Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 15, 2023

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

RE: CCN: 245270
Cycle Start Date: July 20, 2023

Dear Administrator:

On September 8, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

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August 15, 2023

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

RE: CCN: 245270
Cycle Start Date: July 20, 2023

Dear Administrator:

On July 20, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 20, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 20, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / 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 electronic 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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 7/17/23 through 7/20/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		

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

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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E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may	E 041		

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E 041	Continued From page 2 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

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E 041	Continued From page 3 Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.4.1, 8.4.2, 8.4.9, 8.5.9.5, 8.4.9.6, 8.4.9.7. This deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the generator is achieving 30% loading, and not required to implement annual load-bank testing. 2. On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that 36 month - 4 hour load bank testing in occurring. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	E 041		
F 000	INITIAL COMMENTS On 07/17/23 through 07/20/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		

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F 000	Continued From page 4 In addition to the recertification survey, the following complaints were reviewed: The following complaints were reviewed with no deficiency issued: H52703602C (MN94172), H52703603C (MN94095), H5270038C (M,N78502), AND H5270039C (MN79855) The following complaint was reviewed: H52703604C (MN83678) with a deficiency issued at F623. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or	F 623		

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F 623	Continued From page 5 discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email),	F 623		

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F 623	Continued From page 6 and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of	F 623		

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F 623	Continued From page 7 the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure written notice was sent to the resident and/or the resident's representatives after emergent transfer from the facility to the hospital for two residents (R185, R11) who were reviewed for hospitalization. Neither R185 and R11 were provided a written transfer notice, nor was R185's representative provided a bed hold notice. The failure to provide the required written notices, containing all required information, places the residents at risk of involuntary transfer, and/or not being informed of their rights, including how to appeal, their transfer. Findings include: R185's electronic medical record (EMR) indicated the resident was admitted to the facility on 04/13/22. R185's Progress Notes dated 05/12/22, indicated the resident was sent to the local hospital to be evaluated and treated due to a change in his medical condition. R185's untitled document, referred to as a "bed hold notice", dated 05/12/22, indicated the resident was willing to pay privately to hold his bed during his emergency treatment while at the facility. A review of R185's clinical record was conducted and there was no evidence the facility provided	F 623		

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F 623	Continued From page 8 the resident with a transfer notice which contained appeal rights. There was no evidence the resident's representative was provided written transfer or bed hold notices. During an interview on 07/18/23 at 10:45 a.m., Administrator A stated the facility did not send a transfer notice to R185 nor to his representative. During an interview on 07/18/23 at 3:13 p.m., R185's representative stated he did not receive a written transfer notice, or a bed hold notice at the time of the resident's transfer. R11's annual Minimum Data Set (MDS) dated 07/19/23, indicated an admission date of 08/26/21. R11's 05/10/23 General Note revealed "ER [emergency room] transfer: resident left facility with [hospital name] non-emergent ambulance at 11:51 a.m. to be assessed at [hospital name] ER for gallbladder sx [symptoms]. Order was given by [MD F] for transfer. Sister, [name], was updated and gave OK for bed hold. R11's 05/10/23 "Communication with the Emergency Dept of the hospital" note indicated "Resident returned around 1730 [5:30 PM]." R11's chart revealed no evidence a hospital transfer notice was provided to the resident or the resident's representative. During an interview on 07/19/23 at 10:51 a.m., the Vice President of Success G was asked if R11 was provided a transfer notice. Vice President of Success reviewed the EMR and stated the facility would not have provided notice	F 623		

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F 623	Continued From page 9 of transfer because R11 came back the same day. Review of a policy provided by the facility titled "Transfer and Discharge" dated 07/15/22 indicated ". . .Emergency Transfers/Discharges...initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident...Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer. . .Provide transfer notice as soon as practicable to resident and representative..."	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure 1 out of 15 residents (R22) had an accurate "Minimum Data Set (MDS)" assessment. Failure to code the "MDS" correctly could potentially lead to inaccurate federal reimbursements and inaccurate assessment and care planning of the resident. Findings include: R22's electronic medical record (EMR) indicated the resident was admitted to the facility on 10/20/21.	F 641		

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F 641	Continued From page 10 R22's physician orders dated 09/13/22, indicated Seroquel (an antipsychotic) 50 milligrams (mg) to be administered at bedtime due to dementia with behaviors. R22's "Encounter" note dated 03/14/23, indicated the primary doctor attempted a gradual dose reduction (GDR) from Seroquel 50 mg to be administered at bedtime to Seroquel 25 mg to be administered at bedtime and then Seroquel 25 mg PRN (as needed) during the day. The GDR was not successful. The resident had an increase in behaviors. R22's "Encounter" note dated 04/04/23, indicated the primary doctor attempted a GDR of the Seroquel, but it was not successful since the clinical notes revealed the resident was yelling in the evening and then overnight, all night long. In addition, it was noted the resident yelled out 50 times during a shift. The physician's progress note revealed an increase of Seroquel to 50 mg at bedtime. R22's quarterly Minimum Data Set (MDS) dated 05/22/23, indicated the resident had a "Brief Interview for Mental Status (BIMS) score of five out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident was administered an antipsychotic medication seven times during this assessment period. The assessment revealed the resident did not have a GDR nor did the physician provide a clinical rationale if the GDR was contraindicated. During an interview on 07/19/23 at 10:41 a.m., the Vice President of Success G stated accuracy was the goal with the MDS.	F 641		

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F 641	Continued From page 11 During an interview on 07/20/23 09:18 a.m., the MDS Coordinator E confirmed that she missed the GDR and confirmed the error. Review of the RAI Manual, dated 10/01/19, indicated, ". . . It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT (Interdisciplinary Team) completing the assessment. . ."	F 641		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 676		

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F 676	Continued From page 12 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide appropriate adaptive equipment as directed by the resident's care plan and Occupational Therapy (OT)-K recommendation, to prevent potential weight loss for 1 of 3 residents (R28) reviewed for nutrition. Findings include: R28's electronic medical record (EMR) indicated admission on 09/19/22 with a diagnosis of cerebral infarction (stroke). R28's quarterly Minimum Data Set (MDS) dated 05/20/23, indicated a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident required supervision with one person to assist. The assessment indicated the resident had an impairment with his upper extremity which included shoulder, arm, and his hand. The	F 676		

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F 676	Continued From page 13 assessment indicated the resident had no weight loss identified during this assessment period. R28's care plan dated 09/27/22, indicated at risk for decreased oral intake due to diagnoses of dysphasia and dementia. An intervention dated 09/29/22, revealed to provide the resident with a spoon only (no knives or forks) due to the utensils being a distraction. R28's EMR Kardex (a care plan for nursing assistants) undated, indicated the resident was to have a spoon only and a fork and knife were not to be set on his meal trays due to them being a potential distraction. R28's EMR nutritional/dietary progress note dated 04/23/23, indicated the resident was at risk nutritionally and was to have a spoon available during mealtimes. The progress note stated no fork or knife was to be present during mealtimes since it was a distraction for the resident. R28's meal ticket undated, indicated R28 was to be provided a spoon only and not a fork or knife since it was distracting. During an observation on 07/17/23 at 5:49 p.m., R28 had his meal plate delivered to him. The plate had chopped broccoli stir fry and a cup of pureed rice. In addition, the resident was served a cup of applesauce. There was a knife, fork and spoon next to his plate. The resident opened the cup of applesauce and then stuck his tongue in the cup to retrieve the applesauce. The resident was then observed picking up a cup of pureed rice and again stuck his tongue in the container. A random staff member approached the resident and handed him a spoon. The resident began to	F 676		

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F 676	Continued From page 14 eat the remaining part of his dinner meal with the spoon. The resident ate approximately 50 percent (%) During an observation on 07/18/23 at 8:12 a.m., R28 was observed sitting at a dining room table. The resident was served hot cereal and scrambled eggs with cheese. R28 was observed to pick up a spoon and began to eat. At 8:45 a.m., the resident left the area. At 9:04 a.m., the resident returned to the dining room. The resident then picked up his fork and attempted to take a bite of his scrambled eggs. The resident was not successful in getting a bite of scrambled eggs into his mouth. The resident left the table at 9:07 a.m. There was approximately 75% of his eggs on his plate. During an observation on 07/19/23 at 7:57 a.m., R28 was observed to be taken to the dining room by staff. At 8:29 a.m., the resident was served hot cereal and pancakes. A random staff took a fork and knife to cut up the resident's pancakes into smaller pieces. The fork was left on the plate and the knife was on the right-hand side of his place setting. The resident was observed to eat his hot cereal with a spoon. The resident was observed to pick up pieces of pancake with his fingers and fed himself. During an interview on 07/19/23 at 12:30 p.m., the Dietary Manager (DM)-H stated all the silverware was pre-rolled prior to serving. She had never seen an order on a meal ticket like this before and was attempting a solution. During an interview on 07/20/23 at 8:48 a.m., Registered Dietician (RD)-I stated R28 required the use of the spoon only and no other eating	F 676		

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F 676	Continued From page 15 utensils since it was a possible distraction. RD-I stated the referral for the use of the spoon only on his meal tray came from OT. RD-I stated the resident was at risk for weight loss. During an interview on 07/2023 at 9:51 a.m., OT-K stated R28 used to be on a pureed diet and previously used a bowl to eat from. OT-K stated it was in April 2023 that RD-I contacted her and asked for a referral on the resident to use a spoon only. OT-K stated there was not a paper referral. OT-K stated she confirmed the use of a spoon only since having the other eating utensils were too distracting for the resident to have around. OT-K stated the resident would use a knife as a spoon in an attempt to get food in his mouth. Review of a policy provided by the facility titled "Assistive Devices" dated 09/17 indicated ". . .Assistive devices/utensils will be provided as identified in the individualized plan of care to main or improve a resident's/patient's ability to eat or drink independently. . .The assistive device/utensil requests will be entered into the individual resident profile in the menu management system for provisions with each meal and snack. . ."	F 676		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under	F 727		

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F 727	Continued From page 16 paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to use the services of a registered nurse (RN) for at least eight consecutive hours a day. This deficient practice had the potential to affect all 34 residents residing in the facility. Findings include: Review of the facility's Assessment dated 01/31/23, revealed "Federal law requires nursing homes to have sufficient staff to meet the needs of residents, to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week." Review of the 02/04/23 through 07/17/23 nursing schedule, revealed an RN was not scheduled in the facility on 07/16/23. During an interview 07/19/23 at 9:05 a.m., the Administrator confirmed there was no RN working on 07/16/23. In a later interview at 2:25 p.m., the Administrator stated the census for 07/16/23 was 34. Review of the facility's policy titled, "Nursing Services-Registered Nurse (RN)," dated 07/22/22, revealed "1. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week."	F 727		

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F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the menus for a renal diet and provide adequate protein substitute for eggs for 2 of 3 residents (R11, R15) reviewed for menus. Findings include: R11's annual Minimum Data Set (MDS) dated	F 803		

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F 803	Continued From page 18 07/19/23, revealed an admission date of 08/26/21. R11 had diagnoses of type 2 diabetes mellitus with other diabetic kidney complications and renal insufficiency, renal failure, or end-stage renal disease (ESRD). R11's orders dated 12/20/22, indicated a "Renal diet, Regular texture, Regular/Thin consistency." R11's 06/13/23 care plan indicated "Obesity (class 3) r/t [related to] greater energy input vs output AEB [as evidenced by] BMI [Body Mass Index] of 47.6 as of 6/17/23 and need for regular nutrition intake monitoring." An intervention included "Provide diet as ordered." R11's nutrition assessment dated 6/20/23, indicated "Renal diet w/ [with] Regular textures & [and] Reg [Regular] consistencies." The facility's food vendor's diet guide, dated 05/2023, under the renal diet section indicated "The diet is high in protein with limited potassium..." "The average sodium or potassium amount in the [menu] cycle (35 days) does not exceed 2000 mg (+/- 200 mg) per day." Review of the potassium food postings from the kitchen, provided by the Dietary Manager (DM) H, revealed tomato paste, potatoes, and soy sauce were high in potassium. Review of the 07/18/23 Renal diet lunch menu revealed "Pork Chop, pasta, corn, dinner roll, and gelatin." On 07/18/23 at 12:23 p.m., R11 was served lunch that included pork chops, mashed potatoes with gravy, corn, and a dinner roll. Review of R11's	F 803		

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F 803	Continued From page 19 07/18/23 lunch tray ticket revealed pork chop, pasta, corn, and a dinner roll. Review of the 07/19/23 Renal diet lunch menu revealed "Beef Tips Au Jus, green peas, noodles, and a dinner roll." The tray line was observed on 07/19/23 at 11:51 a.m.. The food items included beef stroganoff, mechanical soft beef stroganoff, pureed beef stroganoff, peas, pureed peas, pasta, mashed potatoes, rolls, fruit, pureed fruit, pound cake, and pureed pound cake. During an interview on 07/19/23 at 11:52 a.m., the Dietary Aide (DA)-A was asked if there were any residents with special diets. DA-A stated "yes, cardiac and renal but the food wasn't different today and everyone was served the same." DA-A went on to say, "some days it's different." The DM-H was present and picked up two meal tickets, one for a cardiac diet that revealed "beef stroganoff" to be served and a renal diet that revealed "beef tips Au Jus" was to be served. DM-H asked what the difference was between beef stroganoff and beef tips Au Jus. DM-A answered, "not much so they both get the same." On 07/19/23 at 12:28 p.m., R11 was served lunch that included Beef Stroganoff with pasta, green peas, roll, and fruit. Review of R11's 07/19/23 lunch tray ticket revealed "Beef Tips Au Jus, green peas, noodles, and a dinner roll." Review of the 07/19/23 lunch entrée recipes revealed: Beef Stroganoff included beef, black pepper, onions, beef stock, canned tomato paste, Worcestershire Sauce, flour, sour cream, and	F 803		

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F 803	Continued From page 20	F 803		

gravy.
Beef Tips Au Jus included beef, black pepper, onions, low sodium beef broth, paprika, and water.

During a telephone interview on 07/20/23 at 8:48 a.m., the Registered Dietitian (RD)-I stated she wasn't aware the therapeutic menus weren't followed for R11. RD-I was informed R11 was served mashed potatoes at one meal when the menus called for pasta and R11 was served same entree as everyone else at another meal even though the menus called for a different entree. RD-I went on to say it was important to follow the menus for the renal diet.

R15's quarterly "MDS"dated 05/18/23, indicated an admission date of 08/08/22.

R15's order dated 08/09/22 indicated a "Regular diet, Regular texture, Regular/Thin consistency."

R15's care plan dated 05/12/23, indicated "Risk of inadequate oral intake r/t dementia Dx [diagnosis] and advanced age AEB [as evidenced by] need for regular nutritional intake monitoring. Food Allergy: Eggs."

R15's 05/17/23 Nutrition Assessment indicated "Reg diet w/ Reg textures & Reg consistencies (cut up foods at meals, Egg Allergy, provide finger foods when able, fortified foods- for example: extra butter, sour cream, gravy, etc.)"

Review of the 07/18/23 Regular diet breakfast menu revealed "Scrambled eggs and cheese, cereal of choice, and toast."

On 07/18/23 at 8:36 a.m., R15 was served

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F 803	Continued From page 21 breakfast that included chocolate pudding, oatmeal, toast, juice, and milk. During an interview on 07/18/23 at 9:25 a.m., DA-A stated R15 couldn't have any eggs, even eggs used in cooking due to a severe allergy to eggs. DA-A stated R15 received the chocolate pudding instead of eggs and egg products. Review of the 07/19/23 Regular diet breakfast menu revealed "Pancakes, sausage link, cereal of choice, and a banana." On 07/19/23 at 8:24 a.m., R15 was served breakfast that included chocolate pudding, oatmeal, banana, toast, apple juice, milk, and coffee. During an interview on 07/20/23 at 9:42 a.m., DM-H provided a review of the product label for the four-ounce chocolate pudding R15 received. The label revealed a protein amount of less than one gram. DA-A was present and stated R15 received the chocolate pudding in place of the pancakes at breakfast on 07/19/23 because pancakes contain eggs. During a telephone interview on 07/20/23 at 8:48 a.m., RD-I was not aware R15's eggs and egg products were replaced with four ounces of a chocolate pudding that supplied less than one gram of protein. RD-I stated the facility failed to follow the menu for a renal diet and failed to provide appropriate protein substitute for 2 residents. Review of the facility's policy titled "Menus," dated 05/2014, revealed "It is the center policy that menus are planned in advance to meet	F 803		

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F 803	Continued From page 22 residents/patients in accordance with the Recommended Dietary Research Council and National Academy of Sciences. Menus will be developed to meet the criteria through the use of an approved menu planning guide." "6. Menus are served as written, unless changed in response to preference, item, or a special meal."	F 803		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to serve meals according to designated times. This had the potential to affect 33 of 34 residents who received meals prepared in the facility's only kitchen.	F 809		

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	245270	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	525 BLUFF AVENUE ST CHARLES, MN 55972

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F 809	Continued From page 23 Findings include: Review of the facility's "Daily Serving Times," provided by the Administrator, included "Breakfast at 8:00 a.m., Lunch at 12:00 p.m., and Dinner at 5:00 p.m." On 07/17/23 at 5:41 p.m., the dinner trays for 14 residents were observed to arrive in the back dining room. On 07/18/23 at 8:30 a.m., the breakfast trays for 14 residents were observed to arrive in the back dining room. On 07/18/23 at 8:36 a.m., R15 was observed being served her breakfast in the back dining room. Resident Council Meeting agenda dated 12/02/22, indicated the resident council members voiced meals were not served timely. In a subsequent agenda dated 02/24/23, it indicated the resident council members continued to complain of the lack of timeliness of meals served. During a random interview conducted on 07/17/23 at 2:42 p.m., R31 stated the meal trays were delayed when they were delivered to his room. During a random interview conducted on 07/17/23 at 4:24 p.m., R25 stated the meals were served late and specifically stated she had to wait 45 minutes to an hour to have her meal delivered to her while in the dining room. During an observation conducted on 07/17/23 at	F 809		

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F 809	Continued From page 24 5:49 p.m., R28 was served his dinner meal. During a group interview with members of the Resident Council (R5, R18, R16, and R8) on 07/18/23 10:03 a.m., residents agreed meal delivery was consistently slow. During an observation on 07/18/23 at 8:37 a.m., R20 had her breakfast delivered to her. During an interview on 07/18/23 11:37 a.m., the Dietary Manager (DM)-H stated breakfast was at served at 8:00 a.m., lunch at 12:00 p.m., and dinner at 5:00 p.m. DM-H stated they had been working shorthanded so meals weren't as timely as they should be. During an interview on 07/19/23 at 11:33 a.m., Administrator stated he had a PIPs [Performance Improvement Project] for mealtimes written but not approved. He went on to say the PIPs hadn't been fully implemented and was still in the QA [Quality Assurance] process. A policy for meal service and/or mealtimes was requested. The Administrator stated the facility did not have a policy.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		

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F 812	Continued From page 25 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the kitchen ceiling, walls, baseboards, appliances, and tumblers were clean and in good repair and the food delivery was promptly put away. This deficient practice had the potential to affect 33 of 34 residents who received meals prepared in the facility's only kitchen. Findings include: During the kitchen tour on 07/17/23 at 2:37 p.m., and on 07/18/23 at 2:11 p.m. with the Dietary Manager (DM)-H the following observations were made: -The wall tile and dry board under the dish machine were observed missing and a collection of old glue and a mold-like substance was present. The baseboards on the lower walls in the dish room were soiled with a build-up of debris and noted to be coming off. More mold-like substances were also observed along the stainless-steel panels and on the tile caulking around the dish machine. -The interior lower wall next to the door to the	F 812		

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F 812	Continued From page 26 dish room was noted to be broken and missing five ceramic tiles. -The wall behind the only hand sink was observed to have a mold-like substance along the tile grout. The metal frame to the hand sink contained worn and scraped paint. -The baseboards along the cabinets between the dish room and the kitchen were observed peeling and stained with a build-up of debris. -The ceiling air conditioner unit located directly above the steam table was observed with peeling paint and dust with a large tray hanging under the unit. DM-H stated the tray was there in case the unit dripped condensation. -The ceiling and fixtures throughout the kitchen were noted to have a collection of dust. -The cabinet under the produce sink was observed with a pan directly under the piping. A collection of rust and mold-like substance was noted throughout the inside cabinet. The Dietary Aide (DA)-A and DM-H stated the sink had a leak due to a broken garbage disposal. -The wall above the back windows was covered with old, worn, peeling paint. DM-H confirmed the wall and stated that the kitchen was old and needed attention. -A tray of clean plastic tumblers observed on the dining room beverage counter were noted to be stained, dingy, and scarred. The DM-H confirmed the tumblers were stained and stated the tumblers were soaked in vinegar to remove stains. On 07/18/23 at 8:13 a.m., the food delivery was observed stacked on a cart in the main dining room. Cases of food requiring cold storage were observed among the delivery. Several of the food cases contained a label "keep frozen." These included pancake, minestrone soup, French	F 812		

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F 812	Continued From page 27 toast, and chicken. Other food cases contained a label "keep refrigerated." These included sour cream, whipped spread, boneless beef chuck pot roast, pork, and chicken soup. DM-H and DA-A were busy preparing and serving breakfast. At 9:02 a.m., the food boxes were gone, and DM-H was bringing back the cart. DM-H stated he just put up the groceries. During an interview on 07/18/23 at 12:07 p.m., Maintenance (MA)-A stated, "I want a lot done in there but it's not in the budget." During an interview on 07/18/23 at 2:12 p.m., DM-H stated there was no one available to put away groceries immediately. However, he got them put up by 9:00 a.m. During an interview on 07/19/23 at 11:39 a.m., DA-A stated food delivery arrived at the facility the morning of 7/18/23 about 6:30 a.m. During an interview on 07/20/23 at 8:48 a.m., the Registered Dietitian (RD)-I stated she did sanitation audits during her weekly visits and had noted some issues. RD-I stated she was aware of the broken garbage disposal under the produce sink and stated she would follow-up. Review of the facility's policy titled "General Sanitation of Kitchen," dated 08/16/22, revealed "Food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule."	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883		

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F 883	Continued From page 28 immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 883		

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F 883	Continued From page 29 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to offer 1 of 5 residents (R18) reviewed for flu/pneumonia vaccinations and/or their representatives, the opportunity for the resident to be vaccinated in accordance with nationally recognized standards. The facility failed to offer R18 the opportunity to be vaccinated with Pneumococcal 15-valent Conjugate Vaccine (PCV15) or one dose of Prevnar 20 (PCV20) in accordance with nationally recognized standards. This practice had the potential to increase the risk for these residents to contract pneumonia. Findings include: Review of the CDC website titled "Pneumococcal Vaccination: Summary of Who and When to Vaccinate," last reviewed 02/13/23, indicated ". . .CDC recommends pneumococcal vaccination for all adults 65 years or older . . . For adults 65 years or older who have only received a PPSV23 [Pneumococcal Polysaccharide Vaccine], CDC recommends you . . . May give 1 dose of PCV15 [Pneumococcal Conjugate Vaccine] or PCV20	F 883		

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F 883	Continued From page 30 [PCV13 was previously recommended by the CDC prior to 10/21/21] . . . The PCV15 or PCV20 dose should be administered at least one year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it." Review of R18's electronic medical record (EMR) indicated admission on 11/20/19. The resident was over the age of 65 at the time of admission. However, there was no evidence R18 was offered a pneumococcal vaccine. Review of a document provided by the facility for R18 titled ". . .PSVC23. . ." dated 01/20/19 indicated the resident refused to be administered the PSVC23 and PCV13. During an interview on 07/18/23 at 11:22 a.m., the Medical Director F stated she would direct staff to offer a resident, with a history of refusing past pneumococcal vaccines, the most current CDC recommendations. Medical Director F stated she would consider the quality and quantity of life of a resident prior to offering the vaccines. During an interview on 07/19/23 at 12:50 p.m., the Director of Nursing (DON)-B confirmed she was contacted by Medical Director F and was addressing this as a potential concern. Review of a policy provided by the facility titled "Pneumococcal Vaccine Series" dated 02/20/23 indicated ". . .It is our policy to offer our residents and staff immunizations against pneumococcal disease in accordance with current CDC guidelines and recommendations. . .Each resident will be offered a pneumococcal	F 883		

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F 883	Continued From page 31 immunization unless it is medically contraindicated, or the resident has already been immunized. . .Consent shall be documented prior to the administration of the vaccine. The resident/representative retains the right to refuse the immunization. Refusals should be documented, along with what education was provided and a risk vs benefit discussion. . .A pneumococcal vaccine (PCV15, PCV20, or PPSV23/PPSV) offered will depend upon the recipient's age. . ."	F 883		

Electronically delivered

August 15, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: R8PL11

Dear Administrator:

The above facility was surveyed on July 17, 2023, through July 20, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00942	A. BUILDING: _____ B. WING _____	C 07/20/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 07/17/23 through 07/20/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the	2 302		

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2 302	Continued From page 3 facility failed to ensure consumers were provided written or electronic information regarding training staff had received for dementia and/or Alzheimer's care. This had the potential to affect all 34 current residents family members, and/ or guardians, and consumers. Findings include: Training records verified "Alzheimer's Disease and Related Disorders" was completed by all staff providing care for residents with dementia and/ or Alzheimer's. However, documents lacked evidence consumers were made aware this training had occured. During interview on 7/20/26, at 10:25 a.m., administrator stated staff training for dementia and/ or Alzheimer's was for all staff and they were trained upon hire and annually. The administrator stated there was no written or electronic notification provided to consumers with a description of the dementia training program, the categories of employees trained, the frequency of training, or the basic topics covered. SUGGESTED METHOD OF CORRECTION: The facility could review the Minnesota statutes for dementia training and develop a written or electronic means of communication for the dementia training to the consumer. The facility could implement the communication into their admission process. The facility could then create and implement an auditing system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		

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2 550	Continued From page 4	2 550		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on record review, staff interview, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure 1 out of 15 residents (R22) had an accurate "Minimum Data Set (MDS)" assessment. Failure to code the "MDS" correctly could potentially lead to inaccurate federal reimbursements and inaccurate assessment and care planning of the resident. Findings include: R22's electronic medical record (EMR) indicated the resident was admitted to the facility on 10/20/21. R22's physician orders dated 09/13/22, indicated Seroquel (an antipsychotic) 50 milligrams (mg) to be administered at bedtime due to dementia with behaviors. R22's "Encounter" note dated 03/14/23, indicated the primary doctor attempted a gradual dose reduction (GDR) from Seroquel 50 mg to be administered at bedtime to Seroquel 25 mg to be administered at bedtime and then Seroquel 25 mg PRN (as needed) during the day. The GDR	2 550		

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2 550	Continued From page 5 was not successful. The resident had an increase in behaviors. R22's "Encounter" note dated 04/04/23, indicated the primary doctor attempted a GDR of the Seroquel, but it was not successful since the clinical notes revealed the resident was yelling in the evening and then overnight, all night long. In addition, it was noted the resident yelled out 50 times during a shift. The physician's progress note revealed an increase of Seroquel to 50 mg at bedtime. R22's quarterly Minimum Data Set (MDS) dated 05/22/23, indicated the resident had a "Brief Interview for Mental Status (BIMS) score of five out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident was administered an antipsychotic medication seven times during this assessment period. The assessment revealed the resident did not have a GDR nor did the physician provide a clinical rationale if the GDR was contraindicated. During an interview on 07/19/23 at 10:41 a.m., the Vice President of Success G stated accuracy was the goal with the MDS. During an interview on 07/20/23 09:18 a.m., the MDS Coordinator E confirmed that she missed the GDR and confirmed the error. Review of the RAI Manual, dated 10/01/19, indicated, ". . . It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that	2 550		

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2 550	Continued From page 6 observation period) by the IDT (Interdisciplinary Team) completing the assessment. . ." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring that each individual resident's comprehensive assessment is accurately completed. The director of nursing or designee could develop a system to educate staff on completing and updating and reassessing a residents need related to use of alarms and security measures and develop a monitoring system to ensure staff accurately complete assessments. This information should be brought to the Quality Assurance committee for review and revision to process as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 810	MN Rule 4658.0510 Subp. 3 Nursing Personnel; On-site coverage Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to use the services of a registered nurse (RN) for at least eight consecutive hours a day. This deficient practice had the potential to affect all 34 residents residing in the facility. Findings include:	2 810		

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2 810	Continued From page 7 Review of the facility's Assessment dated 01/31/23, revealed "Federal law requires nursing homes to have sufficient staff to meet the needs of residents, to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week." Review of the 02/04/23 through 07/17/23 nursing schedule, revealed an RN was not scheduled in the facility on 07/16/23. During an interview 07/19/23 at 9:05 a.m., the Administrator confirmed there was no RN working on 07/16/23. In a later interview at 2:25 p.m., the Administrator stated the census for 07/16/23 was 34. Review of the facility's policy titled, "Nursing Services-Registered Nurse (RN)," dated 07/22/22, revealed "1. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could develop policies and procedures to ensure nursing coverage is provided eight hours per day, seven days per week. The DON or designee could educate staff regarding these polices, and audit staff schedules for compliance. The DON or designee could take the results of these audits to the QAPI committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 810		

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2 915	Continued From page 8	2 915		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide appropriate adaptive equipment as directed by the resident's care plan and Occupational Therapy (OT)-K recommendation, to prevent potential weight loss for 1 of 3 residents (R28) reviewed for nutrition. Findings include: R28's electronic medical record (EMR) indicated admission on 09/19/22 with a diagnosis of cerebral infarction (stroke). R28's quarterly Minimum Data Set (MDS) dated 05/20/23, indicated a Brief Interview for Mental	2 915		

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2 915	Continued From page 9 Status (BIMS) score of 6 out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident required supervision with one person to assist. The assessment indicated the resident had an impairment with his upper extremity which included shoulder, arm, and his hand. The assessment indicated the resident had no weight loss identified during this assessment period. R28's care plan dated 09/27/22, indicated at risk for decreased oral intake due to diagnoses of dysphasia and dementia. An intervention dated 09/29/22, revealed to provide the resident with a spoon only (no knives or forks) due to the utensils being a distraction. R28's EMR Kardex (a care plan for nursing assistants) undated, indicated the resident was to have a spoon only and a fork and knife were not to be set on his meal trays due to them being a potential distraction. R28's EMR nutritional/dietary progress note dated 04/23/23, indicated the resident was at risk nutritionally and was to have a spoon available during mealtimes. The progress note stated no fork or knife was to be present during mealtimes since it was a distraction for the resident. R28's meal ticket undated, indicated R28 was to be provided a spoon only and not a fork or knife since it was distracting. During an observation on 07/17/23 at 5:49 p.m., R28 had his meal plate delivered to him. The plate had chopped broccoli stir fry and a cup of pureed rice. In addition, the resident was served a cup of applesauce. There was a knife, fork and spoon next to his plate. The resident opened the	2 915		

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2 915	Continued From page 10 cup of applesauce and then stuck his tongue in the cup to retrieve the applesauce. The resident was then observed picking up a cup of pureed rice and again stuck his tongue in the container. A random staff member approached the resident and handed him a spoon. The resident began to eat the remaining part of his dinner meal with the spoon. The resident ate approximately 50 percent (%) During an observation on 07/18/23 at 8:12 a.m., R28 was observed sitting at a dining room table. The resident was served hot cereal and scrambled eggs with cheese. R28 was observed to pick up a spoon and began to eat. At 8:45 a.m., the resident left the area. At 9:04 a.m., the resident returned to the dining room. The resident then picked up his fork and attempted to take a bite of his scrambled eggs. The resident was not successful in getting a bite of scrambled eggs into his mouth. The resident left the table at 9:07 a.m. There was approximately 75% of his eggs on his plate. During an observation on 07/19/23 at 7:57 a.m., R28 was observed to be taken to the dining room by staff. At 8:29 a.m., the resident was served hot cereal and pancakes. A random staff took a fork and knife to cut up the resident's pancakes into smaller pieces. The fork was left on the plate and the knife was on the right-hand side of his place setting. The resident was observed to eat his hot cereal with a spoon. The resident was observed to pick up pieces of pancake with his fingers and fed himself. During an interview on 07/19/23 at 12:30 p.m., the Dietary Manager (DM)-H stated all the silverware was pre-rolled prior to serving. She had never seen an order on a meal ticket like this	2 915		

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2 915	Continued From page 11 before and was attempting a solution. During an interview on 07/20/23 at 8:48 a.m., Registered Dietician (RD)-I stated R28 required the use of the spoon only and no other eating utensils since it was a possible distraction. RD-I stated the referral for the use of the spoon only on his meal tray came from OT. RD-I stated the resident was at risk for weight loss. During an interview on 07/2023 at 9:51 a.m., OT-K stated R28 used to be on a pureed diet and previously used a bowl to eat from. OT-K stated it was in April 2023 that RD-I contacted her and asked for a referral on the resident to use a spoon only. OT-K stated there was not a paper referral. OT-K stated she confirmed the use of a spoon only since having the other eating utensils were too distracting for the resident to have around. OT-K stated the resident would use a knife as a spoon in an attempt to get food in his mouth. Review of a policy provided by the facility titled "Assistive Devices" dated 09/17 indicated ". . .Assistive devices/utensils will be provided as identified in the individualized plan of care to main or improve a resident's/patient's ability to eat or drink independently. . .The assistive device/utensil requests will be entered into the individual resident profile in the menu management system for provisions with each meal and snack. . ." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could revise policies and procedures for documentation and implementation of adaptive equipment and educate staff related to the changes. The DON or designee could audit for ongoing compliance	2 915		

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2 915	Continued From page 12 and report results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 915		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the kitchen ceiling, walls, baseboards, appliances, and tumblers were clean and in good repair and the food delivery was promptly put away. This deficient practice had the potential to affect 33 of 34 residents who received meals prepared in the facility's only kitchen. Findings include: During the kitchen tour on 07/17/23 at 2:37 p.m., and on 07/18/23 at 2:11 p.m. with the Dietary Manager (DM)-H the following observations were made: -The wall tile and dry board under the dish machine were observed missing and a collection of old glue and a mold-like substance was present. The baseboards on the lower walls in the dish room were soiled with a build-up of debris	21015		

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21015	Continued From page 13 and noted to be coming off. More mold-like substances were also observed along the stainless-steel panels and on the tile caulking around the dish machine. -The interior lower wall next to the door to the dish room was noted to be broken and missing five ceramic tiles. -The wall behind the only hand sink was observed to have a mold-like substance along the tile grout. The metal frame to the hand sink contained worn and scraped paint. -The baseboards along the cabinets between the dish room and the kitchen were observed peeling and stained with a build-up of debris. -The ceiling air conditioner unit located directly above the steam table was observed with peeling paint and dust with a large tray hanging under the unit. DM-H stated the tray was there in case the unit dripped condensation. -The ceiling and fixtures throughout the kitchen were noted to have a collection of dust. -The cabinet under the produce sink was observed with a pan directly under the piping. A collection of rust and mold-like substance was noted throughout the inside cabinet. The Dietary Aide (DA)-A and DM-H stated the sink had a leak due to a broken garbage disposal. -The wall above the back windows was covered with old, worn, peeling paint. DM-H confirmed the wall and stated that the kitchen was old and needed attention. -A tray of clean plastic tumblers observed on the dining room beverage counter were noted to be stained, dingy, and scarred. The DM-H confirmed the tumblers were stained and stated the tumblers were soaked in vinegar to remove stains. On 07/18/23 at 8:13 a.m., the food delivery was observed stacked on a cart in the main dining	21015		

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21015	Continued From page 14 room. Cases of food requiring cold storage were observed among the delivery. Several of the food cases contained a label "keep frozen." These included pancake, minestrone soup, French toast, and chicken. Other food cases contained a label "keep refrigerated." These included sour cream, whipped spread, boneless beef chuck pot roast, pork, and chicken soup. DM-H and DA-A were busy preparing and serving breakfast. At 9:02 a.m., the food boxes were gone, and DM-H was bringing back the cart. DM-H stated he just put up the groceries. During an interview on 07/18/23 at 12:07 p.m., Maintenance (MA)-A stated, "I want a lot done in there but it's not in the budget." During an interview on 07/18/23 at 2:12 p.m., DM-H stated there was no one available to put away groceries immediately. However, he got them put up by 9:00 a.m. During an interview on 07/19/23 at 11:39 a.m., DA-A stated food delivery arrived at the facility the morning of 7/18/23 about 6:30 a.m. During an interview on 07/20/23 at 8:48 a.m., the Registered Dietitian (RD)-I stated she did sanitation audits during her weekly visits and had noted some issues. RD-I stated she was aware of the broken garbage disposal under the produce sink and stated she would follow-up. Review of the facility's policy titled "General Sanitation of Kitchen," dated 08/16/22, revealed "Food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule." SUGGESTED METHOD OF CORRECTION: The	21015		

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21015	Continued From page 15 food service director or designee could review any policies, procedures or facility processes to ensure safe and sanitary food service maintainence, and make any necessary revisions. Appropriate staff could be educated regarding any changes. The food service director or designee could develop audits to monitor staff for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21030	MN Rule 4658.0620 Subp. 1 Frequency of Meals; Time of meals Subpart 1. Time of meals. The nursing home must provide at least three meals daily at regular times. There must be no more than 14 hours between a substantial evening meal and breakfast the following day. A "substantial evening meal" means an offering of three or more menu items at one time, one of which is a high-quality protein such as meat, fish, eggs, or cheese. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to serve meals according to designated times. This had the potential to affect 33 of 34 residents who received meals prepared in the facility's only kitchen. Findings include: Review of the facility's "Daily Serving Times," provided by the Administrator, included "Breakfast at 8:00 a.m., Lunch at 12:00 p.m., and Dinner at 5:00 p.m."	21030		

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21030	Continued From page 16 On 07/17/23 at 5:41 p.m., the dinner trays for 14 residents were observed to arrive in the back dining room. On 07/18/23 at 8:30 a.m., the breakfast trays for 14 residents were observed to arrive in the back dining room. On 07/18/23 at 8:36 a.m., R15 was observed being served her breakfast in the back dining room. Resident Council Meeting agenda dated 12/02/22, indicated the resident council members voiced meals were not served timely. In a subsequent agenda dated 02/24/23, it indicated the resident council members continued to complain of the lack of timeliness of meals served. During a random interview conducted on 07/17/23 at 2:42 p.m., R31 stated the meal trays were delayed when they were delivered to his room. During a random interview conducted on 07/17/23 at 4:24 p.m., R25 stated the meals were served late and specifically stated she had to wait 45 minutes to an hour to have her meal delivered to her while in the dining room. During an observation conducted on 07/17/23 at 5:49 p.m., R28 was served his dinner meal. During a group interview with members of the Resident Council (R5, R18, R16, and R8) on 07/18/23 10:03 a.m., residents agreed meal delivery was consistently slow.	21030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00942	A. BUILDING: _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	525 BLUFF AVENUE ST CHARLES, MN 55972

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21030	Continued From page 17 During an observation on 07/18/23 at 8:37 a.m., R20 had her breakfast delivered to her. During an interview on 07/18/23 11:37 a.m., the Dietary Manager (DM)-H stated breakfast was at served at 8:00 a.m., lunch at 12:00 p.m., and dinner at 5:00 p.m. DM-H stated they had been working shorthanded so meals weren't as timely as they should be. During an interview on 07/19/23 at 11:33 a.m., Administrator stated he had a PIPs [Performance Improvement Project] for mealtimes written but not approved. He went on to say the PIPs hadn't been fully implemented and was still in the QA [Quality Assurance] process. A policy for meal service and/or mealtimes was requested. The Administrator stated the facility did not have a policy. SUGGESTED METHOD OF CORRECTION: The dietary manager, or designee, review and/or revise policies and procedures regarding serving meals. Staff could then be trained on the policies and procedures. Audits could be conducted to ensure meal delivery is occurring as expected. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21030		
21050	MN Rule 4658.0625 Subp. 1 Menus; Meal Planning Subpart 1. Menu planning. All menus must be planned in advance, dated, and followed. Any changes in the meals actually served must be of equal nutritional value. The general menu for a seven-day period must be posted prior to the	21050		

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21050	Continued From page 18 start of that seven-day period at a location readily accessible to residents, and any changes to the general menu must be noted on that posted menu. All menus and any changes for the current and following seven-day periods must be posted in the dietary area. Records of menus and of foods purchased must be filed for six months. A variety of foods must be provided. A file of tested recipes adjusted to a yield appropriate for the size of the home must be maintained. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the menus for a renal diet and provide adequate protein substitute for eggs for 2 of 3 residents (R11, R15) reviewed for menus. Findings include: R11's annual Minimum Data Set (MDS) dated 07/19/23, revealed an admission date of 08/26/21. R11 had diagnoses of type 2 diabetes mellitus with other diabetic kidney complications and renal insufficiency, renal failure, or end-stage renal disease (ESRD). R11's orders dated 12/20/22, indicated a "Renal diet, Regular texture, Regular/Thin consistency." R11's 06/13/23 care plan indicated "Obesity (class 3) r/t [related to] greater energy input vs output AEB [as evidenced by] BMI [Body Mass Index] of 47.6 as of 6/17/23 and need for regular nutrition intake monitoring." An intervention included "Provide diet as ordered." R11's nutrition assessment dated 6/20/23,	21050		

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21050	Continued From page 19 indicated "Renal diet w/ [with] Regular textures & [and] Reg [Regular] consistencies." The facility's food vendor's diet guide, dated 05/2023, under the renal diet section indicated "The diet is high in protein with limited potassium..." "The average sodium or potassium amount in the [menu] cycle (35 days) does not exceed 2000 mg (+/- 200 mg) per day." Review of the potassium food postings from the kitchen, provided by the Dietary Manager (DM) H, revealed tomato paste, potatoes, and soy sauce were high in potassium. Review of the 07/18/23 Renal diet lunch menu revealed "Pork Chop, pasta, corn, dinner roll, and gelatin." On 07/18/23 at 12:23 p.m., R11 was served lunch that included pork chops, mashed potatoes with gravy, corn, and a dinner roll. Review of R11's 07/18/23 lunch tray ticket revealed pork chop, pasta, corn, and a dinner roll. Review of the 07/19/23 Renal diet lunch menu revealed "Beef Tips Au Jus, green peas, noodles, and a dinner roll." The tray line was observed on 07/19/23 at 11:51 a.m.. The food items included beef stroganoff, mechanical soft beef stroganoff, pureed beef stroganoff, peas, pureed peas, pasta, mashed potatoes, rolls, fruit, pureed fruit, pound cake, and pureed pound cake. During an interview on 07/19/23 at 11:52 a.m., the Dietary Aide (DA)-A was asked if there were any residents with special diets. DA-A stated "yes, cardiac and renal but the food wasn't different	21050		

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21050	Continued From page 20 today and everyone was served the same." DA-A went on to say, "some days it's different." The DM-H was present and picked up two meal tickets, one for a cardiac diet that revealed "beef stroganoff" to be served and a renal diet that revealed "beef tips Au Jus" was to be served. DM-H asked what the difference was between beef stroganoff and beef tips Au Jus. DM-A answered, "not much so they both get the same." On 07/19/23 at 12:28 p.m., R11 was served lunch that included Beef Stroganoff with pasta, green peas, roll, and fruit. Review of R11's 07/19/23 lunch tray ticket revealed "Beef Tips Au Jus, green peas, noodles, and a dinner roll." Review of the 07/19/23 lunch entrée recipes revealed: Beef Stroganoff included beef, black pepper, onions, beef stock, canned tomato paste, Worcestershire Sauce, flour, sour cream, and gravy. Beef Tips Au Jus included beef, black pepper, onions, low sodium beef broth, paprika, and water. During a telephone interview on 07/20/23 at 8:48 a.m., the Registered Dietitian (RD)-I stated she wasn't aware the therapeutic menus weren't followed for R11. RD-I was informed R11 was served mashed potatoes at one meal when the menus called for pasta and R11 was served same entree as everyone else at another meal even though the menus called for a different entree. RD-I went on to say it was important to follow the menus for the renal diet. R15's quarterly "MDS"dated 05/18/23, indicated an admission date of 08/08/22.	21050		

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21050	Continued From page 21 R15's order dated 08/09/22 indicated a "Regular diet, Regular texture, Regular/Thin consistency." R15's care plan dated 05/12/23, indicated "Risk of inadequate oral intake r/t dementia Dx [diagnosis] and advanced age AEB [as evidenced by] need for regular nutritional intake monitoring. Food Allergy: Eggs." R15's 05/17/23 Nutrition Assessment indicated "Reg diet w/ Reg textures & Reg consistencies (cut up foods at meals, Egg Allergy, provide finger foods when able, fortified foods- for example: extra butter, sour cream, gravy, etc.)" Review of the 07/18/23 Regular diet breakfast menu revealed "Scrambled eggs and cheese, cereal of choice, and toast." On 07/18/23 at 8:36 a.m., R15 was served breakfast that included chocolate pudding, oatmeal, toast, juice, and milk. During an interview on 07/18/23 at 9:25 a.m., DA-A stated R15 couldn't have any eggs, even eggs used in cooking due to a severe allergy to eggs. DA-A stated R15 received the chocolate pudding instead of eggs and egg products. Review of the 07/19/23 Regular diet breakfast menu revealed "Pancakes, sausage link, cereal of choice, and a banana." On 07/19/23 at 8:24 a.m., R15 was served breakfast that included chocolate pudding, oatmeal, banana, toast, apple juice, milk, and coffee. During an interview on 07/20/23 at 9:42 a.m., DM-H provided a review of the product label for	21050		

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21050	Continued From page 22 the four-ounce chocolate pudding R15 received. The label revealed a protein amount of less than one gram. DA-A was present and stated R15 received the chocolate pudding in place of the pancakes at breakfast on 07/19/23 because pancakes contain eggs. During a telephone interview on 07/20/23 at 8:48 a.m., RD-I was not aware R15's eggs and egg products were replaced with four ounces of a chocolate pudding that supplied less than one gram of protein. RD-I stated the facility failed to follow the menu for a renal diet and failed to provide appropriate protein substitute for 2 residents. Review of the facility's policy titled "Menus," dated 05/2014, revealed "It is the center policy that menus are planned in advance to meet residents/patients in accordance with the Recommended Dietary Research Council and National Academy of Sciences. Menus will be developed to meet the criteria through the use of an approved menu planning guide." "6. Menus are served as written, unless changed in response to preference, item, or a special meal." SUGGESTED METHOD OF CORRECTION: The dietary director, or designee, could develop, review, and/or revise policies and procedures related to therapeutic menus. The dietary director, or designee, could educate staff on applicable policies and procedures. The dietary director, or designee, could conduct audits to ensure posted menus are being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21050		

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21426	Continued From page 23	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to perform a two-step tuberculin skin test (TST) for 1 of 6 newly admitted residents (R29). Additionally, the facility failed to perform a Facility TB Risk Assessment on an annual basis as directed by the Minnesota Department of Health (MDH); this had the potential to affect all 34 residents residing in the facility. Findings include: R29's admission record, dated 7/20/23, indicated	21426		

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21426	Continued From page 24 R29 was admitted to the facility on 4/25/23. R29's Medication Administration Record (MAR) for April 2023, indicated a step one TST was read on 4/29/23, with a negative result. However, the facility did not have a record of the step two TST for R29. On 7/17/23, a copy of the facility's current Facility TB Risk Assessment was requested. On 7/18/23, the facility provided a TB assessment dated 7/18/23. The previous Facility TB Risk Assessment was requested, but not provided. On 7/20/23, at 10:01 a.m. director of nursing/infection preventionist (DON) stated there was no evidence a step two TST was completed for R35. DON stated the order for the step one TST was entered into the MAR, but the order for the step two TST was not entered. Additionally, DON stated the completion of the Facility TB Risk Assessment "fell through the cracks", and she understands that it needed to be completed annually. The facility's Tuberculosis Screening - Residents policy dated 2017, indicated for all new admissions, a first step TST would be performaed within 72 hours of admission. If the first step is non-reactive, the second TST would be administered one to three weeks later. The facility's TB Exposure Control Plan dated 2017, indicated the Infection Preventionist (IP) or designee, determined the setting's TB risk classification based ont he results of the TB risk assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could	21426		

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21426	Continued From page 25 review and/or revise the current TB policies and procedures to ensure all residents are screened for physical signs and symptoms of active TB disease on admission. The DON or designee could develop a monitoring system by auditing residents' charts to ensure ongoing compliance. The director of DON or designee could review the facility TB risk assessment to be sure the documentation is completed annually. The DON or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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	245270	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/19/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/19/2023. At the time of this survey, WHITEWATER HEALTH SERVICES was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 08/25/2023

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

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K 000	Continued From page 1 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.	K 000		

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K 000	Continued From page 2 Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 34 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain an emergency notification list per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6,	K 346	This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission	9/6/23

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K 346	Continued From page 3 and NFPA 72 (2010 edition) National Fire Alarm and Signaling Code, section(s) 10.19, 10.19.3, 26.3.7.3(3)(4). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by a review of available documentation that "out of service" emergency notification call list was missing State of Minnesota authorities having jurisdiction. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied. On 8/24/23, Emergency Operations Plan “out of service” emergency notification call list was updated so that Minnesota Authorities were listed as having jurisdiction. An annual audit will be completed by Maintenance Director, Executive Director, or Designee to ensure the Emergency Notification call list is correct and shows Minnesota as having Jurisdiction. Results of audits will be submitted to the Quality Assurance Committee for review and recommendations. During the annual review of Emergency Operations Plan, emergency notification call list will be reviewed to ensure the “out of service” list includes Minnesota jurisdiction. Maintenance Director, Executive Director, or designee will be responsible for the corrective actions and for monitoring	

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	245270	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 346	Continued From page 4	K 346	compliance This alleged deficient practice will be corrected by 9/6/2023	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.1.1.1, 5.2.1.1.2(5), 5.2.2.2, NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.5.6.1. These deficient	K 353	This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or severity regarding any of	9/6/23

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K 353	Continued From page 5 findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by observation that the sprinkler heads located in the West Dining Room exhibited signs of debris loading. 2. On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by observation that the in the West Boiler Room that sprinkler system piping was weight loaded by other piping and plumbing 3. On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by observation that in Wings 200 and 300, in resident room closets, items were placed and/or stacked closer than 18" to the sprinkler head An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied. Between 8/14/23-8/18/23, All sprinkler heads in the building were cleaned off using compressed air. On 8/30/23 the sprinkler line in the west boiler room was lowered to remove any load from being bared on the line. Between 8/14/23-8/31/23 All closets had their shelves below the sprinkler heads removed to ensure nothing could be stacked up close to the sprinkler head. Formal Audits on all of sprinkler heads and possible debris loading will be completed by Maintenance Director or designee weekly moving forward. Formal Audits on sprinkler lines will be completed by Maintenance Director or designee Weekly for four weeks then Monthly moving forward. Formal Audits will be completed on resident closet storage weekly for four weeks then monthly moving forward. Results of audits will be submitted to the Quality Assurance Committee for review	

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	245270	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/19/2023**

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K 353	Continued From page 6	K 353	and recommendations. On a monthly basis, Maintenance Director or designee will round to ensure that sprinkler heads throughout the entire building do not have any debris loading present. On a monthly basis, Maintenance Director or designee will audit to ensure sprinkler lines are free of any extra weight being loaded on them. On a Monthly basis, Maintenance Director or designee will check all resident closets to ensure nothing is being stacked under the sprinkler head in the closet. Maintenance Director, Executive Director or designee will be responsible for the corrective actions listed above. This alleged deficient practice will be corrected by 9/6/2023	
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the	K 354		9/6/23

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K 354	Continued From page 7 sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain an emergency notification list per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 15.5, 15.5.1(6), 15.6, 15.7(4) This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by a review of available documentation that "out of service" emergency notification call list was missing State of Minnesota authorities having jurisdiction An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354	This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied. On 8/24/23, Emergency Operations Plan “out of service” emergency notification call list was updated so that Minnesota Authorities were listed as having jurisdiction. An annual audit will be completed by Maintenance Director, Executive Director, or Designee to ensure the Emergency Notification call list is correct and shows Minnesota as having Jurisdiction. Results of audits will be submitted to the	

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K 354	Continued From page 8	K 354	Quality Assurance Committee for review and recommendations. During the annual review of Emergency Operations Plan, emergency notification call list will be reviewed to ensure the “out of service” list includes Minnesota jurisdiction. Maintenance Director, Executive Director, or designee will be responsible for the corrective actions and for monitoring compliance This alleged deficient practice will be corrected by 9/6/2023	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly secure electrical panel(s) per NFPA 101 (2012 edition), Life Safety Code,	K 511	This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to	9/6/23

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K 511	Continued From page 9 section 19.5.1.1, 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.27. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by observation that the electrical panel located in the Kitchen Corridor was found to be unsecured and readily accessible to unqualified individuals An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	long term care providers. The submission of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied. Electrical panel located in the kitchen corridor was locked on 8/24/23. Maintenance Director or Designee will complete audits on all “accessible” fire panels on a weekly basis moving forward Results of audits will be submitted to the Quality Assurance Committee for review and recommendations. On a weekly basis, Maintenance Director or Designee will ensure that all electrical panels that are “accessible” are locked/secured. Maintenance Director, Executive Director, or designee will be responsible for the corrective actions and for monitoring compliance This alleged deficient practice will be	

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K 511	Continued From page 10	K 511	corrected by 9/6/2023	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1, and 19.7.1.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed during a review of available documentation, that no documentation was presented to confirm that fire drills were conducted on 2nd and 3rd shifts during 3rd quarter. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied. A fire drill schedule was reviewed on 8/24/2023 by Maintenance Director and	9/6/23

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K 712	Continued From page 11	K 712	Executive Director to ensure all shifts get fire drills whether Maintenance Director is present or not. Monthly Audits will be completed by Executive Director or designee to ensure fire drills are happening on all shifts each month and that the schedule is being followed. Results of audits will be submitted to the Quality Assurance Committee for review and recommendations. Maintenance Director or designee will monitor Fire Drills on a monthly basis to ensure drills are being completed as scheduled on all shifts. Maintenance Director, Executive Director, or designee will be responsible for the corrective actions and for monitoring compliance This alleged deficient practice will be corrected by 9/6/2023	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this	K 918		9/6/23

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K 918	Continued From page 12 capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.4.1, 8.4.2, 8.4.9, 8.5.9.5, 8.4.9.6, 8.4.9.7. This deficient findings could have a widespread impact on the residents within the facility.	K 918	This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or severity regarding any of	

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K 918	Continued From page 13 Findings include: 1. On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the generator is achieving 30% loading, and not required to implement annual load-bank testing. 2. On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that 36 month - 4 hour load bank testing in occurring. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 918	the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied. On 8/29/23 Total Energy is scheduled to come and complete a 4-hour load bank test. If possible, during monthly generator checks, percentage load will be checked and documented to ensure it is running at least at 30% load. If this is not possible, four-hour load test will be completed annually Audits will be completed monthly or annually by Maintenance Director, Executive Director or designee based on what can be done. Results of audits will be submitted to the Quality Assurance Committee for review and recommendations. Maintenance Director, Executive Director or designee will monitor generator load to ensure 30% load is being reached on monthly checks or annual load bank tests. Maintenance Director, Executive Director, or designee will be responsible for the corrective actions and for monitoring compliance	

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K 918	Continued From page 14	K 918		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage of relocatable power taps in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and	K 920	This alleged deficient practice will be corrected by 9/6/2023 This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission of the plan does not constitute an agreement by the facility that the	9/6/23

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K 920	Continued From page 15 UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: 1. On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by observation, that in the Med Room at the Main Nurses Station an extension cord was found in use. 2. On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by observation, that in the Social Services Office an extension cord was providing power to a relocatable power tap. 3. On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by observation, that in the Kitchen Office relocatable power taps were found daisy-chained together. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied. On 8/24/23, all extension cords in offices/med rooms were removed and all relocatable power taps were removed from one another. Maintenance Director or Designee will audit all offices and medication rooms to ensure there are no power cords present, and no relocatable power taps are daisy chained together. Audits will be completed weekly for four weeks then monthly moving forward. Results of audits will be submitted to the Quality Assurance Committee for review and recommendations. On a monthly basis, Maintenance Director or designee will check offices and medication rooms to ensure there are no power cords present, and no relocatable power taps are daisy chained together. Maintenance Director, Executive Director, or designee will be responsible for the	

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WHITEWATER HEALTH SERVICES	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 16	K 920	corrective actions and for monitoring compliance This alleged deficient practice will be corrected by 9/6/2023	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full	K 923		9/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/19/2023**

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K 923	Continued From page 17 cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5, 11.6.5.2, 11.6.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/19/2023 between 9:00 AM and 1:00 PM, it was revealed by observation that in the Med Gas Storage Room there was mixed storage of empty / full cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied. On 8/15/23, racks in the oxygen room were painted to separate full and empty tanks. Green racks contain the full tanks, and the red racks contain the empty tanks. Nursing Staff educated on this change beginning the week of 8/28/23. Signage posted in oxygen room explaining this info on 8/24/23. Oxygen room will be audited by Executive Director or Designee four times weekly for four weeks then 3 times weekly to ensure racks full and empty tanks are separated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/19/2023**

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K 923	Continued From page 18	K 923	Results of audits will be submitted to the Quality Assurance Committee for review and recommendations. Executive Director or Designee will monitor oxygen room monthly to ensure full and empty tanks are being separated. Executive Director, or designee will be responsible for the corrective actions and for monitoring compliance This alleged deficient practice will be corrected by 9/6/2023	