DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 22, 2020

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

RE: CCN: 245270
Cycle Start Date: November 5, 2020

Dear Administrator:

On December 14, 2020, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
November 18, 2020

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

RE: CCN: 245270
Cycle Start Date: November 5, 2020

Dear Administrator:

On November 5, 2020, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 February 5, 2021 (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 May 5, 2021 (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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@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 11/05/2020

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
F 000	INITIAL COMMENTS On 11/4/2020 to 11/5/2020, an abbreviated survey was completed at your facility to conduct a complaint investigations. Your facility was found to be NOT compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED with a deficiency cited at F689 H5270019C H5270020C H5270022C H5270021C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to conduct a thorough analysis of resident's falls in a timely manner, review of appropriate patient-centered interventions, and evaluate the	F 689	R 1 no longer resides at the facility. Residents who experience falls have the potential to be impacted by this practice. Review of IDT process post falls was	12/7/20

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

Electronically Signed | 12/03/2020

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F 689	Continued From page 1 effectiveness of current interventions to prevent and/or reduce the likelihood of future falls for 1 of 2 residents (R1) reviewed for accidents. Finding include: R1's annual Minimum Data Set (MDS) assessment dated 8/7/2020, indicated R1 had moderate cognitive impairment, rejection of care behaviors that occurred on 1 to 3 days during the assessment period, and R1 had severely impaired vision. The MDS also indicated R1 was occasional urinary incontinence and no falls since the last assessment completed on 5/8/2020. R1's Transfer/Discharge Report dated 10/20/2020, included diagnoses of Alzheimer's disease, atrial fibrillation (A disease of the heart characterized by irregular and often faster heartbeat) and chronic obstructive pulmonary disease (A group of progressive lung disorders characterized by increasing breathlessness). R1's Fall risk assessment dated 8/7/2020, was at low risk for falls, had no falls in the last 6 months, had severely impaired vision, was occasionally incontinent of urine, and was administered diuretic, antihypertensive, narcotic, and psychotropic medications. According to R1's vision care plan dated 4/9/2019, R1 was legally blind. R1's care plan for falls dated 4/9/2019, included "Potential for injury; fall risk related to use of psychotropic drugs and impaired vision as evidenced by forgetting to use assistive devices." Fall interventions included: - Anticipate and meet needs, encourage resident to always call for assistance (4/9/2019),	F 689	completed and determined that updating notes during the morning clinical meeting will ensure that notes are made timely, root cause discussion is documented, and new interventions are validated or updated. Education was provided to the Director of Nursing and Executive Director on root cause analysis and falls interventions by Director of Clinical Services upon survey exit. Education included that identification of the root cause of falls can result in more effective interventions. The Director of Nursing or designee will provide education to licensed nurses on identifying the probable cause of the fall, implementing a new intervention, and documenting these decisions at the time of the fall. The executive director or designee will audit risk management reports three times weekly for four weeks. Results of audits will be reviewed, and ongoing auditing will be completed based on the recommendation of the quality assurance and performance improvement committee.	

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F 689	Continued From page 2	F 689		

-educate the resident on fall prevention measures. Assure resident that calling for help is not a bother (4/9/2019)
-Ensure that the resident is wearing appropriate footwear (4/9/2019)
-Place call light or communication device within reach. Answer light promptly-always (4/9/2020)
R1's activity of daily living care plan dated 5/18/2020, identified for bed mobility R1 required extensive assist of one however was sometimes independent, for toileting R1 required extensive assist of one however was independent at times but incontinent, and for transfers R1 was independent to extensive assistance of one with gait belt.

R1's record review of fall incident reports from 8/31/2020 included 2 falls from 8/31/2020 to 10/16/2020.

1. R1's fall incident report dated 8/31/2020, indicated R1 had an unwitnessed fall with no injuries. The time of the fall was not identified on the report. Nursing assistant (NA) heard a crashing noise coming from the resident's room; upon entry, tray table had been pushed to the bathroom door and lunch tray was on the floor, and the resident was on the floor by his chair. Resident stated "I was trying to stand up from my chair and the chair slid back and I lost my balance." The immediate action taken was collection of vital signs and the resident was transferred to bed. Predisposing factors check marked on the report included; furniture, narcotic and diuretic administration, and during a transfers. R1's record lacked identification of root cause analysis, and lacked immediate interventions were developed and implemented. According to the report, the interdisciplinary team

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F 689	Continued From page 3	F 689		

(IDT) review of the fall was not completed until 9/18/2020, "Resident states he was trying to get up from the chair and slid. Reminded resident to ask for (sic) when he wants to transfer. Ensured that chair is sturdy and not able to slip around. Noted that the chair was placed up against the wall." The report did not identify why R1 attempted self-transfer.

R1's care plan lacked revision of fall interventions that were identified on the fall report.

R1's record lacked evidence of a completed post-fall risk assessment per the facility's policy and procedures.

2. R1's fall incident report dated 10/16/2020, indicated R1 had an unwitnessed fall with laceration to back of head and scratch/excoriation to face. The report did not identify the time of the fall. "Call to room due to resident had falling for stand position and was lying on floor on his right side." Resident stated he lost his balance. The report did not identify why R1 had attempted self-transfer. Predisposing factors checked marked on the report included: bed in low position, furniture, recent change in condition, narcotic and diuretic administration, anticoagulant, confused, incontinent, and ambulating without assist. Immediate action taken included, "Found on the floor on his right side with bright red blood on the floor". The record lacked evidence of root cause analysis and immediate fall interventions were developed and implemented. According to the report, the IDT review of the fall was not completed until 10/22/2020, "[name of resident] will need frequent reminders to ask for help prior to transferring. [R1] stated he knew to push his call light but

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F 689	Continued From page 4	F 689		

didn't. A call before you fall sign will be in place as a reminder for him to call for help. Resident did have clutter in his room which was cleared. Resident and family did not want any medical attention for this fall. Staff will continue with post fall follow-up. Orders received from MD for treatment of pain.

R1's care plan lacked revision to include the interventions that were identified in the fall incident report.

R1's record lacked evidence of a completed post-fall risk assessment per the facility's policy and procedures.

During an interview on 11/4/2020, at 10:00 a.m. licensed practical nurse (LPN)-B stated she was working on 10/16/2020, when R1 fell. LPN-B stated she entered the room, R1 was lying on the floor right inside the door lying on his side without his oxygen on; R1 frequently took his oxygen off because he didn't like it. LPN-B indicated R1's oxygen saturations were between 66 and 70%. LPN-B stated R1 and his family did not want further evaluation at the hospital. LPN-B indicated she was not aware of why R1 had attempted self-transfer because she didn't ask R1 because more worried about the injury. LPN-B stated his nurse was on lunch break at the time, and she had just been called to help with the fall. LPN-B stated she had started a fall incident report. When asked what intervention was put into place to decrease/prevent R1's risk of subsequent falls, LPN-B stated R1 was transferred via full body mechanical lift back into bed, the physician was notified. LPN-B indicated an unawareness of R1's fall on 8/31/2020.

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F 689	Continued From page 5	F 689		

During an interview on 11/4/2020, at 10:14 a.m. nursing assistant (NA)-B indicated fall interventions were listed on the care plan or Kardex (abbreviated care plan). NA-B indicated any changes to the care plan would be communicated in shift report or on a daily report sheet. NA-B stated she was working on 10/16/2020, when R1 fell and had went had went to his room to help. NA-B stated the nurse was in the room, thought R1 had fallen onto his tray table, "I think he was trying to stand up and got to the toilet, he was independent with toileting but I think he was weak." NA-B stated R1 had just started declining, however he still could transfer ok, but he was unstable when he walked. NA-B stated R1 was sometimes incontinent of urine. NA-B indicated R1 was checked on frequently because he didn't like his oxygen and would take it off causing his oxygen saturations to decrease. NA-B stated R1 would use his call light sporadically, however, he would not push the button, he would pull the cord out of the wall. NA-B indicated R1 was always encouraged to use the call light when staff left the room, however would forget. NA-B did not recall new fall interventions after R1 fell on 10/16/2020.

During an interview on 11/4/2020, at 11:15 a.m. family member (FM)-1 stated R1 had trouble with his memory, had really bad vision, and was not the type of person to ask for help when he needed it. FM-1 stated R1 had started using oxygen back in August, however would not keep it on. FM-1 stated R1 was on "water pills" that made him have to go to the bathroom "right now" and he would have to go sometimes almost every half hour. FM-1 stated the last couple of months had been hard for R1 and he started giving up. FM-1 indicated R1 required more assistance from

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F 689	Continued From page 6	F 689		

staff especially in the last couple of weeks after he was diagnoses with pneumonia. FM-1 stated that they had been notified after R1's falls. FM-1 did not recall the facility discussing further fall interventions, and there was "nothing ever communicated about a toileting schedule or plan" and indicated that could have been why he fell.

During an interview on 11/4/2020, at 11:59 a.m. LPN-C stated after a fall, an incident report was filled out, supposed to figure out what caused the fall, and implement an intervention to prevent more falls. LPN-C reviewed R1's fall interventions from 10/16/2020, and stated "reminding someone who is confused to remember something is not appropriate. Putting signs in his room; he had a hard time seeing so that would not have been right either."

During an interview on 11/4/2020, at 12:14 p.m. director of nursing (DON) stated the expectation of when nurses fill out the fall report they be as thorough as possible which includes the time fall occurred, where in the room it occurred, what was the resident trying to do, and immediate interventions to prevent/reduce risk of another fall. DON stated after a fall post fall risk assessment was expected to be completed. DON confirmed post fall risk assessments were not completed after R1's falls. R1's fall incident reports were reviewed with DON. In regards to the 8/31/2020, fall report the DON stated the following: had no idea what time the fall actually occurred, R1 was trying to stand up however did not know why he was trying to stand up, and could not ascertain if R1's self-transfer attempt was related to toileting. DON stated there was not enough information in the fall report to determine root cause, and if it was a toileting issue then we

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F 689	Continued From page 7 would want to know that. DON stated the intervention was to move R1's recliner up against the wall. DON confirmed that IDT note was not written until 9/18, however IDT meetings were every morning and the note was entered late although the intervention was implemented immediately. DON verified it was not evident in R1's record the intervention was implemented immediately. In regards to the 10/16/2020, fall report the DON stated the following: the report did not identify the time of the fall, if the time of the falls are not indicated a trend was difficult to identify, unknown where he was found lying in his room, and unknown what he was trying to do. DON indicated if the fall was a toileting related issue, it would be important to know that. DON stated R1's last bladder assessment had not been completed since his recent decline and the last assessment was completed in august. DON stated the care plan was not revised to include the interventions after the 10/16/2020 fall. Facility policy and procedure Accidents and Incidents dated 3/6/2020, included; All accidents and incidents involving residents, employees, visitors, vendors, etc., occurring on the facility premises shall be investigated and reported to the administrator. 1. Residents will be assessed for falls and other accidents upon admission, readmission, quarterly, with significant change in condition, and after each fall. 2. Complete an incident/accident report when staff is are that an incident occurred. Review each incident report at morning or daily clinical meeting. 3. Complete a fall investigation after every fall. 4. Notify the physician and responsible party as appropriate and update the care plan.	F 689		

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F 689	Continued From page 8 Facility policy Fall Prevention and Management Guidelines dated 2/2017, The facility will maintain a fall prevention and management program. In as much as it is in the power of the facility, the facility will prevent and/or manage the resident's risk for falls. Fall Prevention and Management Guideline Objectives: -Appropriate fall management needs to result in reducing falls, minimizing injuries, and ultimately improving the quality of lift of residents -Limit and/or prevent the occurrence of falls within the parameters that can be controlled through structured program interventions. Details of Key Elements- detailed different types of assessments areas used to determine risk for falls and interventions; Assessments that may assist with identification of fall risk and/or interventions to prevent falls included; Clinical assessment, rehabilitation assessment, continence protocol, mental status, pain assessment, diagnosis that increase risk for falls, pharmacological assessment and review, and environment assessment. Identify level of risk based on collective assessments and professional judgment. Dynamic Treatment Plan 1. Specific interventions are based on results of the fall assessments and individual resident's preferences; the section directed what should be addressed. Evaluation: 1. Complete a post fall evaluation and complete required notifications after every fall, near miss fall or assisted fall. a.) An investigation and a fall risk assessment must be completed. These need to include Root Cause Analysis.	F 689		

R 1 no longer resides at the facility.

Residents who experience falls have the potential to be impacted by this practice. Review of IDT process post falls was completed and determined that updating notes during the morning clinical meeting will ensure that notes are made timely, root cause discussion is documented, and new interventions are validated or updated.
Education was provided to the Director of Nursing and Executive Director on root cause analysis and falls interventions by Director of Clinical Services upon survey exit. Education included that identification of the root cause of falls can result in more effective interventions. The Director of Nursing or designee will provide education to licensed nurses on identifying the probable cause of the fall, implementing a new intervention, and documenting these decisions at the time of the fall.

The executive director or designee will audit risk management reports three times weekly for four weeks. Results of audits will be reviewed, and ongoing auditing will be completed based on the recommendation of the quality assurance and performance improvement committee.

Date of compliance is December 7, 2020

Electronically delivered
November 18, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: MSJS11

Dear Administrator:

The above facility was surveyed on November 4, 2020 through November 5, 2020 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@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 11/05/2020

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) COMPLETE DATE
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 11/4/2020 to 11/5/2020, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be	2 000		

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2 000	Continued From page 1 completed. The following complaint was found to be SUBSTANTIATED: H5270019C with a deficiency cited at F689 H5270020C was substantiated with no deficiency H5270022C was substantiated with no deficiency H5270021C was substantiated with no deficiency The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to conduct a thorough analysis of resident's falls in a timely manner, review of appropriate patient-centered interventions, and evaluate the effectiveness of	2 830	POC for F689 will be used to remedy state licensure tag.	12/7/20

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2 830	Continued From page 2 current interventions to prevent and/or reduce the likelihood of future falls for 1 of 2 residents (R1) reviewed for accidents. Finding include: R1's annual Minimum Data Set (MDS) assessment dated 8/7/2020, indicated R1 had moderate cognitive impairment, rejection of care behaviors that occurred on 1 to 3 days during the assessment period, and R1 had severely impaired vision. The MDS also indicated R1 was occasional urinary incontinence and no falls since the last assessment completed on 5/8/2020. R1's Transfer/Discharge Report dated 10/20/2020, included diagnoses of Alzheimer's disease, atrial fibrillation (A disease of the heart characterized by irregular and often faster heartbeat) and chronic obstructive pulmonary disease (A group of progressive lung disorders characterized by increasing breathlessness). R1's Fall risk assessment dated 8/7/2020, was at low risk for falls, had no falls in the last 6 months, had severely impaired vision, was occasionally incontinent of urine, and was administered diuretic, antihypertensive, narcotic, and psychotropic medications. According to R1's vision care plan dated 4/9/2019, R1 was legally blind. R1's care plan for falls dated 4/9/2019, included "Potential for injury; fall risk related to use of psychotropic drugs and impaired vision as evidenced by forgetting to use assistive devices." Fall interventions included: - Anticipate and meet needs, encourage resident	2 830		

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2 830	Continued From page 3 to always call for assistance (4/9/2019), -educate the resident on fall prevention measures. Assure resident that calling for help is not a bother (4/9/2019) -Ensure that the resident is wearing appropriate footwear (4/9/2019) -Place call light or communication device within reach. Answer light promptly-always (4/9/2020) R1's activity of daily living care plan dated 5/18/2020, identified for bed mobility R1 required extensive assist of one however was sometimes independent, for toileting R1 required extensive assist of one however was independent at times but incontinent, and for transfers R1 was independent to extensive assistance of one with gait belt. R1's record review of fall incident reports from 8/31/2020 included 2 falls from 8/31/2020 to 10/16/2020. 1. R1's fall incident report dated 8/31/2020, indicated R1 had an unwitnessed fall with no injuries. The time of the fall was not identified on the report. Nursing assistant (NA) heard a crashing noise coming from the resident's room; upon entry, tray table had been pushed to the bathroom door and lunch tray was on the floor, and the resident was on the floor by his chair. Resident stated "I was trying to stand up from my chair and the chair slid back and I lost my balance." The immediate action taken was collection of vital signs and the resident was transferred to bed. Predisposing factors check marked on the report included; furniture, narcotic and diuretic administration, and during a transfers. R1's record lacked identification of root cause analysis, and lacked immediate interventions were developed and implemented.	2 830		

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2 830	Continued From page 4 According to the report, the interdisciplinary team (IDT) review of the fall was not completed until 9/18/2020, "Resident states he was trying to get up from the chair and slid. Reminded resident to ask for (sic) when he wants to transfer. Ensured that chair is sturdy and not able to slip around. Noted that the chair was placed up against the wall." The report did not identify why R1 attempted self-transfer. R1's care plan lacked revision of fall interventions that were identified on the fall report. R1's record lacked evidence of a completed post-fall risk assessment per the facility's policy and procedures. 2. R1's fall incident report dated 10/16/2020, indicated R1 had an unwitnessed fall with laceration to back of head and scratch/excoriation to face. The report did not identify the time of the fall. "Call to room due to resident had falling for stand position and was lying on floor on his right side." Resident stated he lost his balance. The report did not identify why R1 had attempted self-transfer. Predisposing factors checked marked on the report included: bed in low position, furniture, recent change in condition, narcotic and diuretic administration, anticoagulant, confused, incontinent, and ambulating without assist. Immediate action taken included, "Found on the floor on his right side with bright red blood on the floor". The record lacked evidence of root cause analysis and immediate fall interventions were developed and implemented. According to the report, the IDT review of the fall was not completed until 10/22/2020, "[name of resident] will need frequent reminders to ask for help prior to	2 830		

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2 830	Continued From page 5 transferring. [R1] stated he knew to push his call light but didn't. A call before you fall sign will be in place as a reminder for him to call for help. Resident did have clutter in his room which was cleared. Resident and family did not want any medical attention for this fall. Staff will continue with post fall follow-up. Orders received from MD for treatment of pain. R1's care plan lacked revision to include the interventions that were identified in the fall incident report. R1's record lacked evidence of a completed post-fall risk assessment per the facility's policy and procedures. During an interview on 11/4/2020, at 10:00 a.m. licensed practical nurse (LPN)-B stated she was working on 10/16/2020, when R1 fell. LPN-B stated she entered the room, R1 was lying on the floor right inside the door lying on his side without his oxygen on; R1 frequently took his oxygen off because he didn't like it. LPN-B indicated R1's oxygen saturations were between 66 and 70%. LPN-B stated R1 and his family did not want further evaluation at the hospital. LPN-B indicated she was not aware of why R1 had attempted self-transfer because she didn't ask R1 because more worried about the injury. LPN-B stated his nurse was on lunch break at the time, and she had just been called to help with the fall. LPN-B stated she had started a fall incident report. When asked what intervention was put into place to decrease/prevent R1's risk of subsequent falls, LPN-B stated R1 was transferred via full body mechanical lift back into bed, the physician was notified. LPN-B indicated an unawareness of R1's fall on 8/31/2020.	2 830		

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2 830	Continued From page 6 During an interview on 11/4/2020, at 10:14 a.m. nursing assistant (NA)-B indicated fall interventions were listed on the care plan or Kardex (abbreviated care plan). NA-B indicated any changes to the care plan would be communicated in shift report or on a daily report sheet. NA-B stated she was working on 10/16/2020, when R1 fell and had went had went to his room to help. NA-B stated the nurse was in the room, thought R1 had fallen onto his tray table, "I think he was trying to stand up and got to the toilet, he was independent with toileting but I think he was weak." NA-B stated R1 had just started declining, however he still could transfer ok, but he was unstable when he walked. NA-B stated R1 was sometimes incontinent of urine. NA-B indicated R1 was checked on frequently because he didn't like his oxygen and would take it off causing his oxygen saturations to decrease. NA-B stated R1 would use his call light sporadically, however, he would not push the button, he would pull the cord out of the wall. NA-B indicated R1 was always encouraged to use the call light when staff left the room, however would forget. NA-B did not recall new fall interventions after R1 fell on 10/16/2020. During an interview on 11/4/2020, at 11:15 a.m. family member (FM)-1 stated R1 had trouble with his memory, had really bad vision, and was not the type of person to ask for help when he needed it. FM-1 stated R1 had started using oxygen back in August, however would not keep it on. FM-1 stated R1 was on "water pills" that made him have to go to the bathroom "right now" and he would have to go sometimes almost every half hour. FM-1 stated the last couple of months had been hard for R1 and he started	2 830		

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2 830	Continued From page 7 giving up. FM-1 indicated R1 required more assistance from staff especially in the last couple of weeks after he was diagnoses with pneumonia. FM-1 stated that they had been notified after R1's falls. FM-1 did not recall the facility discussing further fall interventions, and there was "nothing ever communicated about a toileting schedule or plan" and indicated that could have been why he fell. During an interview on 11/4/2020, at 11:59 a.m. LPN-C stated after a fall, an incident report was filled out, supposed to figure out what caused the fall, and implement an intervention to prevent more falls. LPN-C reviewed R1's fall interventions from 10/16/2020, and stated "reminding someone who is confused to remember something is not appropriate. Putting signs in his room; he had a hard time seeing so that would not have been right either." During an interview on 11/4/2020, at 12:14 p.m. director of nursing (DON) stated the expectation of when nurses fill out the fall report they be as thorough as possible which includes the time fall occurred, where in the room it occurred, what was the resident trying to do, and immediate interventions to prevent/reduce risk of another fall. DON stated after a fall post fall risk assessment was expected to be completed. DON confirmed post fall risk assessments were not completed after R1's falls. R1's fall incident reports were reviewed with DON. In regards to the 8/31/2020, fall report the DON stated the following: had no idea what time the fall actually occurred, R1 was trying to stand up however did not know why he was trying to stand up, and could not ascertain if R1's self-transfer attempt was related to toileting. DON stated there was	2 830		

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2 830	Continued From page 8 not enough information in the fall report to determine root cause, and if it was a toileting issue then we would want to know that. DON stated the intervention was to move R1's recliner up against the wall. DON confirmed that IDT note was not written until 9/18, however IDT meetings were every morning and the note was entered late although the intervention was implemented immediately. DON verified it was not evident in R1's record the intervention was implemented immediately. In regards to the 10/16/2020, fall report the DON stated the following: the report did not identify the time of the fall, if the time of the falls are not indicated a trend was difficult to identify, unknown where he was found lying in his room, and unknown what he was trying to do. DON indicated if the fall was a toileting related issue, it would be important to know that. DON stated R1's last bladder assessment had not been completed since his recent decline and the last assessment was completed in august. DON stated the care plan was not revised to include the interventions after the 10/16/2020 fall. Facility policy and procedure Accidents and Incidents dated 3/6/2020, included; All accidents and incidents involving residents, employees, visitors, vendors, etc., occurring on the facility premises shall be investigated and reported to the administrator. 1. Residents will be assessed for falls and other accidents upon admission, readmission, quarterly, with significant change in condition, and after each fall. 2. Complete an incident/accident report when staff is are that an incident occurred. Review each incident report at morning or daily clinical meeting. 3. Complete a fall investigation after every fall.	2 830		

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2 830	Continued From page 9 4. Notify the physician and responsible party as appropriate and update the care plan. Facility policy Fall Prevention and Management Guidelines dated 2/2017, The facility will maintain a fall prevention and management program. In as much as it is in the power of the facility, the facility will prevent and/or manage the resident's risk for falls. Fall Prevention and Management Guideline Objectives: -Appropriate fall management needs to result in reducing falls, minimizing injuries, and ultimately improving the quality of lift of residents -Limit and/or prevent the occurrence of falls within the parameters that can be controlled through structured program interventions. Details of Key Elements- detailed different types of assessments areas used to determine risk for falls and interventions; Assessments that may assist with identification of fall risk and/or interventions to prevent falls included; Clinical assessment, rehabilitation assessment, continence protocol, mental status, pain assessment, diagnosis that increase risk for falls, pharmacological assessment and review, and environment assessment. Identify level of risk based on collective assessments and professional judgment. Dynamic Treatment Plan 1. Specific interventions are based on results of the fall assessments and individual resident's preferences; the section directed what should be addressed. Evaluation: 1. Complete a post fall evaluation and complete required notifications after every fall, near miss fall or assisted fall. a.) An investigation and a fall risk assessment must be completed. These need to include Root Cause Analysis. SUGGESTED METHOD OF CORRECTION: The	2 830		

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2 830	Continued From page 10 DON or designee could review the facility's fall program policies and procedures and reeducate licensed staff on ensuring complete fall documentation, ensuring completion of fall incident reports, determination of root cause, and implementation of appropriate immediate interventions to prevent/reduce the risk of resident falls. The DON/designee could then develop an auditing system to ensure ongoing compliance as part of the facility's quality assurance program. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		