incident, and dings, either use a Hoyer lift or, to place the resident into				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X	(3) DATE SURVEY COMPLETED
		245270	B. WING			C 10/18/2021
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 726 Continued From page 79 including transfer to the hospital. Following the fall, DON stated a nurse is expected to docum in "risk management" (incident report) in the E which triggers post-fall observation documentation to be done by nurses on the up-coming shifts. DON confirmed PN-A had note this, nor had PN-A written a progress not Although DON had initiated the risk managem incident report, DON was unable to state whe PN-A had asked R10 any questions about the or his condition, or if PN-A had tried to figure of why the incident had happened (root cause) to initiate any new and appropriate intervention. DON said, "(PN-A) said it wasn't a fall, but of course we know it is considered a fall, but she said he looked fine." During the 10/14/21, 10:42 a.m. interview, DC said PN-A had started work on 8/10/21. DON confirmed the facility did not have a copy of PN-A's nursing license upon hire, and did not have one as of 10/14/21. DON said facility had check list of skills that a nurse trainer would g through with a newly hired nurse during orientation shifts, but they did not have any ty of skills tests. DON stated the nurse providing orientation would see if the newly hired nurse comfortable with the skill, and then mark if the were competent or not. A request was made for a copy of PN-A's nursikills checklist, but facility was unable to providing orientation.				STREET ADDRESS, CITY, STATE, ZIF 525 BLUFF AVENUE ST CHARLES, MN 55972	, CODE	10/10/2021
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		ON SHOULD BE HE APPROPRIA	
F 726	including transfer to fall, DON stated a in "risk management which triggers post documentation to lup-coming shifts. It done this, nor had Although DON had incident report, DC PN-A had asked Roor his condition, or why the incident had initiate any new an DON said, "(PN-A) course we know it said he looked fine During the 10/14/2 said PN-A had state confirmed the facil PN-A's nursing lice have one as of 10/check list of skills through with a new orientation shifts, ho skills tests. DON orientation would scomfortable with the were competent of A request was mad skills checklist, but this document. According to a photological in May of 2 a nurse before. PN	on the hospital. Following the nurse is expected to document ent" (incident report) in the EHR t-fall observation of done by nurses on the DON confirmed PN-A had not PN-A written a progress note. It initiated the risk management DN was unable to state whether the theorem and the tried to figure out and happened (root cause) to an appropriate intervention. It is a fall, but of its considered a fall, but of its considered a fall, but she of the tried work on 8/10/21. DON it is did not have a copy of the tried work on the tried to facility had a that a nurse trainer would go but they did not have any type of the skill, and then mark if they root.	F 7	726		

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		245270	B. WING			<u> 10/</u>	18/2021
NAME OF F	PROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE		
\A/LITE\A/	ATED HEALTH CEDV	UCES.			525 BLUFF AVENUE		
VVIIIEVV	ATER HEALTH SERV	ICES		,	ST CHARLES, MN 55972		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 726	Continued From pa	age 80	F 7	726	3		
		PN-A said she was told by the					
		waiver, and she was able to					
		he was licensed. She had not					
		the Minnesota Board of					
		she had received a checklist					
		be trained on during her first					
		but said this did not include a					
		, but rather was a list for all					
		said she had not undergone					
		acility to determine her					
		PN-A said she had received					
		or orientation, but had not been					
		ady to work independently, or if					
		training. PN-A was unable to					
		out stated there were some					
		ent a text to the physician to					
		ause she felt she did not know					
		ed at that time. PN-A said she					
		d to call the DON if she had					
	questions, but said	the DON did not always					
		calls. PN-A said she had asked					
		ound care and was told to just					
		e already on the wound and					
		the same." When R10					
		9/22/21, PN-A stated she was					
		e, and it was the first fall that					
		to as a nurse. PN-A was					
		what she had learned in					
		out what to do if a resident had					
		er experience with falls was					
		s a nursing assistant, but said					
		ould be done by the nurse,					
		ital signs , the nurse should					
		and notify the DON and the					
		uld not recall if she had written					
		progress note was found);					
		ay have given R10 some					
		cause he complained of pain					
		not localize the pain. PN-A					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	CON	E SURVEY MPLETED
		245270	B. WING			1	C / 18/2021
	ATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION X			5	STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	1 10	10/2021
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 726	said she had called paperwork she had her she did not have was "lowered to the asked if she needed the DON said she' said "I found out the and I felt horrible, a do." PN-A said she over-night nurse had did not have to do a According to an interest of the with the newly hired not any hand-outs of information that she nurse should have check-list mostly conditionally administration. A bic common emergency stations, but RN-A or competency chee According to an interest of chee According to an i	If the DON and asked what I to do, but said the DON told be to do anything because R10 of floor" and did not fall. PN-A do to call the physician, but said would take care of it." PN-A enext day things were worse and asked what I needed to was told by the DON that the ad charted everything, and she anything else. Berview 10/14/21, 2:44 p.m. of participates in orientation do nurses. RN-A said there were not written orientation ewas aware of, but said a new as check-list. RN-A said the overed medication nder of steps to take with cles was kept at the nurses' said there were no skills tests, cks related to those items. Berview 10/14/21, 2:52 p.m. the stated it was extremely lity to have competent staff. It was ensuring staff had ining, and he stated the department was to check effore they started to work. Stated PN-A's lack of licensure ght to his attention and she		726			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION (X3	O DATE SURVEY COMPLETED
		245270	B. WING		C 10/18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	he stated the DON competency progra had been accomplicated a conjugation of the care they result the care the care they result the care the care they result the care they result the care they result	was responsible to develop a m, but he did not believe this shed yet. The Executive oncern that residents may not quire if the facility employed staff who's competence had nined. Error Rts 5 Prent or More	F 726		12/1/21
	§483.45(f) Medication The facility must en §483.45(f)(1) Medication percent or greater; This REQUIREMENT by: Based on observation review, the facility formedication error ratidentified during obwith 7 errors (for rean error rate of 26.9 Findings include: On 10/13/21, at 8:1 was observed and (RN)-A. RN-A was following five medication five medication error rate of 26.9 Findings include: On 10/13/21, at 8:1 was observed and (RN)-A. RN-A was following five medication for the following five medication for five fill five fill fill fill fill fill fill fill fil	on Errors. sure that its- cation error rates are not 5 NT is not met as evidenced cion, interview and record ailed to be free from the of 5 percent or greater servations of 26 medications sident R24) which resulted in		R24 orders in electronic charting syst updated to read, "may crush medication and give individually via G-tube." Facility residents with enteral tube medications have the potential to be affected. Licensed staff educated by the Director Clinical Services starting on 11/12/21 the Enteral Tube Medication Administration policy and procedures. Director of Nursing/Designee to comprandom med pass audits on all shifts including enteral tube med administration weekly for 8 weeks. The results of the audits will be review by the QAPI committee for trends and needs for adjustment of audit schedules.	or of to lete tion red any

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY PLETED
		245270	B. WING			1	C 18/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	10/	10/2021
WHITEW	ATER HEALTH SERV	ICES			25 BLUFF AVENUE T CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 759	Continued From pa	ge 83	F 7	59			
	cc of water to each 30 cc of water, adm medications, flushe administered secon	ily via g-tube. RN-A added 60 cup, flushed R24's g-tube with ninistered first cup of crushed ad with with 30 cc of water then ad cup of medications with 120 shed with 30 cc water flush.			or content, as well as any further educational needs. The Executive Director is responsible to ensure thaction occurs.	iis	
	a.m. RN-A stated the meds had to be give	th RN-A on 10/13/21, at 8:10 here was no order stating the en separately therefore all liven together except for given separately.					
	was conducted with combining medicati administration is ho	1 a.m. a follow-up interview n RN-A. RN-A stated ions together for g-tube w RN-A has always given except potassium was to be					
	(DON) was asked i G-Tubes and DON	20 p.m. the director of nursing f staff were trained on stated there was no education N was hired a year and a half					
	p.m. DON verified t administering medi medication was to I flush in between ea what could happen	cations via G-Tube was each be given individually with a loch medication. When asked if medications were given allow, "Many things, meds may					
	dated June 2017 di administer medicat	Medication Administration d not address how to ions via G-Tube. Facility policy onal Therapy (Tube Feeding)					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245270	B. WING		C 10/18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 759 F 761 SS=D	dated June 2017 al administer medicat Label/Store Drugs at CFR(s): 483.45(g)(§483.45(g) Labeling Drugs and biological labeled in accordar professional princip appropriate access instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In acceptant laws, the fabiologicals in locked temperature contropersonnel to have a §483.45(h)(2) The locked, permanentl storage of controlle the Comprehensive Control Act of 1976 abuse, except when package drug distriquantity stored is more presented.	so did not address how to ions via G-Tube. and Biologicals h)(1)(2) g of Drugs and Biologicals als used in the facility must be nee with currently accepted oles, and include the ory and cautionary e expiration date when s of Drugs and Biologicals cordance with State and acility must store all drugs and docompartments under proper ls, and permit only authorized access to the keys. facility must provide separately y affixed compartments for d drugs listed in Schedule II of a Drug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the minimal and a missing dose can	F 759		12/1/21
	by: Based on observative review the facility faproperly labeled to use date and avoid medications after b	tion, interview, and document ailed to ensure inhalers were allow staff to identify a beyond administration of inhalant eyond use date for 3 of 3 9 and R184) reviewed for safe		R13, R19, R184 medication labele appropriately. Facility residents have the potential affected.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	COM	E SURVEY IPLETED	
		245270	B. WING _		l l	C 18/2021	
	PROVIDER OR SUPPLIER	ICES	STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 761	to dispose of expire medication carts ar rooms. Findings include: On 10/12/21, at 9:3 medication cart wa Nurse (RN)-A prese found: - R13's open Flove indicate when it wa - R19's open Spiriv found with no date - R184's open Albu to indicate when it v - A stock bottle of fiexpiration date of 0 During an interview director of nursing nurses open a new pen they should lab date open. On 10/15/2021 at 1 room was observed (DON) present and - 8 boxes of stock of expired in 07/2021.	Additionally, the facility failed and medications in 1 of 1 and 1 of 11 medication storage as observed with Registered and the following was an inhaler found with no date to sopened. a inhaler and Albuterol inhaler to indicate when opened. The inhaler found with no date was opened. The inhaler found with an an inhaler found with an an inhaler, eye drop or insuling the medication with the case of with Director of Nursing the following was found: the recommendation inhaler found with the case of with Director of Nursing the following was found: the recommendation in that suppositories prescribed to R8	F 76	Medication storage room and audited for any opened medic without a date opened label president name present on 10/medications found without corwere disposed of. NOC shift nurse to complete vichecking of the medication castorage room with sign off on sheet. Nursing staff to check items for label, etc. throughout med pass Monthly pharmacy reviews to Clinical Services starting on 1's the Medication storage, labeling expiration information and tips Medication expiration dates earned the Medication storage procedures. Director of Nursing/Designee NOC shift checkoff sheet wee completion for 8 weeks. Licensed staff educated to the storage, labeling, and expiration expiration and tips education expiration dates education, Medication storage policy and procedures and policy and procedures of the storage policy and procedures and the storage policy and procedures of the storage policy and the storage policy and the storage polic	ations resent or 18/21. Any rect labeling veekly rts and checkoff or date, es. continue. e director of 1/12/21 to ng, and e education, ducation, dicy and to audit kly for e Medication on on Medication edication edures and		
	DON stated that wh	on 10/15/21 at 1:44 P.M., the nen nurses open a new insulin pen they should label		The results of the audits will b by the QAPI committee for tre needs for adjustment of audit	nds and any		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		245270	B. WING _			C / 18/2021
	PROVIDER OR SUPPLIER ATER HEALTH SERV	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		.0.202
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPOPER DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 761	verified the boxes of expired and should Facility policy titled dated June 2017, in date a bottle or come as well as to return medications promp Staff Qualifications CFR(s): 483.70(f)(1) S483.70(f)(1) The facility full-time, part-time of professionals necesprovisions of these \$483.70(f)(2) Profe certified, or register applicable State law This REQUIREMENT	the date open. The DON also of cerumen ear drops were have been disposed. Medication Administration, adicated on page 4 to record tainer is opened on the label, expired or outdated tly to the pharmacy. (2) alifications. acility must employ on a per consultant basis those essary to carry out the requirements. ssional staff must be licensed, ed in accordance with	F 76	or content, as well as any further educational needs. The Execut Director is responsible to ensuraction occurs.	ive	12/1/21
	facility failed to ens (PN)-A and 1 of 3 li	v and document review, the ure 1 of 1 practicing nurse censed practical nurse was licensed by the State to		PN-A removed from schedule background check completed a license obtained. PN-C license obtained.		
	LPN-C stated PN-A did not have license licensed practical n let me work as a license	on 10/11/21, at 7:01 p.m. had passed her boards but yet and was working as a urse. LPN-C stated, "they also ensed practical nurse for a was assigned a license		Facility residents have the pote affected. Audit of current employees to vertification documentation con 10/17/21 Employees will have on file cur	erify d nplete	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245270	B. WING			10/1	C 1 8/2021
	PROVIDER OR SUPPLIER	CES		5	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BLUFF AVENUE 3T CHARLES, MN 55972	107	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 839	Practical Nurse (PN was reviewed. The hire date of 8/10/21 revealed PN-A did in nursing in the state. During an interview the business office timecard was review and revealed PN-A licensed practical in license 28 times. The during her interview start before her lice she was told yes. The BOM stated NILPN and stated she copy of a temporary thought it was like a that when they pass to go. The BOM stated she was underneat. The BOM stated she granursing school and 2021. PN-A when she had passed he to LPN-C, and she stated she explaine gotten her official in the process of the stated she explaine gotten her official in the process of the stated she explaine gotten her official in the process of the stated she explaine gotten her official in the process of the stated she explaine gotten her official in the process of the stated she explaine gotten her official in the process of the stated she explained gotten her official in the process of the stated she explained gotten her official in the process of the stated she explained gotten her official in the process of the stated she compared to the process of the stated she are the process of the stated she was undernead to the process of the stated she are the process o	I)-A's employee personal file record indicated an original . The personal file review not have a license to practice	F 8	339	validated license information, and credential documentation prior to with residents. Interdisciplinary team educated by Director of Clinical Services startin 11/12/21 on the new hire policy and state of Minnesota regulations and need to verify license/certification pworking with residents. Executive Director/Designee will an new hires for 8 weeks for complete documentation. Audit tracking tool developed. The results of the audits will be reveloped for adjustment of audit scheor content, as well as any further educational needs. The Executive Director is responsible to ensure the action occurs.	the g on d the the prior to udit e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245270	B. WING			1	C 18/2021
	PROVIDER OR SUPPLIER			52	REET ADDRESS, CITY, STATE, ZIP CODE 5 BLUFF AVENUE 1 CHARLES, MN 55972	10/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 839	aware she did not there was a waiver a new graduate nuby the DON it took pass her boards a waiver. PN-A State executive director have a valid licens practical nurse. Phe manipulated and to be state of 2/15 nurse. LPN-A's per Minnesota LPN lice However, between did not have a lice state of Minnesota During an interview the business office February of 2021, was hired back on nurse (LPN) as she BOM stated LPN-03/17/21. During a sam. LPN-C's time 2/15/21 to 3/17/21 worked in the facil without supervision During an interview executive director facility had an unlike building. The executive director facility had an unlike building.	hire they (DON and BOM) were have her license and stated that she could work under as irse. PN-A stated she was told LPN-C it took three times to ad LPN-C had worked under a ed I was suspended by the on Monday because I do not e to work as a licensed I-A stated she felt like she was aken advantage off. nurse (LPN)-C's employee eviewed. The record indicated I/21 as a licensed practical resonnel record indicated a ense was issued on 3/17/21.	F8	339			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG	COM	E SURVEY MPLETED C
		245270	B. WING_			18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 839	Minnesota Board or executive director is the loop if the DON member under any where the staff merexecutive director is checks should be keepen to be a check of the Pre-Employmen License/Certification included, "1. Prospivalid license and/or application when a	onal file and to check the f Nursing registry. The stated he would want to be in and BOM were hiring a staff abnormal circumstances mber was not licensed yet. The stated a copy of background ept in employee personal files	F 8	39		
	2. Licensure Desi applicable state lice the prospective em license and/pr certi standing and applic Required In-Service CFR(s): 483.95(g)(ignee must check with all ensing board(s) to confirm that ployee possesses a valid fication that is in good cable to the position." Training for Nurse Aides 1)-(4) d in-service training for nurse	F 94	47		12/1/21
	continuing compete be no less than 12 §483.95(g)(2) Inclu training and resider §483.95(g)(3) Addr determined in nurse and facility assessr	ufficient to ensure the ence of nurse aides, but must hours per year. de dementia management nt abuse prevention training. ess areas of weakness as a aides' performance reviews ment at § 483.70(e) and may I needs of residents as				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245270	B. WING				18/2021
	PROVIDER OR SUPPLIER	ICES		52	REET ADDRESS, CITY, STATE, ZIP CODE 5 BLUFF AVENUE C CHARLES, MN 55972	10/	10,2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 947	to individuals with of address the care of This REQUIREMENT by: Based on interview facility failed to ensimize reviews were conducted assistants (NA-A. New personnel records of the personnel records of the personnel record lacked documentate evaluation. NA-D's was dated 10/31/160 NA-E was hired on lacked documentate evaluation. NA-D's was dated 10/31/160 NA-F was hired on lacked documentate evaluation. NA-D's was dated 10/31/160 NA-F was hired on record lacked documentate evaluation. NA-D's was dated 10/31/160 NA-F was hired on record lacked documentate evaluation. NA-D's was dated 10/31/160 NA-F was hired on record lacked documentate evaluation. NA-D's was dated 10/31/160 NA-F was hired on record lacked documentate evaluation. NA-D's was dated 10/31/160 NA-F was hired on record lacked documentate evaluation.	racility staff. for a cility	F 9	47	Performance evaluations complet current staff. Facility residents have the potential affected. Performance evaluations will be completed annually for licensed and certified staff. Interdisciplinary team educated by Director of Clinical Services starting 11/12/21 on performance evaluation requirements per policy. Executive Director/Designee will as performance evaluation completion annually. The results of the audits will be revely the QAPI committee for trends an eeds for adjustment of audit scheor content, as well as any further educational needs. The Executive Director is responsible to ensure the action occurs.	the g on on wiewed and any edules	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245270	B. WING				C 18/2021
	PROVIDER OR SUPPLIER			525 BLU	ADDRESS, CITY, STATE, ZIP CODE FF AVENUE ARLES, MN 55972	<u> 10/</u>	16/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI ROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 947	reviews were support December 2020. The caught up on performance evaluating the requested from the not get to them." The performance evaluating the requested staff started managing the During an interview executive director scalendar year, North complete performant to include strengths for growth. The execunder the assumption completed the performant of last year like the stated he was not at A policy and process.	osed to be completed by the DON stated they were not remance reviews, "We did not any of the five staff members survey team and we just did the DON stated no ations had been completed for since 2017 when Northshore	F9	47			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245270	B. WING			C / 18/2021
	PROVIDER OR SUPPLIER ATER HEALTH SERV	ICES		STREET ADDRESS, CITY, STATE, ZIP C 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		
	10/15/21 and 10/18 with Appendix Z, Er Requirements, §48 during a standard refacility was NOT in	·				
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the form.	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required the first page of the CMS-2567				
	onsite revisit of you	t Population	E 0	07		12/1/21
	§441.184(a)(3), §485.483.73(a)(3), §485.68(a)(3), §	16.54(a)(3), §418.113(a)(3), 460.84(a)(3), §482.15(a)(3), 3.475(a)(3), §484.102(a)(3), 5.625(a)(3), §485.727(a)(3), 91.12(a)(3), §494.62(a)(3).				
	and maintain an em that must be review	n. The [facility] must develop nergency preparedness plan /ed, and updated at least every nust do the following:]				
	but not limited to, p services the [facility an emergency; and	t/client] population, including, ersons at-risk; the type of dependent in the ability to provide in continuity of operations, as of authority and succession				

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

TITLE

(X6) DATE

Electronically Signed

11/19/2021

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.

	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPL		(X3) DATE SURVEY COMPLETED		
		245270	B. WING _		C 10/18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
E 007	Plan. The LTC facilian emergency prepreviewed, and updar plan must do all of the (3) Address resider limited to, persons a LTC facility has the emergency; and coincluding delegation plans. *NOTE: ["Persons a hospice, PACE, HHRHC/FQHC, or ESI This REQUIREMENT by: Based on interview facility failed to add including the person operations plan. The facility failed to impopulation to include: The facility's Emergundated, failed to impopulation to include During interview on executive director viplan did not addresserved.	at §483.73(a):] Emergency ity must develop and maintain aredness plan that must be ated at least annually. The the following: It population, including, but not at-risk; the type of services the ability to provide in an intinuity of operations, as of authority and succession at risk" does not apply to: ASC, IA, CORF, CMCH, RD facilities.] Note that is not met as evidenced and document review, the ress their resident population as at risk, in their emergency his had the potential to affect ding at the facility.	E 00	Assessment of current resident population conducted on 11/19/2027 Assessment tool placed in emergent evacuation kit at each nurse's station use by staff in the event of an emergy Assessment will be updated weekly Audits will be conducted weekly to ecompliance. Audit findings will be reviewed at QAPI meeting.	ncy on for gency.
	CFR(s): 483.73(b)(201		, 1, _ 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245270	B. WING		10	C / 18/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 525 BLUFF AVENUE ST CHARLES, MN 55972	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 015	§403.748(b)(1), §4 (1), §460.84(b)(1), §483.475(b)(1), §4 [(b) Policies and proceed plans and proceed plans are forth in partial assessment at partial and the communicity this section. The procedures must an end patients whether place, include, but (i) Food, water, measupplies (ii) Alternate source following: (A) Temperatures to safety and for the sprovisions. (B) Emergency light (C) Fire detection, systems. (D) Sewage and weight in the systems. [For Inpatient Hose	18.113(b)(6)(iii), §441.184(b) §482.15(b)(1), §483.73(b)(1), 85.625(b)(1) rocedures. [Facilities] must ment emergency preparedness dures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of policies and procedures must pdated every 2 years [annually At a minimum, the policies and iddress the following: If subsistence needs for staff her they evacuate or shelter in are not limited to the following: It is of energy to maintain the experience of energy to maintain the experience and sanitary storage of extinguishing, and alarm aste disposal.	EC			
	hospice-operated i The policies and policies and policies and policies and policies and policies and policies are policies.	dures. re additional requirements for npatient care facilities only. rocedures must address the of subsistence needs for				

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		245270	B. WING		C 10/1	8/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 015	evacuate or shelter limited to the follow (A) Food, water, me supplies. (B) Alternate source following: (1) Temperatures to safety and for the sprovisions. (2) Emergency light (3) Fire detection, esystems. (C) Sewage and water and the sewage and water acility failed to inclusive operations plan (EC) pharmaceutical supsewage and waster emergency. This have sidents at the factor of the facility would obtain pharm they would maintain during an emergency.	and patients, whether they in place, include, but are not ing: edical, and pharmaceutical es of energy to maintain the protect patient health and afe and sanitary storage of ing. Extinguishing, and alarm este disposal. Extra of their emergency energy e	E 015	Shelter in place and evacuation procedures updated in emergency preparedness plan to reflect how we would ensure delivery of medication either situation. Agreement with Kim obtained in the event our sewage sy fails. In this situation, Kimo's would portable bathrooms and we would ecommodes and sewage into the porbathrooms, keeping a few designate staff use. Agreement has been added emergency preparedness plan. Will ensure compliance upon annual reverse emergency preparedness plan.	n in no's ystem bring empty rtable ed for ed to	12/1/21
	CFR(s): 483.73(b)(· · · - ·

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245270	B. WING _		10	C / 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP C 525 BLUFF AVENUE ST CHARLES, MN 55972	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
E 023	§441.184(b)(5), §46 §483.73(b)(5), §483 §485.68(b)(3), §485	ge 4 60.84(b)(6), §482.15(b)(5), 3.475(b)(5), §484.102(b)(4), 5.625(b)(5), §485.727(b)(3), 86.360(b)(2), §491.12(b)(3),	E 02	23		
	develop and implen policies and proced plan set forth in parassessment at para and the communicathis section. The pobe reviewed and up [annually for LTC fa	pocedures. The [facilities] must ment emergency preparedness ures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must odated at least every 2 years cilities]. At a minimum, the ures must address the				
	protects confidentia	system of medical preserves patient information, lity of patient information, and availability of records.				
	procedures. (5) As that does the follow (i) Preserves patien (ii) Protects confide					
	procedures. (2) As documentation that donor information, potential and actual	5.360(b):] Policies and system of medical preserves potential and actual protects confidentiality of donor information, and ains the availability of records.				

AND DIAN OF CODDECTION IDENTIFICATION NUMBER.		PLE CONSTRUCTION (G		(X3) DATE SURVEY COMPLETED		
		245270	B. WING			C 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	1 10	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)) BE	(X5) COMPLETION DATE
	This REQUIREMENT by: Based on interview facility failed to devige for preservation of the potential to affee the facility. Findings include: The facility's emerge 10/18/21, was revied director. The facility would preserve path confidentiality of parand maintain availar an emergency. During an interview the executive direct policy or procedure documents. Roles Under a Wait CFR(s): 483.73(b)(8), §441.184(b)(8), §443.748(b)(8), §441.184(b)(8), §483.73(b)(8), §485.920(b)(7). [(b) Policies and procedure policies policies and procedure policies	And document review, the elop a policy and procedure medical documents. This had ct all 34 residents residing in gency operations plan reviewed ewed with the executive had no system in place that ient information, protect tient information, and secure ability of records in the event of to n 10/18/21, at 10:32 a.m. tor verified there was not a to preserve medical ever Declared by Secretary 8) 16.54(b)(6), §418.113(b)(6)(C), §460.84(b)(9), §482.15(b) §483.475(b)(8), §485.625(b)	E 026	Resident demographic pages, incl physician and contact information, in the center's emergency evacuati by 12/1/2021 and will be updated o weekly basis. Audits will be conduct weekly to ensure compliance. Audifindings will be reviewed at QAPI metals.	placed ion kit on a cted it	12/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED C
		245270	B. WING _		10	/18/2021
	ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 245270 IAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP COI 525 BLUFF AVENUE ST CHARLES, MN 55972		
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 026	[annually for LTC far policies and proced following:] (8) [(6), (6)(C)(iv), (facility] under a wain accordance with provision of care at care site identified officials. *[For RNHCIs at §4 procedures. (8) The waiver declared by with section 1135 of at an alternative camanagement official. This REQUIREMED by: Based on docume facility failed to devin its emergency plin providing care at sites under section potential to affect a residing in the facility Findings Include: The facility emerged did not contain infoothe facility's role in at alternate care site. During an interview the executive direct policy and proceduthe facility's role in at alternate care site.	acilities]. At a minimum, the dures must address the (7), or (9)] The role of the aiver declared by the Secretary, section 1135 of the Act, in the nd treatment at an alternate by emergency management (403.748(b):] Policies and e role of the RNHCI under a the Secretary, in accordance of Act, in the provision of care are site identified by emergency als. NT is not met as evidenced and review and interview, the relop policies and procedures an describing the facility's role and treatment at alternate care 1135 act waiver. This had the all 34 residents currently ity.	E 02	Information regarding 1135 V placed in emergency prepare on 11/17/2021. Will ensure coupon annual review of emerg preparedness plan.	dness plan ompliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	/ICES		STREET ADDRESS, CITY, STATE, ZIP 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 030 SS=C	CFR(s): 483.73(c)(§403.748(c)(1), §48 §441.184(c)(1), §48 §483.73(c)(1), §48 §485.68(c)(1), §48 §485.920(c)(1), §48 §494.62(c)(1). [(c) The [facility mule emergency prepare that complies with land must be review 2 years [annually for communication plate following: (i) Names and confollowing: (ii) Entities providin (iii) Patients' physic (iv) Other [facilities (v) Volunteers. *[For Hospitals at §§485.625(c)] The coinclude all of the for (1) Names and confollowing: (ii) Staff. (iii) Entities providin (iiii) Patients' physic (iv) Other [hospitals (v) Volunteers. *[For RNHCIs at §485.625(c)] The coinclude all of the for (1) Names and confollowing: (i) Staff. (ii) Entities providin (iii) Patients' physic (iv) Other [hospitals (v) Volunteers.	1) 16.54(c)(1), §418.113(c)(1), 60.84(c)(1), §482.15(c)(1), 3.475(c)(1), §484.102(c)(1), 85.625(c)(1), §485.727(c)(1), 86.360(c)(1), §491.12(c)(1), 1st develop and maintain an edness communication plan Federal, State and local laws wed and updated at least every or LTC facilities]. The n must include all of the 1st develop and maintain an edness communication plan Federal, State and local laws wed and updated at least every or LTC facilities]. The n must include all of the 1st develop and maintain an edness communication for the 1st develop and maintain an edness communication for the 1st develop and maintain an edness communication for the 1st develop and maintain an edness communication for the 1st develop and maintain an edness communication for the 1st develop and maintain an edness communication for the 1st develop and maintain an edness communication for the 1st develop and maintain an edness communication for the 1st develop and maintain an edness communication plan 1	E 03			12/1/21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245270	B. WING				C 1 8/2021
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICE	ES		525 B	ET ADDRESS, CITY, STATE, ZIP CODE BLUFF AVENUE HARLES, MN 55972		
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
(iii) Next of kin, guardi (iv) Other RNHCls. (v) Volunteers. *[For ASCs at §416.45 plan must include all of (1) Names and contact following: (i) Staff. (ii) Entities providing some (iii) Patients' physician (iv) Volunteers. *[For Hospices at §41 communication plan of the following: (1) Names and contact following: (i) Hospice employees (ii) Entities providing some (iii) Patients' physician (iv) Other hospices. *[For HHAs at §484.1 plan must include all of (1) Names and contact following: (i) Staff. (ii) Entities providing some (iii) Patients' physician (iv) Volunteers.	ct information for the services under arrangement. ian, or custodian. 5(c):] The communication of the following: ct information for the services under arrangement. ns. 8.113(c):] The must include all of the ct information for the s. services under arrangement. ns. 02(c):] The communication of the following: ct information for the services under arrangement. ns. 660(c):] The communication	EO	30			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	PLE CONSTRUCTION IG	COM	E SURVEY IPLETED
		245270	B. WING _		1	C 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	1 10/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 030	following: (i) Staff. (ii) Entities providing (iii) Volunteers. (iv) Other OPOs. (v) Transplant and of Donation Service A This REQUIREMEN by: Based on interview	g services under arrangement. donor hospitals in the OPO's rea (DSA). NT is not met as evidenced and document review, the	E 03	Physician information and conta		
	required information and contact numbe information for physic affect all 34 resident Findings include: During interview on executive director a list of physicians and staff names and the information in the e	10/18/21, at 10:46 a.m. the acknowledged there was not a ad their contact numbers or eir contact numbers mergency operations plan. as Contact Information	E 03	information is included on reside demographic sheets which were the nurses stations in the evacua by 12/1/2021. Audits will be concuevely to ensure compliance. Fit will be reviewed at QAPI meeting	placed at ition kits lucted ndings	12/1/21
	§441.184(c)(2), §46 §483.73(c)(2), §485 §485.68(c)(2), §485 §485.920(c)(2), §485 §494.62(c)(2). [(c) The [facility] mule emergency prepare that complies with F	16.54(c)(2), §418.113(c)(2), 60.84(c)(2), §482.15(c)(2), 8.475(c)(2), §484.102(c)(2), 6.625(c)(2), §485.727(c)(2), 86.360(c)(2), §491.12(c)(2), set develop and maintain an edness communication plan Federal, State and local laws yed and updated at least every				

NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES ST BLUFF AVENUE ST CHARLES, MN 55972 [(A) ID PREVIX REGULATORY OR LSC IDENTIFYING INFORMATION) E 031 Continued From page 10 2 years [annually for LTC facilities]. The communication plan must include all of the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (ii) The State Licensing and Certification Agency. (iii) The State Licensing state. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (ii) Federal, State, tribal, regional, and local emergency preparedness staff. (iii) The State Licensing and Certification Agency. (iii) The State Licensing and Certification Agency. (iv) The State State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance.			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	СОМ	(X3) DATE SURVEY COMPLETED C	
WHITEWATER HEALTH SERVICES STRUCT ADDRESS, CITY, STATE, ZIP CODE S25 BLUFF AVENUE S25 BLUFF AVENUE			245270	B. WING				
E 031 Continued From page 10 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The State Licensing and Certification Agency. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Licensing and Certification Agency. (iv) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.		NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 031 Continued From page 10 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency preparedness staff. (iii) Other sources of assistance. (iv) The State Protection and Advocacy Agency This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Operations Plan (EOP) included contact information for federal emergency preparedness i			525 BLUFF AVENUE		10.10.2021	
2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE	
Based on interview and document review, the facility failed to ensure their Emergency Ombudsman contact information added to emergency preparedness plan on	E 031	2 years [annually for communication plat following: (2) Contact information Federal, State, the emergency prepared (ii) Other sources of the sources of source	or LTC facilities]. The n must include all of the n must include all of the ation for the following: ribal, regional, and local edness staff. of assistance. The at §483.73(c):] (2) Contact following: ribal, regional, and local edness staff. sing and Certification Agency. The State Long-Term Care of assistance. The assistance. The action of the Certification Agency. The action and Advocacy Agency. The action of the Advocacy Agency action of the Advocacy Agency. The action of the Advocacy Agency acti	EO	Ombudsman contact inform to emergency preparedness 11/17/2021. Will ensure con annual review of emergency	s plan on npliance upon		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG	· /	E SURVEY IPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 031	lacked documentat federal emergency contact information	ommunication plan however, ion of contact information for preparedness staff and for the Ombudsman.	E 03	31		
	verified this informa	naring Plan with Patients	E 03	35		12/1/21
	§483.73(c)(8); §483	3.475(c)(8)				
	an emergency prep that complies with I and must be review	must develop and maintain paredness communication plan Federal, State and local laws yed and updated at least munication plan must include				
	emergency prepare that complies with I and must be review	est develop and maintain an edness communication plan Federal, State and local laws yed and updated at least every nunication plan must include				
	emergency plan, th is appropriate, with families or represent This REQUIREMENT by: Based on interview facility failed to ens Plan (EOP) was co	aring information from the at the facility has determined residents [or clients] and their ntatives. NT is not met as evidenced and document review, the ure the Emergency Operations mmunicated to residents ves. This had the potential to		Emergency preparedness info shared with residents and repr by 12/1/2021 including informa to obtain additional details. Ne	resentatives ation on how	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	COM	E SURVEY MPLETED
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	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 037 SS=C	affect all 34 resider Findings include: The facility's EOP procumentation of a information from the had determined application of a information from the had determined application of a information from the had determined application of the emergency plant families or reputation of the emergency plant families. EP Training Program CFR(s): 483.73(d)(1), \$483.73(d)(1), \$483.73(d	plan reviewed 10/18/21, lacked method for sharing e emergency plan the facility propriate with residents and resentatives. I on 10/19/21, at 2:20 p.m. the confirmed the facility had not d for sharing information from with residents and their man with residents and with residents at §483.475(d)(1), §485.727(d)(1), §485.727(d)(1), §485.727, RHC/FQHCs at §485.727, RHC/FQHCs at §491.12:] m. The [facility] must do all of the emergency preparedness and existing the poviding services under volunteers, consistent with their man with the w	E 03	and representatives will be provi emergency preparedness inform upon admission via the new adm packet. Training provided to soci services director regarding the requirement to include in the adr packet.	nation nission ial	12/1/21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		MPLETED
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E 037	procedures. (v) If the emergency procedures are signated to all (i) Initial training in policies and procedures are expected roles. (ii) Demonstrate staprocedures. (iii) Provide emergency prepare employees (including special emphasis procedures necess others. (v) Maintain docum preparedness training (vi) If the emergency preparedness are signated to all (vi) If the emergency preparedness training procedures are signated to all (vi) If the emergency	ng. aff knowledge of emergency y preparedness policies and nificantly updated, the [facility] ng on the updated policies and 418.113(d):] (1) Training. The of the following: emergency preparedness lures to all new and existing , and individuals providing ingement, consistent with their aff knowledge of emergency ency preparedness training at iew and rehearse its edness plan with hospice ng nonemployee staff), with laced on carrying out the ary to protect patients and entation of all emergency	EO	37		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG	CON	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
E 037	preparedness train (iii) Demonstrate st procedures. (iv) Maintain docum preparedness train (v) If the emergence procedures are sig must conduct training procedures. *[For PACE at §460 organization must of (i) Initial training in policies and proced staff, individuals pre arrangement, contrivolunteers, consist (ii) Provide emerge least every 2 years (iii) Demonstrate st procedures, includi what to do, where to case of an emerge (iv) Maintain docum (v) If the emergency procedures are sig must conduct training procedures. *[For LTC Facilities Program. The LTC following: (i) Initial training in policies and proced staff, individuals procedures are staff, individuals procedures.	ing, provide emergency ing every 2 years. aff knowledge of emergency mentation of all emergency ing. by preparedness policies and nificantly updated, the PRTF ing on the updated policies and 0.84(d):] (1) The PACE do all of the following: emergency preparedness dures to all new and existing oviding on-site services under factors, participants, and ent with their expected roles. Incomprehency preparedness training at a caff knowledge of emergency informing participants of to go, and whom to contact in	EO	37		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C	
		245270	B. WING _		10	/18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP COI 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 037	least annually. (iii) Maintain documpreparedness training (iv) Demonstrate st procedures. *[For CORFs at §48 CORF must do all of (i) Provide initial training and existing staff, in under arrangement with their expected (ii) Provide emerge least every 2 years (iii) Maintain docum (iv) Demonstrate st procedures. All new and assigned specithe CORF's emerge their first workday, include instruction in alarm systems and equipment. (v) If the emergen procedures are sign must conduct training procedures. *[For CAHs at §488 The CAH must do and in the conduct training in the conduct training and exting and where necessarial in the conduct in the conduct reporting and exting and where necessarial in the conduct in the conduct reporting and exting and where necessarial in the conduct reporting and exting and where necessarial in the conduct reporting and exting and where necessarial in the conduct reporting and exting and where necessarial in the conduct reporting and exting and where necessarial in the conduct reporting and exting and where necessarial in the conduct reporting and exting and where necessarial in the conduct reporting and exting and where necessarial in the conduct reporting and exting and where necessarial in the conduct reporting and exting and where necessarial in the conduct reporting and exting and where necessarial in the conduct reporting and exting and where necessarial in the conduct reporting and exting and exting and the conduct reporting and exti	ncy preparedness training at lentation of all emergency ng. aff knowledge of emergency 85.68(d):](1) Training. The of the following: ining in emergency ies and procedures to all new ndividuals providing services, and volunteers, consistent roles. Incy preparedness training at entation of the training. aff knowledge of emergency or personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of The training program must in the location and use of signals and firefighting cy preparedness policies and inficantly updated, the CORF ing on the updated policies and inficantly (1) Training program.	EO	37		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	СОМ	E SURVEY IPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	authorities, to all n individuals providir and volunteers, co roles. (ii) Provide emerge least every 2 years (iii) Maintain docur (iv) Demonstrate s procedures. (v) If the emerger procedures are sigmust conduct train procedures. *[For CMHCs at §4 CMHC must provide preparedness policand existing staff, under arrangement with their expected documentation of the demonstrate staff procedures. There emergency prepar years. This REQUIREME by: Based on interview facility failed to core mergency Opera staff. This had the residents and staff. Findings include: During an interview executive director.	refighting and disaster ew and existing staff, ag services under arrangement, insistent with their expected ency preparedness training at it. Inentation of the training. Itaff knowledge of emergency ency preparedness policies and inificantly updated, the CAH ing on the updated policies and enitial training in emergency cies and procedures to all new individuals providing services t, and volunteers, consistent a roles, and maintain the training. The CMHC must knowledge of emergency eafter, the CMHC must provide edness training at least every 2 eafter, the common training of the duct annual training of the duct annual training of the tons Plan (EOP) plan with a potential to affect all 34	EC	037	All staff were provided training on emergency preparedness by 12/1/2 Annual training will be provided on ongoing basis. Compliance with emergency preparedness training monitored at QAPI meetings.	an	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED C	
		245270	B. WING_		10	/18/2021
	AME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 037 Continued From page 17 documentation to indicate the facility had annutraining based on the emergency plan and risk assessment completed by the facility. The executive director verified the facility was not completing annual training on the EOP. INITIAL COMMENTS On 10/11/21, 10/12/21, 10/13/21, 10/14/21 10/15/21 and 10/18/21, a standard recertificatisurvey was conducted at your facility. Complainvestigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5270031C (MN73537), with a deficiency cite F661. The following complaints were found to be UNSUBSTANTIATED: H5270032 (MN55823), H5270033 (MN54134), and H5270034 (MN53307), H5270035 (MN53097), H5270036 (MN48867). The IJ began on 8/11/21, when R13 was admit to the facility and the facility failed to address code status, therefore considering him to be FC Code status, when R13 wished not to be resuscitated if his heart were to stop. R10 had returned from the hospital on 9/30/21, and had both Full Code and DNR (Do Not Resuscitate)			STREET ADDRESS, CITY, STATE, ZIP C 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 037	documentation to itraining based on the assessment complexecutive director completing annual	ndicate the facility had annual the emergency plan and risk leted by the facility. The verified the facility was not training on the EOP.	E 0	37		
	10/15/21 and 10/1 survey was conduction investigations were was found to be N requirements of 42 Requirements for	8/21, a standard recertification cted at your facility. Complaint e also conducted. Your facility OT in compliance with the 2 CFR 483, Subpart B, Long Term Care Facilities.				
	H5270031C (MN7 F661. The following com UNSUBSTANTIAT H5270033 (MN54' (MN53307), H5270	3537), with a deficiency cited at plaints were found to be ED: H5270032 (MN55823), 134), and H5270034				
	to the facility and to code status, therefore Code status, when resuscitated if his returned from the both Full Code and directions in the middirections for Full Corders for life susta 4/20/21, a physicial	he facility failed to address fore considering him to be Full i R13 wished not to be heart were to stop. R10 had hospital on 9/30/21, and had				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245270	B. WING		10	C / 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972	•	110/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL PROPERTY OF THE ADDI	SHOULD BE	(X5) COMPLETION DATE
F 000	administrator and d notified of the IJ on was removed on 10 noncompliance rem severity of an E- pa which indicated no more than minimal jeopardy.	ge 18 status was on hold. The irector of nursing (DON) were 10/12/21, at 2:35 p.m. The IJ 0/13/21, at 4:30 p.m. but nained at the lower scope and attern scope and severity level, actual harm with potential for harm that is not immediate constituted substandard	F0	00		
F 561 SS=D	quality of care and a conducted 10/18/21 The facility's plan or as your allegation of Departments accept enrolled in ePOC, yat the bottom of the form. Your electronic be used as verificated. Upon receipt of an onsite revisit of you validate that substate regulations has been self-Determination CFR(s): 483.10(f)(1) §483.10(f) Self-determination certainly support of incomplete and facilitate through support of incomplete the region of the region	an extended survey was l. f correction (POC) will serve of compliance upon the stance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will cion of compliance. acceptable electronic POC, an of facility may be conducted to notial compliance with the en attained. (a)-(3)(8) Description of the facility must after resident self-determination resident choice, including but ghts specified in paragraphs (f)	F 5	61		12/1/21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	COM	E SURVEY PLETED
		245270	B. WING _			18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 561	waking times), hea care services cons assessments, and applicable provision §483.10(f)(2) The reduces about asper facility that are sign §483.10(f)(3) The reduces with members of the community activities facility. §483.10(f)(8) The reduced participate in other religious, and communiterfere with the reducible participate in other religious, and communiterfere with the reducible passed on interview facility. This REQUIREME by: Based on interview facility failed to ensure preferences for free for 1 of 1 resident (Finding include: During an interview stated he got one shave two and they even interviewed metallity would like, and I to week."	Ith care and providers of health istent with his or her interests, plan of care and other	F 56	R86 interviewed and care plan reflect bathing preferences. Facility residents have the pote affected. Residents interviewed for bathing preferences; care plans update those preferences. Residents will be interviewed of admission and as requested for preferences which will be reflected care plan, and bath schedule. Interdisciplinary team and nurs were educated by Director of Coservices starting on 11/12/21 on	ential to be ng ed to reflect n r bathing cted in the ling staff	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LTIPLE CONSTRUCTION (X3) DATE SUI COMPLET C		PLETED
		245270	B. WING			C 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 561	R86's bathing prefeindicated resident's shower and indicated acceptable. During an interview nursing assistant (Non Mondays, and ha week. NA-A show that indicated room the bath schedule for the stated she would fir surveyor. LPN-B reupon admission the resident how often type of bath and the schedule. During a p.m. LPN-B verification form after she com LPN-B stated she will be placed in the bo (DON) door for the schedule. During an interview the DON stated the by LPN-A or herselipreference sheet won their door, then selected the selected the selected the selected the by LPN-A or herselipreference sheet won their door, then selected the sele	rence form dated 9/27/21, preference for a morning ed twice a week would be on 10/13/21, at 12:45 p.m. NA)-A stated R86 had a bath e was just scheduled for once red surveyor the bath schedule (R86's room number) was on or Monday only. I on 10/13/21, at 12:51 p.m. urse (LPN)-B stated she was rocess was to determine how a resident wanted a bath and not and get back to turned to surveyor and stated admitting nurse asked the they would like a bath, what ey were to put it on the bath subsequent interview at 1:04 If she was the nurse who had athing preference form and know where she placed the pleted it upon admission. Was unaware the form was to ax on the director of nursing's DON to update the bath schedules were updated for the DON stated the bathing as to be placed in the mailbox they update the bath sheet, if in the resident chart. This	F 56	Resident Rights Policy which bathing preferences, and shand nail care education. Task was added to the revis Admission/Re-admission checare plans once weekly x 8 ensure bathing preferences and care plans are up to date. The results of the audits will by the QAPI committee for the needs for adjustment of audion or content, as well as any fureducational needs. The Exe Director is responsible to enaction occurs.	ed ecklist. e will audit weeks to are honored te. be reviewed rends and any lit schedules rther ecutive	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	COM	E SURVEY IPLETED C
		245270	B. WING		1	18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 561		•	F 50	61		
	A policy was request preferences and was Resident/Family Gr CFR(s): 483.10(f)(5)	oup and Response	F 50	65		12/1/21
	and participate in re (i) The facility must group, if one exists reasonable steps, voto make residents a upcoming meetings (ii) Staff, visitors, or resident group or fathe respective grou (iii) The facility must person who is approgroup and the facility providing assistance requests that result (iv) The facility must resident or family gothe grievances and groups concerning in the facility. (A) The facility must response and ration (B) This should not facility must implement request of the resident of th	t provide a designated staff oved by the resident or family ty and who is responsible for e and responding to written from group meetings. It consider the views of a roup and act promptly upon recommendations of such issues of resident care and life to be able to demonstrate their hale for such response. The construed to mean that the nent as recommended every lent or family group. The sident has a right to have				

PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 565 Continued From page 22 F 565		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	СОМ	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972 ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 565 Continued From page 22 STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972 ID PREFIX (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 565			245270	B. WING _			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 565 Continued From page 22 F 565					525 BLUFF AVENUE		10/2021
	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE
residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure concerns raised at the resident council meetings were documented and presented back to the council, for 5 of 5 resident (R26, R21, R4, R23, and R186) who were present during the resident council meeting with survey team. Findings include: The resident council meeting minutes were reviewed for the months of 7/23/21, 8/27/21 and 9/30/21. The meeting minutes revealed the following concerns were shared. The meeting minutes from the resident council meeting held on 3/30/21. The meeting minutes were reviewed for the months of 7/23/21, 8/27/21 and 9/30/21. The meeting minutes revealed the following concerns were shared. The meeting minutes from the resident council meeting held on meeting held on the shared with resolution. Resolutions will be shared with individuals involved with specific concerns and will be shared with resident council group at next meeting in November. Facility residents have the potential to be affected. Activity Director, Executive Director, and other invited Interdisciplinary team members will document grievances from the Resident Council meetings and ensure follow up is complete per policy. Current staff educated by Executive Director starting on 11/12/21 to the Grievance policy and procedure and the Resident Council policy and procedure. Executive Director/Designee will audit the Grievance binder weekly x 8 weeks to ensure all grievances were addressed and complete. The results of the audits will be reviewed by the QAPI committee for trends and any needs for adjustment of audit schedules or content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	F 565	residents in the fact This REQUIREME by: Based on interview facility failed to ensure resident council may presented back to (R26, R21, R4, R2) present during the survey team. Findings include: The resident councreviewed for the may 9/30/21. The meet following concerns The meeting minutation meeting held 7/23/1 quality of food and the nursing assistate communication be would like to be into Residents also voi and missing clothin. The meeting minutation meeting held on 8/1 housekeeping resineed better ramps front lobby doors, the and is hard for resident meal ticket preferences, short shower days seem outside of resident meal to the resident meal ticket preferences, short shower days seem outside of resident meal ticket preferences, short shower days seem outside of resident meal ticket preferences, short shower days seem outside of resident meal ticket preferences, short shower days seem outside of resident meal ticket preferences, short shower days seem outside of resident meal ticket preferences, short shower days seem outside of resident meal ticket preferences, short shower days seem outside of resident meal ticket preferences.	sility. NT is not met as evidenced w and document review, the sure concerns raised at the eetings were documented and the council, for 5 of 5 resident 3, and R186) who were resident council meeting with cil meeting minutes were onths of 7/23/21, 8/27/21 and ing minutes revealed the were shared. tes from the resident council 21, included concerns with food being cold, the attitude of ints, the need for better tween staff and residents roduced to new staff. Ced housekeeping concerns and concerns with dent room and bathroom dirty, for going inside and outside the social work office is small idents to get wheelchairs in her if need be, making sure ets are accurate with staffed on weekends and to be the worst. Staff talking rooms about stuff they do not	F 56	Resident Council meeting held 10/28/21 R26, R21, R4, R23 in attendance. R186 discharged. concerns documented approprious followed up on with resolution. Resolutions will be shared with involved with specific concerns shared with resident council grameeting in November. Facility residents have the pote affected. Activity Director, Executive Director invited Interdisciplinary te members will document grievathe Resident Council meetings ensure follow up is complete performed by Executive Director starting on 11/12/21 to Grievance policy and procedure Resident Council policy and procedure Resident Council policy and procedure Resident Council policy and procedure all grievances were add and complete. The results of the audits will be by the QAPI committee for trein needs for adjustment of audit sor content, as well as any furthed educational needs. The Execut Director is responsible to ensure	Grievances riately and individuals and will be oup at next ential to be ector, and earn inces from and er policy. Cutive of the re and the ocedure. Will audit the reeks to dressed ereviewed and any schedules er tive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245270	B. WING _		10	C / 18/2021
	PROVIDER OR SUPPLIER	/ICES		STREET ADDRESS, CITY, STATE, ZIF 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 565	are not being passibetween staff all st page and if you do The meeting minut meeting held 9/30/of large furniture in completed, requescleaned. Would like On 10/13/21, at 10 meeting was held with R186 and one survice following questions views of the reside promptly upon grie recommendations? respond to the resiconcerns? If the faconcerns, does the rationale for the resiconcerns with they had shared the council meetings in the time her food wher room. The resicollow-up on concecouncil meetings. During an interview licensed social work honest I was not any other grievance obviously in the fut stated there was on	ed, lack of communication aff should be on the same not know find out. es from the resident council 21, included concerns dusting common areas needs to be to for all windowsills to be all activities to last an hour. :00 a.m. a resident council with R26, R21, R4, R23 and reyor. When asked the council council council with R26, R21, R4, R23 and reyor. When asked the council council with R26, R21, R4, R23 and reyor. When asked the council counc	F 56	55		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		245270	B. WING		10	C / 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP COL 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 565	residents have the resolved." During an interview executive director's shared in the reside documented in the worker to share the responsible and that to follow up to addr with the resident. To would expect the form the residents to be a policy and proceed grievances was reconstructed by the facility where can be a cellular phone expense. §483.10(g)(7) The facilitate that resides	SW-A stated, "Its like the same concerns that do not get on 10/14/21, at 11:05 a.m. the stated he expected concern ent council meeting to be meeting minutes, the social concern with the department at it was that staff members job ess the concern and follow up he executive director stated he ollow-up and the resolution with documented. Sure for resident council quested and not provided.	F 5	65		12/1/21
	(i) A telephone, incl (ii) The internet, to facility; and	asonable access to: uding TTY and TDD services; the extent available to the age, writing implements and nail.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	COMI	E SURVEY PLETED
		245270	B. WING				C 18/2021
	PROVIDER OR SUPPLIER			525	REET ADDRESS, CITY, STATE, ZIP CODE 5 BLUFF AVENUE CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
F 576	§483.10(g)(8) The and receive mail, a and other material resident through a service, including to (i) Privacy of such with this section; a (ii) Access to static implements at the §483.10(g)(9) The reasonable access electronic communicat (i) If the access is (ii) At the resident's expense is incurre access to the resid (iii) Such use must law. This REQUIREME by: Based on interview failed to ensure mail, including but (R26, R21, R4, R2 council meeting, we receiving mail on Spotential to affect a facility. Findings include: On 10/13/21, at 10 met to discuss the whether residents	resident has the right to send and to receive letters, packages a delivered to the facility for the means other than a postal he right to: communications consistent and onery, postage, and writing resident's own expense. resident has the right to have a to and privacy in their use of hications such as email and ons and for internet research. Available to the facility is expense, if any additional d by the facility to provide such	F 5	76	Facility residents have the potential affected. Weekend manager task list update include delivery of mail on Saturday manager is not available, nursing sideliver mail. Interdisciplinary team and nursing educated by the Director of Clinical Services starting on 11/12/21 on the Residents Rights policy and proced which includes the right to send an receive mail and the Mail policy and procedures. Executive Director/Designee will be	e to ys if a staff to staff l e dures d	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	COM	E SURVEY PLETED
		245270	B. WING				C 18/2021
	PROVIDER OR SUPPLIER ATER HEALTH SERV			52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BLUFF AVENUE T CHARLES, MN 55972	10/	16/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 576	shared the staff do The residents share when the activity dir During an interview activity director (AD member that delive Saturday, the mana deliver the mail. The to work on a Monda delivered and state. The AD was not sur during the week if s During an interview executive director s manager on duty or responsibility to pas A policy on resident provided. The Combined Fed revised 6/18/19 incl respect the residen	n Saturdays. The residents not deliver mail on Saturdays. ed they only received mail rector (AC) was working. on 10/14/21, at 4:24 p.m.) stated she was the staff red the mail. The AD stated on ager on duty was supposed to be AD stated she had come in any and the mail had not been do this has been frustrating. The if the mail was delivered the was not at work. on 10/14/21, at 4:29 p.m. the tated the facility had a saturdays and it was their	F 5	76	responsible to ensure manager on schedule is complete monthly for Saturdays with nursing staff back-uneeded. Executive Director/Designee will au Manager on duty task list for comple and check off of the mail pass task for 8 weeks. The results of the audits will be revely the QAPI committee for trends a needs for adjustment of audit schedor content, as well as any further educational needs. The Executive Director is responsible to ensure the action occurs.	ip as dit the etion weekly iewed and any dules	
	is, spoken), written communications, in promptly receive un packages and othe facility for the reside through a means of Request/Refuse/Ds CFR(s): 483.10(c)(6) The resident through a means of Request/Refuse/Ds CFR(s): 483.10(c)(6) The resident through a means of Request/Refuse/Ds CFR(s): 483.10(c)(6) The resident through a means of Reguest/Refuse/Ds CFR(s): 483.10(c)(6) The resident through the resident t	and electronic cluding the right to send and appended mail and other letters, r materials delivered to the ent, including those delivered ther than a postal service."	F 5	78			12/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING DESCRIPTION A. BUILDING		(X3) DATE SURVEY COMPLETED C				
		245270	B. WING _		10	/18/2021
	NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 578 Continued From page 27 to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adding residents concerning the right to accept or refusive medical or surgical treatment and, at the resident's option, formulate an advance directive (ii) This includes a written description of the facility's policies to implement advance directive and applicable State law. (iii) Facilities are permitted to contract with othe entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or shas executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordants.			STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972	· · · · · · · · · · · · · · · · · · ·	
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 578	to participate in exp formulate an advar §483.10(c)(8) Noth construed as the right the provision of me services deemed in inappropriate. §483.10(g)(12) The requirements specially requirements specially inform and provide residents concerning medical or surgical resident's option, for (ii) This includes a facility's policies to and applicable Stat (iii) Facilities are per entities to furnish the legally responsible requirements of thic (iv) If an adult indivitime of admission a information or artice has executed an admay give advance individual's resident with State Law. (v) The facility is not provide this information or she is able to reconstructions.	erimental research, and to ace directive. ing in this paragraph should be ght of the resident to receive dical treatment or medical nedically unnecessary or e facility must comply with the fied in 42 CFR part 489, Directives). ents include provisions to written information to all adult not the right to accept or refuse treatment and, at the formulate an advance directive. Written description of the implement advance directives are law. ermitted to contract with other his information but are still for ensuring that the section are met. idual is incapacitated at the and is unable to receive ulate whether or not he or she dvance directive, the facility directive information to the	F 57	78		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	СОМ	E SURVEY PLETED
		245270	B. WING _		I	C 18/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
WHITEW	ATER HEALTH SERV	ICES		525 BLUFF AVENUE		
VVIII EVV	AIER NEALIN SERV	ICE3		ST CHARLES, MN 55972		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE
F 578	Continued From pa	ge 28	F 57	78		
	Based on interview	and document review, the		Residents R13, R10, and R	32 Advance	
	facility failed to ens	ure a system was in place to		Directives reviewed and upd	ated, to	
		lent wishes for code status,		reflect accurate information.	Physician	
		suscitation (CPR), for 6 of 34		updated.		
		0, R32, R184, R26 and R86)				
		ced directives. This failure		R184, R26, and R86 Advance		
		ediate jeopardy (IJ) for R13,		addressed with the resident,	,	
		n their medical records failed ents wishes accurately. In		updated, and care plan upda	ilea.	
		lents in immediate jeopardy,		Facility residents have the po	ntential to be	
		ensure R184, R26, and R86's		affected.	oteritial to be	
		were addressed with the		anotica.		
	resident or ordered			Resident orders in electronic	charting	
		, , ,		system, care plans and hard	charts	
	The IJ began on 8/	11/21, when R13 was admitted		audited and updated with ac	curate,	
		e facility failed to address		complete, signed, and dated		
		ore considering him to be Full		status and POLST for each i		
		R13 wished not to be		(10/11/2021 and 10/12/2021		
		eart were to stop. R10 had		or conflicting information det		
		ospital on 9/30/21, and had		forms were corrected and se		
		DNR (Do Not Resuscitate) edical record. R32 had		Physician for review and sign 10/12/2021.	lature on	
		code on a POLST (provider		If not already completed prio	r to	
		ining treatment) dated		admission and provided to fa		
		n order dated 9/21/21		residents will be asked to co		
		care plan dated 9/7/21		Advance Directive. Resident	s will be given	
		status was on hold. The		the opportunity to complete t		
		irector of nursing (DON) were		(Physician Orders for Life-Su		
		10/12/21, at 2:35 p.m. The IJ		Treatment). The admitting no		
		0/13/21, at 4:30 p.m. but		responsible to enter this info		
		nained at the lower scope and		the resident's chart, resident		
		attern scope and severity level,		PCC, and care plan. The add	•	
		actual harm with potential for harm that is not immediate		will verify upon admission the		
	jeopardy.	namı macıs nocımmediate		Directive wishes are current processing. Clear identificati		
	joopardy.			available for staff regarding (
				status and POLST in PCC (r		
	Findings include:			orders), in residents' hard ch		
	ago moiado.			resident care plan.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	` '	E SURVEY IPLETED
		245270	B. WING			C
NAMEOF	PROVIDER OR SUPPLIER		B: Wiito _	CTREET ADDRESS CITY STATE ZID CODE	•	18/2021
NAME OF F	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
WHITEW	ATER HEALTH SER	VICES		525 BLUFF AVENUE		
				ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 578		age 29 I/DS dated 8/11/21, included vith diagnoses of lung disease	F 57	Interdisciplinary team and licen educated by the Director of Clin Services starting on 11/12/21 or	nical	
	R13's physician's of failed to include ar or code status. The	orders in the EHR on 10/11/21 ny order for advanced directives e code status banner in the ate a wish for CPR or DNR.		Will/Advance Directives/Life-su treatment orders policy and pro including CPR/code status and Policy and procedure, and defa status of "full code" if POLST documentation is undecided.	staining cedure, POLST	
	which was signed (MD)-A on 8/5/21,	cal chart contained a POLST by the facility's medical director but the form was blank and not shes were not expressed on ed form.		Director of Nursing/Designee wadmission checklist for comple admission tasks during next dameeting. If advance directive/C documentation is absent, incorcontains conflicting instructions	tion of ys clinical PR/POLST nplete, or	
	stated, nobody at t	on 10/11/21, at 2:35 p.m. R13 the facility has asked about 13 would want to be		of Nursing/designee will follow determine status of documenta resident's wishes. If resident had make decisions as to advance planning, the default status of "	up to tion and/or as yet to d care	
	7/30/21, included a with diagnoses included heart failure. R10 anticipated MDS wunplanned dischar 9/23/21. An entry to	nimum Data Set (MDS) dated moderate cognitive impairment cluding Alzheimer's disease and had a discharge, return which indicated he had an acute care hospital on cracking MDS indicated he had cility from the hospital on		will be entered/verified and follobe completed with resident untare made. Advance Directives reviewed with resident/represe during care plan meetings, with in resident condition, and as reresident/representative. Executive Director/Designee warandom audits of Advance Director/DeST documentation three x	ow up will I decisions will be ntative changes quested by II complete ctive,	
	initiated of 2/3/18, advanced directive nutrition, IV/IM [int antibiotics." The go wishes will be hon Code [CPR] Long antibiotics. Follow	ated 5/24/21, with a date identified, "[R10] has an e. Full Code, Long term artificial ravenous/intramuscular] oal was listed as, "Resident ored." Staff were directed, "Full term artificial nutrition, IV/IM facility protocol for identification view code status at least		12 weeks. The results of the audits will be by the QAPI committee for tren needs for adjustment of audit s or content, as well as any furth educational needs. The Execut Director is responsible to ensuraction occurs.	reviewed ds and any chedules er ive	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTIC NG	N	СОМ	E SURVEY PLETED
		245270	B. WING				C 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS 525 BLUFF AVEN ST CHARLES, I		1 10/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	IDER'S PLAN OF CORRECTIC CORRECTIVE ACTION SHOULI EFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 578	quarterly and as dir resident's/responsite R10's physician ord record (EHR) did not status when review the EHR also did not for full code (cardio DNR (do not resuscition of cardiac arresidents desired or paper medical reco (Provider Orders for LPN-B retrieved R1 located a POLST in POLST was dated wished to have card (CPR) and full med preferences were cartificial nutrition by antibiotic treatment discussion was held agent and was sign family member (FM this form on 1/31/18 located, this one was (SW)-B and R10 or a note scribbled net resuscitation (CPR) "Discussed with PT 12/1/202 [unknown "Attempt Resuscitation/DNR (an X in it and was control or contro	ected by ble party's wishes." lers in the electronic health but include any order for code ed on 10/11/21. The banner in but identify if R10's wishes were pulmonary resuscitation) or for	F 5	78			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		CONSTRUCTION	COMPLETED		
		245270	B. WING				C 1 8/2021
	PROVIDER OR SUPPLIER	ICES		525	REET ADDRESS, CITY, STATE, ZIP CODE BLUFF AVENUE CHARLES, MN 55972	10/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	treatment and Oral had an X in them. I were conflicting and on the event of coording to happen, we are not supposed noted any conflicting the director of nurs 2:35 p.m. R10's meand remained unch	antibiotics only (no IV/IM) both LPN-B stated the POLST's d staff would not know what to ardiac arrest, "A mistake is e are going to do CPR when ed to." LPN-B stated if she ig orders, she would report it to ing (DON). On 10/12/21, at edical record was reviewed langed with the conflicting hysician order addressing code	F 5	578			
	cognitive impairme heart failure and lui R32's order summa an order for DNR/D 9/7/21. On 10/12/21, R32's contained a POLST indicated R32 wish R32's care plan day Status: Changed at DNR/DNI per MD at of 9/7/2021." Howe directed staff, "ON Cares, No artificial	ary dated 10/12/21, included oNI [do not intubate] dated oNI [do not intubate] dated appear medical record dated 4/20/21, which ed to have CPR performed. Ited 9/7/21, included, "Code gain from Full CODE to and POA [power of attorney] as ver, listed under interventions HOLD: DNR/DNI, Comfort nutrition, IV/IM ATB a unclear if the full code or					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION IG	C C		
		245270	B. WING _		10	/18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP COI 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 578	Continued From pa	ge 32	F 57	8		
		MDS dated 10/7/21, included impairment with diagnoses lung disease.				
		10/11/21, R184's EMR and rd failed to include any s or POLST.				
	stated, if was found	on 10/11/21, at 5:42 p.m. R184 I with no pulse and was not Id like CPR performed.				
	R184's family mem like to have CPR pe	on 10/11/21, at 7:22 p.m. ber (FM)-E stated R184 would erformed. The facility had not either R184 or FM-E.				
		DS dated 9/1/21, included th diagnosis including heart				
	included an order for dated 9/17/21. How	ders in the EHR on 10/11/21, or, "Full Code," which was vever, there was no apparent der from the physician.				
	dated 9/21/21. The out, however MD-A POLST and dated i	al record contained a POLST POLST was blank/not filled and LPN-B had signed the t with 9/21/21. Even though ned by the physician, R26's the form.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245270	B. WING		10	C 0/18/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 525 BLUFF AVENUE ST CHARLES, MN 55972		710/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 578	licensed practical in was going around of the POLST's an residents. LPN-C so of them (the POLS important to have it the time when the chart they were no did her best to updeverybody. LPN-C her concerns with and the social work and the social was found in a me expected to perfor have no pulse and When interviewed LPN-A also stated code status of resicurrent POLST was by the physician and facility staff would "as you can't ask a code status." When interviewed LPN-B stated, she completed the POL but did not recall work and the social wore and the social work and the social work and the social work and	on 10/11/21, at 7:01 p.m. nurse (LPN)-C she stated she trying to find the orders for all d getting information for the stated she had to fill out some it is herself as it was so chose. LPN-C stated most of POLST's were in a resident's at filled out. LPN-C stated she late them but could not get to stated she'd previously shared the DON, executive director, ker. LPN-C stated it caused her laff would not know what to do LPN-C stated if no code status dical record, the staff would be m CPR if they were found to	F 5	578			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245270	B. WING		10	C 0/18/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972	· · · · · · · · · · · · · · · · · · ·	710/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 578	status as the form would look in the hPOLST and if the have needed to look there was a verbal LPN-B stated she EHR had indicated. When interviewed LPN-D stated she front of the resider resident's code sta POLST was blank you know their CP charge nurse com admission. When interviewed DON stated, "In the do CPR if we don DON stated, "In the do CPR if we don DON stated the POR resident or represed "We need to make they want for code nurse that prepare the resident wishe back, and then rousignature. The phy POLST form prior the form. R86's baseline car and orientated and 9/24/21. R86's POLST in the 9/27/21, indicated	was blank. LPN-B stated she hard (paper) chart for the POLST was blank, she would ok in the computer and verified order that indicated full code. Would have started CPR as the d R26 was full code. on 10/11/21, at 4:12 p.m. would look at the POLST in the nt's medical record for a latus. LPN-D stated, if the pleted the POLST upon on 10/12/21, at 1:37 p.m. the e state of Minnesota, we would ot have a signed POLST." The DLST was reviewed with the entative upon admission and, e sure we are checking what e status." The DON stated the estatus." The bold stated the estatus and the late it to the physician for visician should not sign a blank the resident wishes added to	F 5	78		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245270	B. WING			1	C 18/2021
	PROVIDER OR SUPPLIER			52	REET ADDRESS, CITY, STATE, ZIP CODE 5 BLUFF AVENUE T CHARLES, MN 55972	1 10/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	signed by LPN-B and no signature from a when interviewed of stated the admitting to discuss the POL determine what the stated once that was a book we put signed." The DON the facility on Tuesd sign items placed in R86 was admitted of the POLST signed. When interviewed of facility medical dire physician, stated in residents, the facility medical recent hospital stay previously been ordered any medical recent hospital stay previously been ordexpectation for the pre-existing POLST orders with the new current wishes, and new orders needed stated, she had been signature from a nuthought it was usual would send it for reher office three day coming to the office come to her attentions.	e treatment. This form was and R86 on 9/27/21. There was a physician. on 10/12/21, at 8:53 a.m. DON a nurse meets with the resident ST, educate the resident and ir wishes were. The DON as completed, "the physician the POLST in for it to be stated the physician comes to days and Thursday and will a a book. The DON verified on 9/24/21, and did not have	F 5	578			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		245270	B. WING _		10	/18/2021	
	PROVIDER OR SUPPLIER	VICES		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972		, 10, 202	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 578	at the facility and we review until the next MD-A confirmed the blank POLST and a it was signed. MD-a so and stated, "that The facility policy tin Directives/Life-Sust dated 6/1/2017, idea offered an option of Advance Directive so, upon admission orders that are devisional formulation to a tot he resident's with The immediate jeo was removed on 10 determined that the appropriate removal correcting/clarifying R32, R86, R184 are residing in the build reviewed it's policy forward, code status would case of cardiac arribe reviewed again weekly until a decis facility reviewed all status wishes with parties and obtained.	rould not be available for her at date she made rounds. at a physician may not sign a allow the facility to fill it in after A confirmed that she had done t is my error. That is on me." Ited, Living Will/Advance taining Treatment Orders entified residents would be f completing a Living Will or if they have not already done in. A POLST is a set of medical reloped and documented t's (or the resident's in-maker) conversation with the POLST form provides for all health care professionals as shes. pardy that began on 8/11/21 0/13/21, when it could be a facility had implemented an	F 57	8			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		E SURVEY PLETED
		245270	B. WING _			C 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	107	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	signed. As well as a clarified and correct educated in the pol status and POLST, educate any staff p not available during system was design was instructed and Develop/Implement CFR(s): 483.12(b)(§483.12(b) The fact implement written p §483.12(b)(1) Prohneglect, and exploit misappropriation of §483.12(b)(2) Estalto investigate any s §483.12(b)(3) Incluparagraph §483.95 This REQUIREMENT by: Based on interview facility failed to enscheck was obtained employment for 1 or reviewed for emplotic Findings include: Review of licensed employee file lacke background study in the policy in the policy include:	as accurate, complete and any conflicting information was ted. Facility staff were icy and procedures for code and a plan was in place to rior to working their next shift if initial training. An audit ed and the medical director updated. Abuse/Neglect Policies 1)-(3) illity must develop and policies and procedures that: ibit and prevent abuse, ration of residents and resident property, blish policies and procedures uch allegations, and de training as required at and document review, the cure a criminal background and verified prior to f 1 practical nurse (PN)-A	F 57		valid to be	12/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245270	B. WING			10/1	C 1 8/2021
NAME OF	PROVIDER OR SUPPLIER	\ \			TREET ADDRESS, CITY, STATE, ZIP CODE	107	.0,2021
WHITEV	VATER HEALTH SER	VICES			25 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	During an interview director of nursing brand-new nurse a license. The DON up by her criminal stated PN-A had n with her criminal because with the forminal background been working as a without a complete since her first date. During an interview executive director facility had an unlied building. The executive director facility had an unlied building. The executive director the loop if the DON member under any where the staff me executive director checks should be. The Background of dated August 2017 required, the B.O.I (or designee) will evill be completed and the completed of the complete	w on 10/11/21, at 7:23 p.m. the (DON) stated PN-A was a and working under a temporary stated PN-A's license was held background check. The DON nade her aware of the concern	F6	607	Employees will have on file complet background check information, curr and validated license information, a credential documentation prior to with residents. Interdisciplinary team educated by Director of Clinical Services starting 10/18/21 on the Background Check and procedure, Abuse prevention pand procedure and state of Minnest regulations. Executive Director/Designee will aunew hires for 8 weeks for complete documentation. Audit tracking tool developed. The results of the audits will be reviby the QAPI committee for trends a needs for adjustment of audit schedor content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	ent ind orking g on a policy olicy ota dit ewed ind any dules	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245270	B. WING _			C 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
F 607	2018 included: 1) S Requirement: It is to screen employees, volunteers and stude and affiliated acade nursing, therapy, so prior to working with components include licenses, certification Procedures: Employees are perroreferences will be volicenses, credential checks. The facility engage individuals abuse, neglect, exproperty, or mistreat facility will not employers assistant where the state registry concerning assistant where the s	ion Program dated March creening: Abuse Policy he policy of this facility to medical directors, contractors, dents (in nurse aide programs mic institutions, including ocial and activity programs) nour residents. Screening everification of references, ons and background checks. yee screening - Before new mitted to work with residents, erified as well as certifications, s, and criminal background will not employ or otherwise who have been found guilty of policitation, misappropriation of atment by a Court of law. The oy or otherwise engage any ith a finding entered into the erning abuse, neglect, propriation of residents. The facility or otherwise engage a all who has a disciplinary inst his/her professional of a finding of abuse, neglect, lent property, or mistreatment innal background check will be ospective employees as per cant finding will result in denied tent with the policy, the ear bars to employment per regulations.	F 60			
	Transfer and Disch CFR(s): 483.15(c)(arge Requirements	F 62	2		12/1/21

[` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245270	B. WING _		10	C / 18/2021	
	PROVIDER OR SUPPLIER ATER HEALTH SERV	/ICES		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 622	remain in the facilit discharge the reside (A) The transfer or resident's welfare a cannot be met in the (B) The transfer or because the reside sufficiently so the reservices provided by (C) The safety of intendangered due to status of the resident (D) The health of intendangered due to status of the resident (E) The resident has appropriate notice, under Medicare or Nonpayment applies submit the necessary payment or after the Medicare or Medicar	er and discharge- ity requirements- permit each resident to y, and not transfer or lent from the facility unless- discharge is necessary for the and the resident's needs he facility; discharge is appropriate ent's health has improved esident no longer needs the by the facility; dividuals in the facility is the clinical or behavioral ent; hidividuals in the facility would higered; has failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. He is if the resident does not hary paperwork for third party he third party, including haid, denies the claim and the hay for his or her stay. For a hes eligible for Medicaid after hity, the facility may charge a hable charges under Medicaid; heses to operate. Interval to appeal a transfer or high to appeal a transfer or	F 62	22			
	exercises his or he discharge notice fro 431.220(a)(3) of th	r right to appeal a transfer or					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	l \	TIPLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		245270	B. WING		10	C / 18/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 525 BLUFF AVENUE ST CHARLES, MN 55972			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 622	or safety of the restacility. The facility that failure to trans §483.15(c)(2) Dock When the facility to resident under any in paragraphs (c)(section, the facility or discharge is dock medical record and communicated to transitution or provide (i) Documentation must include: (A) The basis for the (ii) of this section. (B) In the case of precisions and the serfacility to meet the (ii) The documentation (2)(i) of this section (A) The resident's discharge is necessified (A) or (B) of this section (B) A physician who necessary under put in the control of the provided (C) (C) Advance Directact information (C) Directact (C) Dire	sident or other individuals in the must document the danger of the or discharge would pose. Sumentation. Sansfers or discharges a of the circumstances specified (1)(i)(A) through (F) of this must ensure that the transfer cumented in the resident's dappropriate information is the receiving health care der. In the resident's medical record the transfer per paragraph (c)(1) (i)(A) of this ic resident need(s) that cannot empts to meet the resident revice available at the receiving need(s). In must be made byphysician when transfer or asary under paragraph (c) (1) ection; and the entransfer or discharge is aragraph (c)(1)(i)(C) or (D) of the ovided to the receiving provider name of the following: ation of the practitioner of care of the resident. Sentative information including in	F6	22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245270	B. WING			C 18/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP OF 525 BLUFF AVENUE ST CHARLES, MN 55972	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 622	copy of the resider consistent with §48 any other document a safe and effectiv This REQUIREME by: Based on interview facility failed to ensincluding skin concontact information health agency, for reviewed for dischabealth services. Findings include: R36's admission redate of 4/7/21 with sclerosis, mild cog contractures. R36's admission M4/16/21, indicated bed mobility, transdressing, toileting ano skin issues. R36's discharge M was an assist of or locomotion on/off opersonal hygiene. had a stage 3 pression of 10/14/21 a reviperformed and the	ppropriate.	F 6.	R36 discharged Facility discharged resident potential to be affected. Transfer/Discharge checklist implemented for nursing stat transfer/discharge is initiated. Interdisciplinary team and I educated by the Director of Services starting on 11/12/2 Discharge-Transfer of Resignocedure including discharge-Transfer of Resignocedure including discharge-Transfer of Resignocedure including discharged documentation, required disinformation provided to resign representative, documentation education, information and the Change of the Resident policy and possible to the Resident policy and polic	st and folder aff when a ed. icensed staff f Clinical 21 on ident policy and rge scharge ident or tion and discharge care e of Condition procedure. ee will complete ent hey occur for 8 Il be reviewed trends and any dit schedules	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245270	B. WING				C 18/2021
NAME OF F	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2021
		W0-70		52	25 BLUFF AVENUE		
WHITEW	ATER HEALTH SERV	ICES					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 622	Continued From pa	nge 43	F6	22			
	A.M. and was titled medical record reve was discharged, wh	Daily Skilled Note. The ealed no evidence that R36 nere R36 was discharged to, on was sent with resident or			educational needs. The Executive Director is responsible to ensure the action occurs.	าเร	
	director of nursing was for the social w progress note the co	on 10/14/21, at 9:36 A.M. the (DON) stated the expectation worker to document in a discharge summary, recap of ersations with home care					
	social worker (SW) make sure home catransportation and of resources if they discharge paperwomedical record and diagnoses, med list substances and if that information is a SW stated, "I have the last few months and I am working 1	on 10/14/21, at 9:52 A.M. the stated it was the SW's job to are is set up, including depending on cognition, a list have other needs. SW stated rk is printed off from the would have admission info, t, prescriptions for controlled here is rehab or wound care also included. Furthermore, not been documenting as well s, but we have been really busy 0-12 hour days so some the cracks, I'll be honest."					
	Resident dated Jura discharge summa care form which shist of medications terms. Do not use rabbreviations. Includischarge care. Rerepresentative. Have representative or possible summariance.	ide instructions for post view with the resident and/or					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245270	B. WING				C 18/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2021
WHITEW	ATER HEALTH SERV	ICES			5 BLUFF AVENUE 「CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	form. This includes copy of form to the or person(s) respor original of form in the	release of medications. Give resident and/or representative asible for care. Place signed		622 636			12/1/21
SS=D	a comprehensive, a	, , , , ,					
	§483.20(b)(1) Res A facility must make assessment of a regoals, life history arresident assessme by CMS. The asset the following: (i) Identification and (ii) Customary routi (iii) Cognitive patter (iv) Communication (v) Vision. (vi) Mood and behad (vii) Psychological (viii) Physical functi (ix) Continence. (x) Disease diagnost (xi) Dental and nutr (xii) Skin Conditions (xiii) Activity pursuit (xiv) Medications. (xv) Special treatmet (xvi) Discharge planting (xiii) Activity pursuit (xvi) Discharge planting (xiii) Activity pursuit (xvi) Discharge planting (xiii) Activity pursuit (xvi) Discharge planting (xviii) Activity pursuit (xviiii) Activity pursuit (xviiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	sident's needs, strengths, and preferences, using the int instrument (RAI) specified ssment must include at least demographic information inc. Ins. Invior patterns. Invior					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245270	B. WING				3
NAME OF I	PROVIDER OR SUPPLIER	243270	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	10/1	18/2021
	ATER HEALTH SERV	ICES		5	25 BLUFF AVENUE T CHARLES, MN 55972		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 636	on the care areas to the Minimum Data (xviii) Documentation assessment. The aninclude direct obserwith the resident, as licensed and nonlice members on all shifts (483.20(b)(2) When timeframes prescrift chapter, a facility meassessment of a restimeframes specified through (iii) of this sprescribed in §413. apply to CAHs. (i) Within 14 calend excluding readmissing significant change is mental condition. (For "readmission" mean following a temporary or the rapeutic leaves (iii) Not less than on This REQUIREMENT by: Based on interview facility failed to communimum Data Set	onal assessment performed riggered by the completion of Set (MDS). On of participation in assessment process must revation and communication with ensed direct care staff fts. In required. Subject to the ped in §413.343(b) of this sust conduct a comprehensive sident in accordance with the ed in paragraphs (b)(2)(i) section. The timeframes 343(b) of this chapter do not arr days after admission, ions in which there is no in the resident's physical or for purposes of this section, has a return to the facility ary absence for hospitalization	F	336	R84 and R86 admission MDS com and submitted. Facility residents have the potential affected.		
		cord printed 10/14/21 sion date to facility of 9/21/21.			MDS schedule reviewed for current resident to ensure MDS timely submission.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		СОМ	E SURVEY PLETED
		245270	B. WING			C 18/2021
NAME OF	PROVIDER OR SUPPLIER	R	<u> </u>	STREET ADDRESS, CITY, STATE,		10/2021
\A/LITE\A	ATER HEALTH SER	VICES		525 BLUFF AVENUE		
VVIIIEV	AIER HEALIH SER	VICES		ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 636		_	F6			
	R84's admission i	MDS indicated, "in progress."		morning meeting.		
	lacked evidence o of an admission M R86's admission r	lectronic health record (EHR) f a completion, or transmission, IDS. ecord printed 10/13/21 ssion date to facility of 9/24/21.		MDS nurse educated by Reimbursement Director The Centers for Medica Services (CMS) Long-T Resident Assessment It 3.0 user's manual compagnisments	or on 10/18/21 to are and Medicaid Ferm Care Facility Instrument (RAI)	
		lectronic health record (EHR) f a completion, or transmission, IDS.		requirements. Executive Director/Desi completion and submis meetings for 8 weeks.		
	licensed practical admissions MDS's 14 days of admiss verified R84's and still in progress an LPN-A stated she completed MDS a stated she was be shared her concerstated she was to hours a day on MI to start last week a stated she had a lenot get any help. L 12 hours a day an anymore and now			Regional Reimburseme closing and submission assessments off-site work. The results of the audition by the QAPI committee needs for adjustment of or content, as well as a educational needs. The Director is responsible traction occurs.	of MDS eekly-on-going. s will be reviewed for trends and any f audit schedules ny further Executive	
	was not provided. The Centers for M (CMS) Long-Term Assessment Instrudated 10/2019, ide	ledicare and Medicare Services Care Facility Resident ument (RAI) 3.0 User's Manual entified the RAI MDS and CAA's vas to identify resident care				

AND DIAN OF CORRECTION 'IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING				
		245270	B. WING		10	C / 18/2021	
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP COD 525 BLUFF AVENUE ST CHARLES, MN 55972		710/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	problems which wo individualized care from MDS assessm Skilled Nursing Fac System (SNF PPS) system, many State systems, and for m provided to nursing identified comprehe completion is define process in addition that the RN [register coordinator has sig (item Z0500) and Completion attestate instructed the MDS (comprehensive) or Z0500 and V0200B "14th calendar day (admission date + [Develop/Implement CFR(s): 483.21(b) (Comprehensive) or S483.21(b) (Comprehensive) in the second of the secon	uld be addressed in an plan. Further, data collected nents was also used for the cility Prospective Payment Medicare reimbursement onitoring the quality of care home residents. The manual ensive "assessment ed as completion of the CAA to the MDS items, meaning ared nurse] assessment ned and dated both the MDS (AA(s) (item V0200B) ions." In addition, the manual and CAA(s) admission completion date(s) (items (2)) were to be no later than the of the resident's admission plus] 13 calendar days)." It Comprehensive Care Plan (2) were to be no later than the of the resident's admission plus] 13 calendar days). The comprehensive Care Plan (2) were to be no later than the of the resident's admission plus] 13 calendar days). The comprehensive Care Plan (2) were to be no later than the of the resident's admission plus] 13 calendar days). The comprehensive Care Plan (2) and includes measurable of the comprehensive care plan must of the comprehensive care plan must	F 6			12/1/21	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245270	B. WING			10/2	5 18/2021
	PROVIDER OR SUPPLIER			52	REET ADDRESS, CITY, STATE, ZIP CODE S BLUFF AVENUE T CHARLES, MN 55972	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 656	(ii) Any services the under §483.24, §4 provided due to the under §483.10, incomposition treatment under §483.10, incomposition the resident of the PAS rationale in the resident's represe (A) The resident's desired outcomes (B) The resident's future discharge. If whether the resident community was as local contact agent entities, for this put (C) Discharge plan plan, as appropriate requirements set if section. This REQUIREMED by: Based on observative with the facility of the	at would otherwise be required .83.25 or §483.40 but are not e resident's exercise of rights cluding the right to refuse .483.10(c)(6). d services or specialized ces the nursing facility will to f PASARR. If a facility disagrees with the SARR, it must indicate its sident's medical record. with the resident and the natative(s)-goals for admission and . preference and potential for eacilities must document ent's desire to return to the sessed and any referrals to receive and/or other appropriate incomes. In sin the comprehensive care te, in accordance with the forth in paragraph (c) of this ent of the service and document failed to develop a care plan for a 1 of 1 resident (R26) reviewed	F6	656	R26 anticoagulant care plan compositive residents prescribed anticomedication have the potential to be affected. Residents with anticoagulant order audited for complete comprehensively plan. Care plan schedule will be reviewed each morning meeting.	agulant s s ve care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245270	B. WING			10/1) 18/2021
	PROVIDER OR SUPPLIER	ICES		52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BLUFF AVENUE T CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETION DATE
F 656	R26's admission M 9/1/21, indicated R2 medications. R26's care plan pripulan of care for R26 interventions for an R26's physician ord (anticoagulant med mouth at bedtime for related to chronic k 10/15/21. (Order st During an interview licensed practical n was a high-risk meon coumadin they sheing at risk for ble comprehensive car and stated it should behind on completi admissions. LPN-A care plan should had During an interview director of nursing care plan was done comprehensive car within 72 hours of a she would expect a was a risk medicati monitoring for bleed not aware LPN-A will plans. The Comprehensive	ge 49 inimum Data Set (MDS) dated 26 required anticoagulant Inted 10/14/21 did not identity a 6's risk for bleeding, goals, and ticoagulation management Iters included: Coumadin ication) 4 milligram (mg) by or Chronic Atrial Fibrillation idney disease stage 5 until art date 10/11/2021). If on 10/14/21, at 12:11 p.m. urse (LPN)-A stated coumadin dication and if a resident was should have a care plan for eding. LPN-A stated R26's e plan was not finished yet 1 be. LPN-A stated she was ng care plans for new 1. stated R26's comprehensive are been complete on 9/15/21. If on 10/18/21, at 8:43 a.m. the (DON) stated the baseline e for the first 72 hours and the e plan should be completed admission. The DON stated care plan for coumadin as it on and residents need to be ding. The DON stated she was as behind in completing care	F6	356	Coumadin orders, PT/INR checks calendar implemented. Interdisciplinary team and licensed seducated by Director of Clinical Service starting on 11/12/21 on the Comprehensive Care Planning policiprocedure, including baseline care prequirements, and comprehensive ciplan requirements. Licensed staff educated on the Warfarin policy and procedure. Director of Nursing/Designee to audit coumadin calendar daily weekly for 8 weeks. Director of Nursing/Designee to audit admissions for complete care plan if receiving anticoagulant medications. The results of the audits will be reviet by the QAPI committee for trends and needs for adjustment of audit schedior content, as well as any further educational needs. The Executive Director is responsible to ensure this action occurs.	vices y and olan are it 8 it - ewed and any ules	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	COMPLETED	
		245270	B. WING _		10/18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	10/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLÉTION
F 656	Continued From pa	ge 50	F 65	6	
E 661	of completion of the assessments (MDS Discharge Summar	,	F 66	1	12/1/21
	CFR(s): 483.21(c)(2	•	F 00	ı	12/1/21
	must have a dischabut is not limited to, (i) A recapitulation of includes, but is not of illness/treatment radiology, and considired items in particulate items in particulate items in particulate items in particulate items in the time of the discrelease to authorize the consent of the representative. (iii) Reconciliation of medications with the medications (both pover-the-counter). (iv) A post-discharge developed with the and, with the reside representative(s), vadjust to his or her post-discharge plarthe individual plans that have been mad care and any post-onon-medical service This REQUIREMENT.	nticipates discharge, a resident arge summary that includes, the following: of the resident's stay that limited to, diagnoses, course or therapy, and pertinent lab, sultation results. To five the resident's status to ragraph (b)(1) of §483.20, at harge that is available for ed persons and agencies, with resident or resident's of all pre-discharge e resident's post-discharge e resident's post-discharge erescribed and the plan of care that is participation of the resident which will assist the resident to new living environment. The nof care must indicate where to reside, any arrangements de for the resident's follow up discharge medical and es. NT is not met as evidenced			
	facility failed to com	s and record review the nplete a comprehensive including a recapitulation of		R36 discharged Facility discharged residents have	the

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245270	B. WING				C 18/2021
NAME OF I	PROVIDER OR SUPPLIER		·	;	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2021
\A/! !!TE\A	ATED HEALTH OED	4050			525 BLUFF AVENUE		
WHITEW	ATER HEALTH SERV	/ICES		;	ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 661	Continued From pa	age 51	F 6	661			
	stay for 1 of 1 residuscharge.	dents (R36) reviewed for			potential to be affected.		
	Findings include:				Transfer/Discharge checklist and f implemented for nursing staff when transfer/discharge is initiated.		
	date of 4/7/21 with	ecord identified an admission diagnoses of multiple nitive impairment and muscle	ed an admission f multiple ment and muscle ment and muscle starting on 11/12/2		Interdisciplinary team and licensed educated by Director of Clinical Se starting on 11/12/21 on Discharge-Transfer of Resident po	rvices	
	4/16/21, indicated bed mobility, transf	136's admission Minimum Data Set (MDS) dated /16/21, indicated R36 was an assist of one with ed mobility, transfers, locomotion on/off unit, ressing, toileting and personal hygiene and had o skin issues.			Discharge Planning policy, the Change of Condition of the Resident policy and procedure including discharge documentation, required discharge information, discharge summary, and recapitulation of stay.		
	was an assist of or locomotion on/off upersonal hygiene.	DS dated 6/2/21 indicated R36 ne with bed mobility, transfers, unit, dressing, toileting and The MDS also indicated R36 sure ulcer in unknown location.			Director of Nursing/Designee will complete audits of discharged resi documentation weekly as they occ 12 weeks.		
	performed and the R36's medical reco A.M. and was titled medical record rev	ew of R36's record was last progress note entered in ord was dated 6/1/21 at 3:24 d Daily Skilled Note. The vealed no evidence that a ry or recapitulation of stay was			The results of the audits will be revelop the QAPI committee for trends an needs for adjustment of audit scheor content, as well as any further educational needs. The Executive Director is responsible to ensure the action occurs.	and any dules	
	DON stated the ex worker to documer discharge summar	y on 10/14/21 at 9:36 A.M., pectation was for the social nt in a progress note the ry, recap of stay and any home care agency.					
	facility social worke	v on 10/14/21 at 9:52 A.M., er (SW) stated discharge d recapitulation of stay should					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972		110/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 661	progress note. SW summary note in the completed by the started resident out the document out of the started out of t	ge 52 he medical record in a then stated that the discharge e medical record should be taff member that saw the or. SW then verified that there ote or recapitulation of stay for SW stated, "I have not been all the last few months, but we say and I am working 10-12 things fall through the cracks, Discharge - Transfer of e 2017 indicated to complete ary and post discharge plan of ould include the following: A	F6	61		
	list of medications of terms. Do not use in abbreviations. Includischarge care. Review representative. Have representative or pedischarge summary form. This includes copy of form to the or person(s) respondinal of form in the Treatment/Svcs to ICFR(s): 483.25(b)(s) \$483.25(b)(s) Skin Integration (s) A resident receives professional standard pressure ulcers and	with instructions in simple medical terms or de instructions for post view with the resident and/or re resident and/or reson responsible for care sign and post discharge care release of medications. Give resident and/or representative asible for care. Place signed the medical record. Prevent/Heal Pressure Ulcer 1)(i)(ii) regrity sure ulcers. weehensive assessment of a	F 6	86		12/1/21

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTIONS	` '	(X3) DATE SURVEY COMPLETED	
		245270	B. WING			C 10/18/2021	
NAME OF I	PROVIDER OR SUPPLIER	र		STREET ADDRESS	S, CITY, STATE, ZIP CODE	10/10/2021	
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VVIII EVV	AIER NEALIN SER	VICES		ST CHARLES,	MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	TIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	demonstrates that (ii) A resident with necessary treatment with professional is promote healing, new ulcers from of This REQUIREMENT by: Based on observ review, the facility provider and obta 1 residents (R10) had developed a refailed to transcribe provider for a new failure resulted in pressure ulcer be deteriorated from Findings include: Pressure Ulcer standard Set (MDS) p Services: Stage I pressure upressure-related a indicators as com area on the body more of the follow temperature (warn consistency (firm itching); and/or a redness in lightly	they were unavoidable; and pressure ulcers receives ent and services, consistent standards of practice, to prevent infection and prevent eveloping. ENT is not met as evidenced ation, interview and document failed to notify the medical in wound care orders when 1 of reviewed for pressure ulcers, new coccyx pressure ulcer, and e and follow orders from a aly developed heel ulcer. This actual harm when R10's coccyx came larger and the heel ulcer a stage 2 to a stage 3 ulcer. Agges defined by the Minimum er Center Medicare/Medicaid ulcer (An observable, alteration of intact skin, whose pared to adjacent or opposite may include changes in one or ing parameters: skin mth or coolness); tissue or boggy); sensation (pain, defined area of persistent bigmented skin, whereas in	Fé	R10 wound MD updated obtained an Facility residents of checks will bath/showe completed obinder devetracking. Licensed st Clinical Ser Skin Managand Non-procedures new wound requiremen and monitor Licensed st	ds measured and assessed d, new treatment orders and care plan updated. dents have the potential to learn to a sments completed for curre in 10/13/21 and 10/14/21. Slear be completed weekly with er. Wound rounds will be every 7 days per policy, workloped to assist with wound affected by Director of vices starting on 11/12/21 of gement policy and Pressure ressure Injury policy and including identification of a requirements, assessment its, notification requirements ring requirements.	nt kin und	
	persistent red, blu Stage II pressure	the ulcer may appear with le, or purple hues.) ulcers (Partial thickness loss of las a shallow open ulcer with a		resident cor after appoir	Nursing/Designee to audit nsultation notes for new ord ntments, hospital stays, and 3 times weekly for 12 week		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 686	red-pink wound bed present as an intace. Stage III pressure to loss. Subcutaneous tendon or muscle is present but does no loss. May include use to loss. May include use the loss. May include use the loss. May include use the loss of loss	d, without slough. May also t or open/ ruptured blister.) ulcers (Full thickness tissue is fat may be visible but bone, is not exposed. Slough may be not obscure the depth of tissue indermining or tunneling.) simum Data Set (MDS) dated inderate cognitive impairment uding, diabetes, Alzheimer's eral vascular disease. R10's ded a recent nondisplaced in the bone breaks in 3 or more the right fibula and tibia (calf 10's MDS indicated he assistance with most activities is) and rejected cares 1-3 days sessment period. R10 was at cers, but did not have any	F 680	Director of Nursing/Designe weekly wound rounds for massessments, notifications, orders for 12 weeks. The results of the audits wiby the QAPI committee for needs for adjustment of au or content, as well as any freducational needs. The Ex Director is responsible to eaction occurs.	neasurements, , and treatment Il be reviewed trends and any dit schedules urther ecutive	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C		
		245270	B. WING_		10	/18/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	to skin: 1)pressure 2)pressure reduction plan lacked identificatual pressure ulder that the lacked identificatual pressure ulder the lacked identified R10 had cast and a call was return to cast room. According to a "wo R10's EHR dated pressure ulcer on I spine/tailbone). No medical record was measurements we with 0.1 cm depth, document indicate having both, "sloug (Slough is necrotic superficial wounds process generally Granulation tissue not generally seen form indicated R10 wound, but did not notified. R10's Cast Visit proposed to the Desurgery and was spractitioner (CNP)-cast on his right let the lower extremity	reduction mattress. on chair cushion." The care cation or staff direction for cers. te dated 10/5/21, identified R10 cast room," and was to continue ring on the right side and to ma control. The note also some loose stools soiling the s placed to advise if needs to	F 68	36			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		245270	B. WING _		10	C / 18/2021	
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP 525 BLUFF AVENUE ST CHARLES, MN 55972			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 686	last visit." The docudirections for care: a stockinette [dress provide skin protect Mepilex heel dress product that lifts the recommend that the immobilizer and stotwice daily. They are multi-Podus boot to The facility can character weekly. He is heel." R10's physician Or electronic health remot include any direct pressure ulcer on buttocks. R10's tree (TAR) and medicat (MAR) from 10/6/2	iment included the following "today patient was placed into sing similar to a thin sock to tion] and knee immobilizer, a ing with a multi-Podus boot [a heel to prevent pressure]. I ey remove the knee ockinette and check his skin re also to remove the vice daily to check his skin ange the Mepilex heel dressing to have no pressure on his der Summary Sheet from the cord (EHR) on 10/11/21, did ection or treatment for a neel, or pressure ulcer on atment administration records 1 to 10/11/21, failed to identify 110's pressure ulcers on heel	F 68	6			
	review," and directed identified to follow p	order for, "Weekly skin ed staff if new skin area is protocol and notify physician. s being completed on 10/4/21					
	R10's EHR dated 1 was measured at b depth of 0.2 cm, sti pressure ulcer, but "worsening." The d indication of the ca include, R10 should	und tracker document" in 0/12/21, the coccyx wound eing 2.2 cm by 2.5 cm with a II rated as a, "stage II" condition listed as, ocument did not provide any res being provided, but did d lay down after meals. The ndicate the medical provider					

AND DIANIOE CORRECTION IDENTIFICATION NUMBER		' '	IPLE CONSTRUCTION NG	, ,	C (X3) DATE SURVEY	
		245270	B. WING_		10	/18/2021
	NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES (X4) ID PREFIX TAG Continued From page 57 was notified of R10's condition. During an observation of morning cares 10/13/27:14 a.m. a nursing assistant (NA)-C and an unidentified NA came into R10's room to provid morning cares. He was laying on his back in his bed. R10 had a scab on his left shin, and had a large plastic leg immobilizer on his right leg, he in place with straps, and a stocking type dressir covered his leg so the skin could not be visualized at that time. There was nothing in plat to prevent pressure to R10's right leg except fo the splint itself. NAs both stated the immobilize was not to be removed as he had a fractured le NAs assisted R10 to turn towards his right, affected side, so they could wash his buttocks. square foam dressing, approximately 3 inches 3 inches and 1/4 inch thick was observed on R10's coccyx, but was not adhered to the skin along the edges and was quite loose along the bottom edge. During cares, R10 began to have bowel movement which oozed up under the loo edge of the dressing and the unidentified NA removed the dressing. R10's entire left buttock was observed to be slightly pink and mottled. A shallow ulcer about the size of a quarter was observed after removal of the foam dressing. T wound was situated between the left ischium at the coccyx. The top layers of skin were missing and the wound bed was a bright red color. The dressing had a small amount of bloody drainag soaked into the foam. After the NAs finished			STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972		710/2021
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	was notified of R10 During an observat 7:14 a.m. a nursing unidentified NA car morning cares. He bed. R10 had a sca large plastic leg im in place with straps covered his leg so visualized at that til to prevent pressure the splint itself. NA was not to be remo NAs assisted R10 affected side, so th square foam dress 3 inches and 1/4 in R10's coccyx, but v along the edges ar bottom edge. Durir bowel movement v edge of the dressir removed the dressi was observed to be shallow ulcer abou observed after rem wound was situate the coccyx. The top and the wound bed dressing had a sm soaked into the foa washing R10's but previous position o NA threw away the said they would ne	tion of morning cares 10/13/21, g assistant (NA)-C and an me into R10's room to provide was laying on his back in his ab on his left shin, and had a mobilizer on his right leg, held s, and a stocking type dressing the skin could not be me. There was nothing in place to R10's right leg except for as both stated the immobilizer oved as he had a fractured leg. To turn towards his right, sey could wash his buttocks. A sing, approximately 3 inches by shich thick was observed on was not adhered to the skin and was quite loose along the neg cares, R10 began to have a which oozed up under the loose and the unidentified NA ing. R10's entire left buttock to slightly pink and mottled. A to the size of a quarter was a loval of the foam dressing. The did between the left ischium and to layers of skin were missing it was a bright red color. The all amount of bloody drainage am. After the NAs finished tocks, they returned him to his in his back. The unidentified soiled dressing, and NA-C eed to report to the nurse that	F 68	36		
	NA threw away the said they would ne R10 needed a new Neither NA knew h	soiled dressing, and NA-C				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245270	B. WING		10	C / 18/2021	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 686	shin. When interviewed of licensed practical in had the long splint week or more, and the splint even thoo by Velcro straps. Lifter skin breakdown splint and it was im condition, but said the skin that was not splint. LPN-B stated a wound on his but days before. LPN-E physician's order for stated they had beed dressing to R10's of (Mepilex is a trade of dressing types, the director of dressing meant to other type of dressing occlusive foam drewhen a new wound getting worse, the indirector of nursing provider to get an orange a new wound or an dressing, the NA is LPN-B stated the remorning, and need reported to her and nurse it should hav	the small scab on R10's left on 10/13/21, at 8:26 a.m. hurse (LPN)-B stated R10 had on his leg for approximately a said they were not to remove ugh it was merely held in place PN-B stated R10 was at risk due to the application of the portant to monitor his they were only able to check ot covered by the straps or d she was aware that R10 had tocks and had seen it several a said she was unable to find a or the care of the wound, but en applying a "Mepilex" open wound near his coccyx name and can mean a variety he most common are a foam be held in place with some ing, or a self-adhesive, ssing). LPN-B stated that I is identified, or a wound is nurse should report it to the (DON) and call the medical order for care. If an NA notices wound that requires a new to report to the nurse on duty. emoval of R10's dressing that for wound care had not been I she would have been the the been reported to.	F 6	86			
	R10's physician ord	onsultant (NC) confirmed that ders did not include any order wound on his buttocks. NC					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C	
		245270	B. WING_		10	/18/2021
	PROVIDER OR SUPPLIER	/ICES	STREET ADDRESS, CITY, STATE, ZIP C 525 BLUFF AVENUE ST CHARLES, MN 55972		· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	stated the expecter in the event of a newere to notify the newere to notify the newere to notify the newere to notify the newere deaded to the fact measurements showeekly measurement the treatment order recommendations provided by the ort 10/7/21, including nobservation and sk pressure ulcer and heel had not been note into R10's phyrecommendations communicated to rand could not be or provided. According to an int DON stated immediand NC had gone to "boot" and the dresstated she had not pressure ulcer prior the recommendation the recommendation of the work and was "healing" condition of the work and yound extends threst involving tendons, wound extends threst the subcutaneous and the subcutane	d process for nurses to follow ewly identified pressure ulcer nedical provider for wound dd new interventions to the n. The resident's name should cility "wound list" and initial ould be taken, followed by ents to monitor the efficacy or r. NC confirmed that for care of a right heel ulcer hopedic services cast room on removal of the splint for a right heel for no pressure to the right transcribed from the paper vician's orders and thus these for care had not been hursing staff through the EHR, confirmed to have been erview 10/13/21, 9:17 a.m. diately prior to interview DON to R10's room, removed his using applied on 10/7/21. DON known about the right heel r to 10/13/21 and had not read ons from CNP-A before that ed CNP-A's documentation d had been "just developing" on 10/7/21, but confirmed the und had deteriorated. DON II by now" (pressure ulcers are I, superficial redness that does ge IV, a deep tissue injury ligament and bone. A stage III ough all layers of the skin into tissue, but not to tendons or an expectation for nurses to	F 68	36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245270	B. WING			C / 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STAT 525 BLUFF AVENUE ST CHARLES, MN 55972	TE, ZIP CODE	10/2021
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F 686	review any papers any medical appoint facility. DON was un recommendations to but said the nurse of their medical direct physician to verify cappointment. DON then entered the or also have reported DON, but said this she had replaced the heel, but had not rethe stockinette due to be in touch with During the 10/13/2 described expectat new pressure ulcer DON said the nurse wound was found wound was found was found was are of the information and a coprogress note. DOI any standing orders on duty would need in order to get treat DON said the nurse who was responsib wound weekly, and injury tracker." DOI aware of R10's wot applied a Mepilex of confirmed she had did not have an order to get the said of the nurse who was responsib wound weekly, and injury tracker." DOI aware of R10's wot applied a Mepilex of confirmed she had did not have an order to get the said of the nurse who was responsib wound weekly, and injury tracker." DOI aware of R10's wot applied a Mepilex of confirmed she had did not have an order to get the said of	accompanying a resident from atment upon their return to the nable to confirm that CNP-A's for care were actual orders, on duty should have contacted or (MD)-A who is also R10's orders following the stated the nurse should have ders into the EHR and should to the nurse manager and the had not occurred. DON stated he soiled Mepilex on R10's emoved the brace or replaced to "pain", saying, "I am going (MD)-A about how to proceed." 1, 9:17 a.m. interview, DON ions of nursing staff when a for wound were identified. In charge at the time the was responsible to take the wound and document this description of the wound in a N said the facility did not have as for wound care so the nurse of the to notify the medical provider ment orders for the wound. The should also notify the DON of the to monitor and assess the document in their "pressure N stated she had become and on his bottom and had dressing; however, DON not notified the physician and	F6	86		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER	1 1		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	•	110/2021
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F 689 SS=D	Orthopedic Surgery been considered as should have been to orders. MD-A stated the recommendation reason for the facility medical director to norders. MD-A stated wound, but said, action description on 10/7/on 10/13/21, the conhad worsened since MD-A stated an exprostify the medical production would be a manager of the condition until that received a copy of the notes from the Orth Facility did not provinct of the facility must en S483.25(d) Acciden The facility must en S483.25(d)(1) The resident in S483.25(d)(2) Each supervision and assaccidents.	CNP-A during the visit to the Cast Room should have medical provider orders, and ranscribed and followed as there was no problems with ms written by CNP-A and no ty to contact the facility review or confirm those she had not seen R10's heel cording to CNP-A's 21 and the DON's description andition of the pressure ulcer the was seen by CNP-A. Sectation for the facility to rovider if a resident's pressure approving, were worsening or if the developed. MD-A confirmed otified of R10's change in morning but had previously his 10/7/21 cast room visit opedic Services. Idea policy related to do to provider, or transcribing cian orders. Izzards/Supervision/Devices 1)(2)	F 6			12/1/21

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NAME OF F	PROVIDER OR SUPPLIER		l I	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2021
					25 BLUFF AVENUE		
WHITEW	ATER HEALTH SERV	ICES			ST CHARLES, MN 55972		
(X4) ID PREFIX TAG) BE	(X5) COMPLETION DATE			
F 689	Continued From pa	ge 62	F 6	89			
	Based on observat review, facility failed investigation and ar causative factors of in a significant injur care-plan with appr	tions, interviews and record to conduct a thorough nalysis to determine the f a resident's fall that resulted y, or update the resident's opriate interventions to reduce nilar incidents for 1 of 2			R10 wounds measured and asses MD updated, new treatment order obtained and care plan updated. Facility residents have the potential affected. Skin assessments completed for other potential affected.	al to be	
	Findings include: According to the ele Admission Record/of following diagnoses	ectronic health record (EHR) diagnoses sheet, R10 had the s, among other co-morbidities,			residents on 10/13/21 and 10/14/2 checks will be completed weekly weath/shower. Wound rounds will be completed every 7 days per policy binder developed to assist with we tracking.	vith e , wound	
	weakness, difficulty classified, and history R10's quarterly Min 7/30/2021, R10 required one person to walk indicated R10 was assistance for balance.	e, generalized muscle walking, not elsewhere ory of falling. imum Data Set (MDS) dated uired extensive assistance of and transfer. The MDS unsteady and required nce and turning. Furthermore, essistance of two persons to			Licensed staff educated by Director Clinical Services starting on 11/12. Skin Management policy and Press and Non-pressure Injury policy and procedures including identification new wound requirements, assessing requirements, notification requirements and monitoring requirements.	/21 on sure d of a nent	
	use the toilet. His comoderately impaire sometimes exhibitin R10 had no falls sin	ognitive status was marked as d and R10 was assessed as ng behaviors of rejecting care. nce the prior assessment. EHR care plan, R10 had a			Licensed staff educated on Physic orders policy and procedure. Director of Nursing/Designee to at resident consultation notes for new after appointments, hospital stays.	ıdit v orders	
	focus problem area R10 had a self-care walking. An intervel indicated: allow [R1 choose to transfer, Be patient and assi intervention dated 4 assist of two with ga	a dated 4/4/2018 that indicated be deficit related to difficulty in ontion dated 12/10/2019 0] to direct cares. He may move, etc. with minimal help. st as he directs, but an 4/20/20 indicated: transfersait belt and a walker. At times due to behaviors. Staff are to			MD rounds 3 times weekly for 12 v Director of Nursing/Designee to at weekly wound rounds for measure assessments, notifications, and treorders for 12 weeks. The results of the audits will be reby the QAPI committee for trends	veeks. udit ements, eatment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 689	leave him in a safe after a short while. dated 2/06/2018 inchas the potential founsteady gait, impapsychotropic medicevidenced by his in without assistance. for this focus probleensure resident is shoes, gripper sock 2/6/2018 and revise of recliner, side of toilet (1/30/20); maensure adequate liginformation on fast cause of falls or ris revised 2/3/20). According to an intestated he had recell broken hip following to relate any other or the injury. According to a phop.m. a certified nurshad been assisting herself on 9/22/21 stand lift rather that in his careplan. Whin the bathroom, Nooff the toilet, but oth NA-D reported she bathroom to his begot R10 as far as the would not fit under able to seat R10 or	environment and reapproach An additional focus problem dicated the following: [R10] or injury-fall risk related to: aired safety awareness, use of cations, impaired mobility as ability to transfer/ambulate. Corresponding interventions em indicated staff should: wearing appropriate footwear ks, or slippers) (date initiated ed 10/25/20); grip strips in front bed, in bathroom in front of intain room free of clutter and ghting (2/03/20); review falls and attempt to determine k factors as indicated (2/6/18, erview 10/11/21, 1:19 p.m. R10 atty been hospitalized with a lang a fall, but he was not able information regarding the fall the interview 10/14/21,1:52 using assistant NA-D stated she R10 to the bathroom by using a mechanical "sit to an the two assist as indicated then R10's cares were complete A-D said he did not want to get the moved R10 from the d, using the lift. When NA-D he bed, NA-D realized the lift the bed and NA-D was only in the very edge of the bed. The and R10 were "scared" and the and R10 were "scared" and the and R10 were "scared" and	F 68	needs for adjustment of a or content, as well as any educational needs. The E Director is responsible to action occurs.	y further Executive	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245270	B. WING				C 18/2021
	PROVIDER OR SUPPLIER			525	REET ADDRESS, CITY, STATE, ZIP CODE 5 BLUFF AVENUE CHARLES, MN 55972	1 10/	16/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	she called for help. working nearby and she asked PN-A to Then they put a tra him to walk to the bed, and R10 said, he went down onto foot. NA-D was una have twisted his leg a Hoyer lift that did they lifted him into NA-D recalled that right leg, but she th use of the Hoyer lift pain to PN-A, and I (RN-B) working the that later she notice like he couldn't stra and I told [PN-A] th wrong with it. She wreported to the night and the night lege in May of 20 a nurse before. PN nursing board exama a nursing license. 9/22/21, PN-A state time, and it was the respond to as a nur describe what she about what to do if said her experience was a nursing assis should be done by vital signs, the nursand notify the DON	A practical nurse (PN-A) was a came to assist. NA-D stated help move R10 to his recliner. Insfer belt on R10 and asked bed. They started towards the "I'm going to sit right now" and PN-D's knees and NA-D's able to say if R10 appeared to gat that time. She went to get not require him to stand, and bed using that equipment. R10 stated he had pain in his rought it was caused by the t. NA-D said she reported this atter to the registered nurse overnight shift. NA-D reported ed "his leg looked extended, highten it, kind of to the right ere was something really was going off duty so she in nurse who followed up." The interview with PN-A on she had graduated from 021, and had never worked as A stated she had taken her in July, but did not yet have when R10 suffered his fall on ed she was working at that a first fall that she had to ree. PN-A was unable to had learned in nursing school a resident had fallen. PN-A with falls was from when she stant, but said an assessment the nurse, including a set of se should document findings and the physician. PN-A could divitten a progress note (no	F6	89			

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F 689	called the DON and had to do, but said have to do anything to the floor" and did needed to call the psaid she "would tak found out the next of felt horrible, and as PN-A said she was over-night nurse had did not have to do a According to a progen of the progress of the progress note of the progress note of the progress note of the progress note did in the progress note did in the progress note of the prog	found). PN-A said she had a sked what paperwork she the DON told her she did not g because R10 was "lowered I not fall. PN-A asked if she ohysician, but said the DON are care of it." PN-A said "I day things were worse and I ked what I needed to do." told by the DON that the ad charted everything, and she anything else. The proof of the floor while trying A notified nurse that resident ain around 23:15 [11:15 p.m.] at approx 23:30 [11:30 p.m.]. turned outward. Swelling and fox 1 inch below right knee ontinued to describe R10's all, notification to physician and of nursing/DON at 5:00 a.m. ansfer to hospital at 7:00 a.m.) not include information about, what happened during the ny immediate interventions to	F 68				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C	
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	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	indicated no injurie not go to the hospit consciousness wern not documented. Titems of predisposi including equipmer marked. The form predisposing physicincluding a recent of weakness, infection only gait imbalance included 47 checklisituation factors included 47 checklisituation factors included and also to "other" and describ factors were check related to whether of were present and first to stand lift was R10's care plan. According to a program to a pr	ent initiated. The report is were observed and he did ital. No pain level, level of ite reported. Mental status was the form included 33 check list ing environmental factors, it issues, but nothing was crovided a checklist of 48 clogical factors to choose from change in condition, illness, in, various medications, but it was marked. The form st items of predisposing cluding footwear, use of whether assistance was being the opportunity to choose ie. No predisposing situation and including any information for not care plan interventions collowed, or why a mechanical used when not indicated on gress note dated 10/12/2021, redisciplinary team (IDT) found:	F 68	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	(X3) DATE SURVEY COMPLETED	
		245270	B. WING_			C / 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP OF 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 689	A request was mad summary for R10 for 9/23/21. Facility on radiology reports an physician progress diagnosis for hospifibula shaft commir initial right, and fract nondisplaced close sepsis was given the studies indicated a specimen collected detected antibodies on 9/27/21. Unknown present prior to hose the follow when a reside nurse was to assess review a possible of based on those find with additional help bed, or call for emerical pool of the follow when a reside nurse was to assess the fall, DON stated a rin "risk management which triggers posted ocumentation to be up-coming shifts. Don confirmed shore port, but had not incident. Although I the risk management was provided to the risk management was a summary to the risk management was management.	R10 cough syrup on several notation on his condition. The for the hospital discharge collowing his admission on the provided R10's hospital labs, and diagnoses list, but no notes. R10's principle tal admission was "fracture nuted nondisplaced closed cture tibia shaft comminuted and initial right." A diagnosis of the days after admission. Lab urinary tract infection with a 19/26/21. A viral panel is to respiratory syncytial virus with it either infection was spitalization. The review 10/14/21, 10:42 a.m. procedure for a nurse to ent falls. DON said first the is the resident for injury, ause of the incident, and dings, either use a Hoyer lift, to place the resident into orgency assistance up to and the hospital. Following the nurse is expected to document int" (incident report) in the EHR	F 68	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245270	B. WING _		10	C / 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIF 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	questions about the PN-A had tried to fi happened (root car appropriate interve it wasn't a fall, but considered a fall, but the management reporsistements from an best determine the completely fill out the best determine apprevent further incirisk management responsible to the fall; did to environmental fact a equipment and with include the names provided only a verifall and no other indiconfirmed the reportion and management in the provided and the reportion and Material factive February. The policy stated the prevention and manage any risk famanage as much a falling and/or sustated the policy statemerefers to unintention ground, floor or other sult of an overwhere.	e fall or his condition, or if gure out why the incident had use) to initiate any new and ntion. DON said, "(PN-A) said of course we know it is ut she said he looked fine." persons completing the risk of twere to get witness my staff who were present to cause of the fall, and were to the report so that the IDT could propriate interventions to dents, but DON confirmed the eport did not include any alluation of the R10's condition not contain information related actors or problems with the ess statements did not or titles of the staff, and y brief account of the actual formation or evaluation. DON rt did not contain evidence of rventions to provide for safety	F 68	39		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245270	B. WING			C / 18/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972	<u> 10/</u>	110/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUNDS OF THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	fall evaluation shou physical assessment witness statement renvironmental asset the fall, medication changes and any not the physician and reas an expectation. "upon initial review, assessment, nurse (1) any new interversions deterrappropriate. The poshould review the fadetermine the poter review updates to the additional revisions Dialysis CFR(s): 483.25(l) Dialysis. The facility must en require dialysis receivith professional stromprehensive per the residents' goals This REQUIREMENT by: Based on observator review, facility failed comprehensively most-treatment stab reviewed for dialysis evaluate R11's fluid	Id be completed including a not with vital signs, resident and regarding the fall, resement, contributing factors to changes, mental status are diagnoses. An update to responsible party was indicated investigation and to update the care plan as to retion put in place to try to realls, and (2) removal of any removal of the fall, and replan of care, and add as needed. Sure that residents who remove such services, consistent and and preferences. The following morning to removal of the fall, and replan of care plan, and and preferences. The following morning to removal of the fall, and replan of care plan, and and preferences. The following morning to removal of the fall, and replan of care, and add as needed.	F 6		per for each ily fluid	12/1/21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		PLETED
		245270	B. WING			10/1	C 1 8/2021
NAME OF	PROVIDER OR SUPPLIER	<u>.</u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	107	
\A/LITE\A	ATER HEALTH SER	/ICES		5	25 BLUFF AVENUE		
WHITEW	AIER HEALIH SER	VICES		S	ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	Findings include: According to R11's Admission Record following diagnose hypertensive chroric kidney discusses, depender on chronic diastolic hypertensive heart According to a mirrassessment dated have a 13/15 BIMS status) showing shatus) showing shatus) showing shat [site] every day related to dependent 11/07/2020 directed catheter site every or warmth and not symptoms present complete dialysis order for vital signs bath day, once we entered on 11/08/2 every day shift was order did not include the control of	s electronic health record (EHR) /diagnosis sheet, R11 has the es among other co-morbidities: nic kidney disease with stage 5 ease or end stage renal nce on renal dialysis and acute c (congestive) heart failure, and	F6	698	,	ector of 21 on colicy Defined and g for mplete idents s, User nitoring. iewed and any dules	
	liters per 24 hours Recommended bro AM/PM shifts, 240 instruct on when to	for Fluid restriction 1.5 to 2 was entered in the EHR. eakdown: 360cc/meal, 340cc cc at night. Order failed to b tally daily intake, or how to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245270	B. WING _		10	C / 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 698	liters daily, or how to the fluid restriction 8/23/21 the order was restriction 1.5 liters breakdown 240cc/r 180cc nights." The a daily total, assess A review of R11 tre (TAR) for August, S showed that nurses completed the Dialy review of the assess failed to show this fraction of the R11's fluid intake was totaled. No corresparelated to R11's intawas within her desi exceeded or had no amount. A review of showed a generally vacillations, except was 5.8 pounds high reweigh noted or of weight remained eldone, and 9/3/21 was pound from the 9/1 not documented. Of moved from the TA administration record documented 9/5/21 on the MAR was 19 day was 201 pound with no evidence of or report. On 9/12/2 the next day 203.6, documented on 9/1 October 2021 MAR	o decide if R11 had exceeded given the ordered range. On as updated to read "fluid per 24 hours. Recommended meal; 300 cc AM/PM shifts; order still failed to instruct on sment or report to be made. atment administration record beptember and October 2021 were documenting they had assist UDA tool; however, a sment portion of the EHR form had been completed. The same of the sent of the sen	F 69	8		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE S COMPL		PLETED		
		245270	B. WING				18/2021
	PROVIDER OR SUPPLIER	ICES		525	EET ADDRESS, CITY, STATE, ZIP CODE BLUFF AVENUE CHARLES, MN 55972	100	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 698	assessment. On 10 on 10/13/21 it was 2 on 10/13/21 it was 2 and only one Dialys found to have been between August and document did not in information except 9/13/21, two days psigns upon return. It documented includ According to an intestated she went to She said the facility she left for dialysis port site to make sure R11 also said staff monitoring how mushowed me she has felt the staff were whad to drink. She will fluid restriction. According to an intellicensed practical in assess a dialysis patemperature and obsending them to a control that information was LPN-B stated the factor of R11's "face sheet" consult sheet," but who would send information. LPN-B was upper the state of the state of R11's "face sheet" consult sheet," but who would send information. LPN-B was upper the state of R11's "face sheet" consult sheet," but who would send information.	out reweigh or other 0/12/21 weight was 196.8 and 202, an increase of 5.2 lbs. HR assessment list was done is Communication UDA was completed (date 9/15/21) d October of 2021. The nelude pre-treatment for a set of vital signs from orior, and the same set of vital No other information was ing a nurse signature. Perview 10/11/21, 3:43 p.m. R11 dialysis three times weekly. It is usually weighed her before and they were to check her are there were no problems. Were supposed to be chefluid she had to drink, and do soda cans in her room, but writing down how much she as unable to state her current erview 10/13/21, 12:10 p.m. a urse stated a nurse should attent's vital signs, including tygen saturation level before dialysis treatment, but stated is not sent with R11 to dialysis. Accility nurse would send a copy t'', medication list and a contact that dialysis was the ones ormation on R11's condition to unable to confirm that apht changes or fluid intake	F6	98			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245270	B. WING _		10	C / 18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 698	what to do with sign weight changes she physician orders. L notify a physician if to 5 pounds in a da a dialysis patient's access the venous assessed every shi swelling or leaking. During an interview director of nursing for nurses to monit to make sure the d were no signs of instate how often this stated an expectati dialysis patient's we three pounds in one physician by the nurses to document to amount consumprovided. The DON calculate what the foften went out of the because she was "consume what she know how much shoft the building; how R11 was their responding and they contain the amount total was overnight nurse and should be document according to the DO any dialysis patient.	inge 73 Ins of fluid overload, such as could be listed in a resident's PN-B said usually they were to a resident had a change of 3 y. LPN-B stated she believed cort (where dialysis would system) site should be fit for signs of redness, 10/13/21, 12:27 p.m. the (DON) stated an expectation for a dialysis patient's port site ressing was intact and there fection. DON was unable to should be done. DON also con for staff to be monitoring a eight and stated a change in the day should be reported to the rese working with that resident that an expectation for the R11's fluid intake, including the from what the kitchen it said they were able to facility offered R11, but R11 the building with family and ther own person" could wanted and they would not the had had when she was out rever, DON, confirmed that the considered and they were about her The documentation of the 24 the responsibility of the dany excess fluid intake and in a progress note DN. The DON confirmed that is considered at high risk for the risks include such things	F 69	8		

, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245270	B. WING				C / 18/2021
	PROVIDER OR SUPPLIER			525	EET ADDRESS, CITY, STATE, ZIP CODE BLUFF AVENUE CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 698	as pulmonary comunable to state any DON explained the EHR called the Discompleted prior to upon her return. Texpected assessment as the patients stability poon before treatment, and sent with R11 treatment. DON contained that the complete in the evidialysis with R11 ereturning to the face evening. DON state any nursing staff	applications, but DON was a additional complications. The se facility had a document in the alysis UDA that was to be R11 leaving for dialysis and the Dialysis UDA contains all the nents for monitoring a dialysis for to and after hemodialysis. Completing in the morning the form could be printed out when she went for her dialysis confirmed that the Dialysis UDA completed in R11's EHR, for completion had been as having been done. DON also order instructed nurses to rening and then to send to even though she was actually cility from dialysis in the ted the facility had not provided education specific to dialysis, assed the care of a dialysis	Fe	598			
	R11's physician ar (MD-A), complicat fluid overload whice conversely, proble electrolyte imbalar monitor R11's daily ensure stability. Fachanges could rescomplications. MD her blood pressure at least daily. MD-often the facility will blood-pressure but	terview 10/13/21, 1:15 p.m. with ad facility medical director ions of hemodialysis include the could result in heart failure or ms with dehydration and also ace. MD-A stated facility should y weights and intake of fluids to ailure to monitor or report out in a failure to identify 10-A also said R11 should have to monitored on a regular basis, A said she was unsure how as checking R11's to confirmed that once a week whate for a dialysis patient.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
		245270	B. WING _		10	C / 18/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 525 BLUFF AVENUE ST CHARLES, MN 55972		, 10, 202
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 698	Continued From pa	age 75	F 69	8		
	care of a dialysis p document titled He policy statement is designed and impli- strives to ensure the appropriate manag- resident regardless at the dialysis cent [facility] will utilize the UDA" for continuity and dialysis unit. Clinical responsibil assure daily asses fistula or graft site description of mon- post-dialysis (dry wonderer in the Dialysis each dialysis treaturesident and maint by Provider/dialysis not follow ordered resident/responsib- choice, document education and noti- center. Complete the electronic medical Further responsibil fluid restrictions as- center; manage sp dietary restrictions policy listed the fol- post-dialysis comp- but are not limited fatigue, signs/symp (low blood-pressur- electrolyte imbalant	de for a policy related to the atient. Facility provided a emodialysis dated 4/13/21. The as follows: The center has emented a process which he comfort, safety, and gement of a hemodialysis if the procedure is performed er or at the center. The center the "Dialysis Communication of care between the facility ities of the facility included: sment and documentation of (policy fails to include itoring of a port); document weight) obtained by the dialysis is Communication UDA afterment; monitor fluid status of ain fluid restriction as ordered as center. If resident chooses to fluid restrictions, educate le part on the risk of their this education and response to fluid restriction and dialysis he Risk vs Benefit UDA in the record. Ities listed include: manage ordered by provider/dialysis he cordered by provider/dialysis he cordered by provider/dialysis hecial dietary regime and as ordered. In addition, the lowing: assess and manage lications which may include, to, the following: bleeding, otoms of infection, hypotension e), chest pain, unsteady gait, ace, seizures, leg cramps, fluid adache. The policy instructs in				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	COMPLETED	
		245270	B. WING _		10/18/2021	
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION	
F 698	the use of the Dialy UDA for continuity of A request was made	sis Center Communication of care. e for a policy related to	F 69	98		
	<u> </u>		F 72	26	12/1/21	
	the appropriate con provide nursing and resident safety and practicable physica well-being of each resident assessme and considering the diagnoses of the fa	ervices live sufficient nursing staff with inpetencies and skills sets to direlated services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by ints and individual plans of care is number, acuity and cility's resident population in in a facility assessment required				
	licensed nurses had and skill sets neces needs, as identified	facility must ensure that we the specific competencies sary to care for residents' through resident described in the plan of care.				
	limited to assessing	iding care includes but is not g, evaluating, planning and ent care plans and responding				
	to demonstrate con	sure that nurse aides are able npetency in skills and ary to care for residents'				

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING C (X3) DATE S COMPLI		PLETED			
		245270	B. WING			C 18/2021
NAME OF F	PROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE	1 .0/	
WHITEW	ATER HEALTH SERV	ICES		525 BLUFF AVENUE		
VVIII EVV	AIER NEALIN SERV	ICES		ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 726	assessments, and	described in the plan of care.	F 726	3		
	by: Based on interview	NT is not met as evidenced v and document review, the		Facility residents have the potent	ial to be	
	unlicensed practica	ure a newly graduated, il nurse (PN-A) received ind demonstrated competency		affected. Current staff to have competency		
	changes in condition	ntifying and responding to on, and documenting resident		checkoff complete per policy annu	,	
	of care specifically resident (R10) suffe fractured fibula/tibia	ursing response for continuity related to falls and injury. A ered a fall resulting in a without a knowledgeable or st-fall by (PN-A). This lack of		Director of Nursing/Designee to ca a competency checklist for license certified staff per policy on hire an annually.	ed and	
	competency training	g and assessment had the li 34 residents in the facility.		Interdisciplinary team educated by Director of Clinical Services startii 11/12/21 to the MN Board of Nurs	ng on	
	Findings include:			license requirements, the Employ orientation policy and procedure a	and the	
	the facility, PN-A re orientation on 8/10/	tion documents provided by ceived general employee (2021. Eighteen general topics		annual competency check off poli procedure.	cy and	
	hour period. A com was completed and to understanding fa	pics were covered in an 8 petency test for hand hygiene I a post-test for all staff related ills and infection control were elated to compliance was		Executive Director/Designee to au hire documentation weekly as new are hired and annually for comple reviews.	v staff	
	completed, but no e test-outs for any sp on that date or any	evidence of competency ecific nursing skills completed other date were provided. N-A completed a half hour		The results of the audits will be re by the QAPI committee for trends needs for adjustment of audit schor content, as well as any further educational needs. The Executive	and any edules	
	documentation 9/9/ college transcript si completed 14 didac totaling only 24 cree process, disease ki documentation. Fac	loudie on general (2021. Facility provided PN-A's howing that PN-A had etic and 10 clinical credit hours, dit hours specific to nursing nowledge, patient care and cility was unable to provide no license for PN-A.		Director is responsible to ensure t action occurs.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 525 BLUFF AVENUE ST CHARLES, MN 55972		110/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 726	According to docur health record (EHF 9/23/21, 6:54 a.m. (RN-B) writing the the evening nurse to the floor while transport of the floor was R10's condition and morning, notifying previous note was R10's condition or the incident on 9/22/responsible for R10 were found docum incident on 9/22/21 According to a doc related to the 9/22/by the director of nurse responsible did not document in the floor of the	mentation in R10's electronic R), a progress note dated indicated the registered nurse note, had received report from [PN-A] that R10 was "lowered ying to get into bed" [9/22/21]. 10's lower right leg was rotated len and bruised, and R10 was nificant pain. The progress note sessed and responded to d sent him to the hospital in the family and physician. No found in R10's EHR describing cares provided prior to or after 2/21 during the time PN-A was 0's care. No vital signs for R10 ented by PN-A following the	F 72	26			
	and of predisposing gait imbalance was According to an int DON explained the follow when a residurse was to assess review a possible obased on those find	erview 10/14/21, 10:42 a.m. er procedure for a nurse to dent falls. DON said first the set the resident for injury, cause of the incident, and dings, either use a Hoyer lift or, to place the resident into					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l \	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP OF 525 BLUFF AVENUE ST CHARLES, MN 55972		110,2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 726	including transfer to fall, DON stated a rin "risk manageme which triggers post documentation to bup-coming shifts. Done this, nor had lathough DON had incident report, DOPN-A had asked Ror his condition, or why the incident hainitiate any new and DON said, "(PN-A) course we know it is said he looked fine. During the 10/14/2 said PN-A had star confirmed the facili PN-A's nursing lice have one as of 10/12 check list of skills through with a new orientation shifts, bof skills tests. DON orientation would scomfortable with the were competent or A request was mad skills checklist, but this document. According to a pho 10/14/21, 2:03 p.m college in May of 2 a nurse before. PN	o the hospital. Following the nurse is expected to document nt" (incident report) in the EHR fall observation be done by nurses on the DON confirmed PN-A had not PN-A written a progress note. Initiated the risk management N was unable to state whether 10 any questions about the fall if PN-A had tried to figure out and happened (root cause) to diappropriate intervention. It is considered a fall, but of its considered a fall, but of its considered a fall, but she it. 1, 10:42 a.m. interview, DON the did not have a copy of the upon hire, and did not have a copy of the upon hire, and did not hat a nurse trainer would go by hired nurse during ut they did not have any type is stated the nurse providing the e skill, and then mark if they	F 72	26			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245270	B. WING	B. WING		C 10/18/2021	
NAME OF F	PROVIDER OR SUPPLIER	240270			TREET ADDRESS, CITY, STATE, ZIP CODE	10/	10/2021
WHITEW	ATER HEALTH SERV	ICES		52	25 BLUFF AVENUE T CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	facility there was a start work before shad confirmed this with Nursing. PN-A said of items she would day of orientation, kist of nursing skills employees. PN-A sany testing by the facompetency level. If four or five shifts for asked if she felt reashe needed further provide specifics, be shifts where she see ask questions because what her job require had been instructed questions, but said respond to phone of questions about would look at the bandage. "try to make it look suffered his fall on working at that time she had to respond unable to describe nursing school about fallen. PN-A said he from when she was an assessment should including a set of vidocument findings physician. PN-A cora progress note (not she thought she mat Tylenol for pain bed	ge 80 PN-A said she was told by the waiver, and she was able to be was licensed. She had not the Minnesota Board of she had received a checklist be trained on during her first but said this did not include a but rather was a list for all aid she had not undergone acility to determine her PN-A said she had received rorientation, but had not been ady to work independently, or if training. PN-A was unable to ut stated there were some and a text to the physician to buse she felt she did not know and at that time. PN-A said she had the DON did not always halls. PN-A said she had asked bund care and was told to just a laready on the wound and the same." When R10 Pl/22/21, PN-A stated she was a nurse. PN-A was what she had learned in the what to do if a resident had be experience with falls was a nursing assistant, but said buld be done by the nurse, tal signs, the nurse should and notify the DON and the land not recall if she had written to progress note was found); and have given R10 some cause he complained of pain not localize the pain. PN-A	F 7	726			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION NG		C C	
		245270	B. WING		10	/18/2021
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972		710/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 726	said she had called paperwork she had her she did not have was "lowered to the asked if she needed the DON said she said "I found out the and I felt horrible, a do." PN-A said she over-night nurse had did not have to do a According to an interest RN-A said she ofter with the newly hired not any hand-outs information that she nurse should have check-list mostly conditions, but RN-A or competency check administration. A bic common emergency stations, but RN-A or competency check according to an interest executive Director important for a faci Part of competence received proper transportant for a faci Part of competence received proper transportant for a faci Part of competence received proper transportant for a faci Part of competence received proper transportant for a faci Part of competence of staff be executive Director in the proper transportant for a faci Part of competence of staff be executive Director staff be executive Director staff be executive Director staff be executive Director staff and not been brought and staff and expedience and exped	If the DON and asked what I to do, but said the DON told be to do anything because R10 of floor" and did not fall. PN-A of to call the physician, but said would take care of it." PN-A of e next day things were worse and asked what I needed to was told by the DON that the ad charted everything, and she anything else. The participates in orientation of nurses. RN-A said there were or written orientation of was aware of, but said a new a check-list. RN-A said the	F 72	26		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION (2	(X3) DATE SURVEY COMPLETED C	
		245270	B. WING		10/18/2021	
	PROVIDER OR SUPPLIER	ICES	5	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
	he stated the DON competency progra had been accomplication been accomplication by the care they result the care they the care they as a second to the care they are the care the care they are they are the care they are the care they are the care they are they are the care they are they are the care they are they are they are they are the care they are the care they are the are they are t	was responsible to develop a m, but he did not believe this shed yet. The Executive oncern that residents may not quire if the facility employed staff who's competence had nined. Error Rts 5 Prcnt or More) on Errors. sure that its- cation error rates are not 5 NT is not met as evidenced ion, interview and record ailed to be free from the of 5 percent or greater servations of 26 medications sident R24) which resulted in	F 726	R24 orders in electronic charting sysupdated to read, "may crush medical and give individually via G-tube." Facility residents with enteral tube medications have the potential to be affected. Licensed staff educated by the Direction of the control of the cont	tions	
	was observed and (RN)-A. RN-A was of following five medic 40 mg 1 tab daily via g-tub every 6 hours via g-tab twice a day via daily via g-tube. RN together and placed the following two m	0 a.m. R24's medication pass completed by registered nurse observed to set up the cations including: atorvastatin a g-tube, vitamin D3 1000 unit e, hydralyzine 25 mg 1 tab-tube, levetiracetam 750 mg 1 g-tube, lisinopril 10 mg 1 tab l-A crushed all five meds d in a plastic cup then set up edications in a separate cup: daily via g-tube and docusate		Clinical Services starting on 11/12/21 the Enteral Tube Medication Administration policy and procedures Director of Nursing/Designee to comrandom med pass audits on all shifts including enteral tube med administration weekly for 8 weeks. The results of the audits will be reviebly the QAPI committee for trends an needs for adjustment of audit scheduling.	to s. plete sation wed d any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
		245270	B. WING _		10	C 10/18/2021	
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP 525 BLUFF AVENUE ST CHARLES, MN 55972		710/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 759	50 mg/5 ml 5 ml da cc of water to each 30 cc of water, adm medications, flushe administered secon cc of water and finitude administered secon cc of water and finitude administered with a.m. RN-A stated the meds had to be given medications were go Potassium, that is go On 10/13/21, at 9:0 was conducted with combining medicate administration is he R24's medications, given separate. On 10/13/21, at 12:0 (DON) was asked in G-Tubes and DON done since this DO ago. During a follow-up p.m. DON verified to administering medication was to flush in between ear what could happen together DON state not be compatible."	illy via g-tube. RN-A added 60 cup, flushed R24's g-tube with inistered first cup of crushed with with 30 cc of water then ad cup of medications with 120 shed with 30 cc water flush. Ith RN-A on 10/13/21, at 8:10 here was no order stating the en separately therefore all given together except for given separately. It a.m. a follow-up interview in RN-A. RN-A stated ions together for g-tube low RN-A has always given except potassium was to be 20 p.m. the director of nursing if staff were trained on stated there was no education N was hired a year and a half interview on 10/13/21, at 2:03 the expectation for cations via G-Tube was each be given individually with a lich medication. When asked if medications were given all ed, "Many things, meds may Medication Administration	F 75	or content, as well as any educational needs. The Exportance of action occurs.	xecutive		
	dated June 2017 di administer medicat	d not address how to ions via G-Tube. Facility policy onal Therapy (Tube Feeding)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245270	B. WING		C 10/18/2021	
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
F 759 F 761 SS=D	dated June 2017 al administer medicat Label/Store Drugs at CFR(s): 483.45(g)(§483.45(g) Labeling Drugs and biological labeled in accordar professional princip appropriate access instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In acceptant laws, the fabiologicals in locked temperature contropersonnel to have a §483.45(h)(2) The locked, permanentl storage of controlle the Comprehensive Control Act of 1976 abuse, except when package drug distriquantity stored is more presented.	so did not address how to ions via G-Tube. and Biologicals h)(1)(2) g of Drugs and Biologicals als used in the facility must be nee with currently accepted oles, and include the ory and cautionary e expiration date when s of Drugs and Biologicals cordance with State and acility must store all drugs and docompartments under proper ls, and permit only authorized access to the keys. facility must provide separately y affixed compartments for d drugs listed in Schedule II of a Drug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the minimal and a missing dose can	F 759		12/1/21	
	by: Based on observative review the facility faproperly labeled to use date and avoid medications after b	tion, interview, and document ailed to ensure inhalers were allow staff to identify a beyond administration of inhalant eyond use date for 3 of 3 9 and R184) reviewed for safe		R13, R19, R184 medication labele appropriately. Facility residents have the potential affected.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245270	B. WING_			C 18/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 525 BLUFF AVENUE ST CHARLES, MN 55972		10/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	to dispose of expir medication carts a rooms. Findings include: On 10/12/21, at 9:3 medication cart wa Nurse (RN)-A pressound: R13's open Flove indicate when it was R19's open Spirit found with no date R184's open Albuto indicate when it A stock bottle of the expiration date of 0. During an interview director of nursing nurses open a new pen they should laid date open. On 10/15/2021 at room was observe (DON) present and 8 boxes of stock expired in 07/2021 at 1 box of Tylenol sthat expired 08/202	e. Additionally, the facility failed ed medications in 1 of 1 and 1 of 11 medication storage 36 a.m. the 300 Wing as observed with Registered tent and the following was ent inhaler found with no date to as opened. 24 inhaler and Albuterol inhaler to to indicate when opened. 25 iterol inhaler found with no date was opened. 26 ish oil was found with an 107/2021. 27 on 10/15/21, at 1:44 p.m. the (DON) stated that when winhaler, eye drop or insuling the medication with the 11:34 P.M., facility med storage d with Director of Nursing d the following was found: 26 cerumen ear drops found that a suppositories prescribed to R8 21.	F 76	Medication storage room and audited for any opened med without a date opened label resident name present on 10 medications found without or were disposed of. NOC shift nurse to complete checking of the medication of storage room with sign off or sheet. Nursing staff to check items label, etc. throughout med particularly pharmacy reviews to Clinical Services starting on the Medication storage, labe expiration information and tip Medication expiration dates and the Medication storage procedures. Director of Nursing/Designer NOC shift checkoff sheet we completion for 8 weeks. Licensed staff educated to the storage, labeling, and expiration dates education, Nadministration policy and promedication storage policy and Medication storage policy and	ications present or b/18/21. Any brrect labeling weekly earts and checkoff for date, ass. continue. he director of 11/12/21 to ling, and be education, education, colicy and the to audit eakly for the Medication bron, Medication brondedication brocedures and d procedures.	
	DON stated that w	v on 10/15/21 at 1:44 P.M., the hen nurses open a new f insulin pen they should label		The results of the audits will by the QAPI committee for to needs for adjustment of aud	ends and any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ′	(X3) DATE SURVEY COMPLETED	
		245270	B. WING			C 10/18/2021	
	PROVIDER OR SUPPLIER ATER HEALTH SERV	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		.0.202	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 761	verified the boxes of expired and should Facility policy titled dated June 2017, in date a bottle or come as well as to return medications promp Staff Qualifications CFR(s): 483.70(f)(1) S483.70(f)(1) The facility full-time, part-time of professionals necesprovisions of these \$483.70(f)(2) Profecertified, or register applicable State law This REQUIREMENT	the date open. The DON also of cerumen ear drops were have been disposed. Medication Administration, adicated on page 4 to record tainer is opened on the label, expired or outdated tly to the pharmacy. (2) alifications. acility must employ on a per consultant basis those essary to carry out the requirements. ssional staff must be licensed, ed in accordance with	F 76	or content, as well as any further educational needs. The Execut Director is responsible to ensuraction occurs.	ive	12/1/21	
	facility failed to ens (PN)-A and 1 of 3 li	v and document review, the ure 1 of 1 practicing nurse censed practical nurse was licensed by the State to		PN-A removed from schedule background check completed a license obtained. PN-C license obtained.			
	LPN-C stated PN-A did not have licensed licensed practical n let me work as a licensed licens	on 10/11/21, at 7:01 p.m. had passed her boards but yet and was working as a urse. LPN-C stated, "they also ensed practical nurse for a was assigned a license		Facility residents have the pote affected. Audit of current employees to vertification documentation con 10/17/21 Employees will have on file cur	erify d nplete		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		245270	B. WING			18/2021	
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP 525 BLUFF AVENUE ST CHARLES, MN 55972			
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F 839	Practical Nurse (Practical Nurse) was reviewed. The hire date of 8/10/21 revealed PN-A did nursing in the state. During an interview the business office timecard was revie and revealed PN-A licensed practical ricense 28 times. To during her interview start before her lice she was told yes. The BOM stated Nursing (DON) thouse temporary license, The BOM stated she copy of a temporar thought it was like at that when they past to go. The BOM stated she was undernead the BOM stated she was unde	N)-A's employee personal file record indicated an original I. The personal file review not have a license to practice	F 839	validated license informatic credential documentation with residents. Interdisciplinary team educe Director of Clinical Services 11/12/21 on the new hire particles of Minnesota regulatineed to verify license/certic working with residents. Executive Director/Design new hires for 8 weeks for documentation. Audit track developed. The results of the audits we by the QAPI committee for needs for adjustment of all or content, as well as any educational needs. The Exportation occurs.	prior to working cated by the es starting on colicy and the cions and the fication prior to ee will audit complete king tool vill be reviewed r trends and any udit schedules further xecutive		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245270	B. WING				C 18/2021
	PROVIDER OR SUPPLIER			52	REET ADDRESS, CITY, STATE, ZIP CODE 5 BLUFF AVENUE 1 CHARLES, MN 55972	10/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 839	aware she did not there was a waiver a new graduate nuby the DON it took pass her boards a waiver. PN-A State executive director have a valid licens practical nurse. Phe manipulated and to be state of 2/15 nurse. LPN-A's per Minnesota LPN lice However, between did not have a lice state of Minnesota During an interview the business office February of 2021, was hired back on nurse (LPN) as she BOM stated LPN-03/17/21. During a sam. LPN-C's time 2/15/21 to 3/17/21 worked in the facil without supervision During an interview executive director facility had an unlike building. The executive director facility had an unlike building.	hire they (DON and BOM) were have her license and stated that she could work under as irse. PN-A stated she was told LPN-C it took three times to ad LPN-C had worked under a ed I was suspended by the on Monday because I do not e to work as a licensed I-A stated she felt like she was aken advantage off. nurse (LPN)-C's employee eviewed. The record indicated I/21 as a licensed practical resonnel record indicated a ense was issued on 3/17/21.	F8	339			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG	COM	COMPLETED	
		245270	B. WING _		C 10/18/2021	
	PROVIDER OR SUPPLIER	ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		10/2021
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F 839	license in the perso Minnesota Board of executive director s the loop if the DON	ge 89 In and to check the found file and to check the foursing registry. The stated he would want to be in and BOM were hiring a staff abnormal circumstances	F 83	39		
	where the staff mer executive director s checks should be k	mber was not licensed yet. The tated a copy of background ept in employee personal files				
	included, "1. Prospet Valid license and/or application when a required as set forth2. Licensure Desi applicable state lice the prospective emilicense and/pr certif standing and applic	ns policy dated July 2018 ective employees must have a certification along with job license or certification is n in the current job description gnee must check with all ensing board(s) to confirm that ployee possesses a valid fication that is in good able to the position."	F 94	17		12/1/21
	aides. In-service training n §483.95(g)(1) Be su	d in-service training for nurse nust- ufficient to ensure the ence of nurse aides, but must				
	§483.95(g)(2) Include training and resider §483.95(g)(3) Addressed to the second secon					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ′сом	(X3) DATE SURVEY COMPLETED C	
		245270	B. WING_			10/18/2021	
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	(X5) COMPLETION DATE		
F 947	determined by the five states of the same states of	acility staff. Surse aides providing services ognitive impairments, also of the cognitively impaired. NT is not met as evidenced of and document review, the cure annual performance fucted for 5 of 5 nursing fala-B, NA-C, and NA-D) whose overe reviewed. 5/18/2019. NA-A's employee mentation of annual fations. 10/4/2019. NA-C's employee mentation of annual fations. 10/4/2013. NA-D's record from fannual performance falast performance evaluation of annual falast	F 94	Performance evaluations current staff. Facility residents have the affected. Performance evaluations completed annually for lice certified staff. Interdisciplinary team edu Director of Clinical Service 11/12/21 on performance requirements per policy. Executive Director/Design performance evaluation of annually. The results of the audits by the QAPI committee for needs for adjustment of a or content, as well as any educational needs. The Endirector is responsible to action occurs.	e potential to be will be censed and ucated by the ces starting on e evaluation nee will audit completion will be reviewed or trends and any audit schedules y further Executive		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 947	reviews were support December 2020. The Caught up on performance evaluating the requested from the not get to them." The performance evaluating the requested staff started managing the During an interview executive directors calendar year, North complete performant to include strengths for growth. The executive director includes the performant of the assumption of last year like the stated he was not at A policy and process.	osed to be completed by the DON stated they were not rmance reviews, "We did not any of the five staff members survey team and we just did the DON stated no ations had been completed for since 2017 when Northshore	F 9	47			

F5270031

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

PRINTED: 12/06/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED			
	245270		B. WING			10/12/2021		
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES				52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BLUFF AVENUE T CHARLES, MN 55972		-	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	OULD BE COMPLÉTIC		
K 000	INITIAL COMMENT	-S	K 0	00				
	conducted by the M	ty recertification survey was innesota Department of						
	10/12/2021. At the WHITEWATER HE not in compliance w participation in Med Subpart 483.70(a), 2012 edition of Nati Association (NFPA) Chapter 19 Existing	ALTH SERVICES was found with the requirements for icare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection 101, Life Safety Code (LSC), Health Care and the 2012						
	THE FACILITY'S PO ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	Health Care Facilities Code. OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.						
	ONSITE REVISIT (CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.						
	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	R THE FIRE SAFETY						
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION).						
ABORATOR)	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE	

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

Electronically Signed

11/19/2021

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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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245270 B. WING 10/12/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **525 BLUFF AVENUE** WHITEWATER HEALTH SERVICES ST CHARLES, MN 55972 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 000 | Continued From page 1 K 000 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. WHITEWATER HEALTH SERVICES is a 1 story building with partial basements. The building was constructed at 2 different times. The original building was constructed in 1967 and is a 1 structure with partial basement and was determined to be Type II (111) construction. In 1969 a 1 story addition with partial basement was constructed and determined to be of Type II (111) construction.

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245270		245270	B. WING		10/12/2021		
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES				52	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BLUFF AVENUE T CHARLES, MN 55972		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 926	Continued From page 11 An interview with the Director of Nursing verified this deficient finding at the time of discovery.		KS	K 926 action occurs.			