

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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

Whitewater Health Services November 18, 2020 Page 2

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

Whitewater Health Services November 18, 2020 Page 3 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

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

PRINTED: 12/04/2020 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245270	B. WING _		C 11/05/2020	
	PROVIDER OR SUPPLIER ATER HEALTH SERV	/ICES		STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE ST CHARLES, MN 55972		
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F 000	INITIAL COMMENTS		F 0	00		
	survey was comple complaint investiga to be NOT complian Requirements for L The following comp SUBSTANTIATED H5270019C H5270020C H5270022C	1/5/2020, an abbreviated ted at your facility to conduct a tions. Your facility was found note with 42 CFR Part 483, ong Term Care Facilities. Islaints were found to be with a deficiency cited at F689				
	signature is not req page of the CMS-28 Although no plan of required that the fact the electronic documents.	correction is required, it is cility acknowledge receipt of ments. azards/Supervision/Devices	F 6	89	12/7/20	
SS=D	as free of accident	ts.				
ADODATOS	supervision and assaccidents. This REQUIREMENT by: Based on interview failed to conduct a falls in a timely mar patient-centered interview.	resident receives adequate sistance devices to prevent NT is not met as evidenced and record review the facility thorough analysis of resident's nner, review of appropriate erventions, and evaluate the	NATURE	R 1 no longer resides at the facil Residents who experience falls h potential to be impacted by this p Review of IDT process post falls	ave the ractice.	

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

(X6) DATE

Electronically Signed

12/03/2020

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	3		S	STREET ADDRESS, CITY, STATE, ZIP CODE		0.2020
WHITEW	ATER HEALTH SER	VICES		525 BLUFF AVENUE ST CHARLES, MN 55972			
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F 689	and/or reduce the 2 residents (R1) r	aurrent interventions to prevent likelihood of future falls for 1 of eviewed for accidents. aum Data Set (MDS) 1 8/7/2020, indicated R1 had e impairment, rejection of care surred on 1 to 3 days during the d, and R1 had severely ne MDS also indicated R1 was incontinence and no falls since nt completed on 5/8/2020. Charge Report dated led diagnoses of Alzheimer's llation (A disease of the heart regular and often faster ronic obstructive pulmonary of progressive lung disorders increasing breathlessness). Essment dated 8/7/2020, was at ad no falls in the last 6 months, ired vision, was occasionally e, and was administered tensive, narcotic, and	F6	589	,	meeting mely, and a rector of a root ons by survey diffication lt in Director e the fall, and the time e will ree ults of ing on the	
	falls dated 4/9/201 injury; fall risk rela drugs and impaire forgetting to use a interventions inclu - Anticipate and m	9, included "Potential for ted to use of psychotropic d vision as evidenced by ssistive devices." Fall					

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

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F 689	-educate the resider measures. Assure not a bother (4/9/2019-Ensure that the residence (4/9/2019-Place call light or creach. Answer light R1's activity of daily 5/18/2020, identified extensive assist of independent, for to assist of one hower but incontinent, and independent to extensive assist of one hower but incontinent, and independent to extensive assist of one hower but incontinent, and independent to extensive assist of one hower but incontinent, and independent to extensive assist of one hower but incontinent, and independent to extensive assist of one hower but incontinent, and independent to extensive sealth. R1's record review 8/31/2020 included 10/16/2020. 1. R1's fall incident indicated R1 had a injuries. The time of the report. Nursing crashing noise componentry, tray tabbathroom door and and the resident was Resident stated "I will be a chair and the chair balance." The imm collection of vital situansferred to bed. marked on the report and diuretic adminitations and the resident was Resident stated "I will be a considered to be and diuretic adminitations and the report. R1's record and diuretic adminitations and the report. The imm collection of vital situansferred to bed. marked on the report. R1's record and diuretic adminitations and the resident was reported to be and diuretic adminitations and the report.	ent on fall prevention resident that calling for help is 019) sident is wearing appropriate	F 6	89		

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

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION		E SURVEY PLETED
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F 689	(IDT) review of the 9/18/2020, "Reside up from the chair are ask for (sic) when he that chair is sturdy a Noted that the chair wall." The report did attempted self-transe R1's care plan lack that were identified R1's record lacked post-fall risk assess and procedures. 2. R1's fall incident indicated R1 had an laceration to back to face. The report fall. "Call to room distand position and side." Resident stat report did not identified." Resident stat report did not identified marked on the repoposition, furniture, report and diuretianticoagulant, confiambulating without taken included, "Foside with bright red record lacked evide and immediate fall and implemented. In IDT review of the fall 10/22/2020, "[name reminders to ask for side with process to ask for si	fall was not completed until nt states he was trying to get and slid. Reminded resident to be wants to transfer. Ensured and not able to slip around. It was placed up against the donot identify why R1 sfer. The drevision of fall interventions on the fall report. The drevision of fall interventions on the fall report. The drevision of fall interventions on the fall report. The drevision of fall interventions on the fall report. The drevision of fall interventions on the fall report. The drevision of fall interventions on the fall report. The drevision of fall interventions on the fall report. The drevision of fall interventions on the fall report. The drevision of fall interventions on the fall report. The drevision of fall interventions on the fall with of head and scratch/excoriation did not identify the time of the ue to resident had falling for was lying on floor on his right the drevision of the lost his balance. The fall with of the lost his balance. The fall with of the lost his balance. The fall report included: bed in low recent change in condition,		889			

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

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F 689	didn't. A call before a reminder for him to have clutter in his rong Resident and family attention for this fall fall follow-up. Order treatment of pain. R1's care plan lacked interventions that we incident report. R1's record lacked post-fall risk assess and procedures. During an interview licensed practical in working on 10/16/20 stated she entered floor right inside the his oxygen on; R1 f because he didn't li oxygen saturations LPN-B stated R1 are further evaluation as he was not aware self-transfer becaus more worried about nurse was on lunch had just been called stated she had star When asked what it to decrease/preven LPN-B stated R1 we mechanical lift backets.	you fall sign will be in place as to call for help. Resident did from which was cleared. It did not want any medical it. Staff will continue with post is received from MD for seed revision to include the ere identified in the fall evidence of a completed sment per the facility's policy on 11/4/2020, at 10:00 a.m. urse (LPN)-B stated she was 020, when R1 fell. LPN-B the room, R1 was lying on the edoor lying on his side without requently took his oxygen off ke it. LPN-B indicated R1's were between 66 and 70%. In the hospital. LPN-B indicated of why R1 had attempted se she didn't ask R1 because if the injury. LPN-B stated his break at the time, and she did to help with the fall. LPN-B ted a fall incident report. Intervention was put into place to the R1's risk of subsequent falls, as transferred via full body into bed, the physician was cated an unawareness of R1's	F6	89				

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

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F 689	During an interview nursing assistant (N interventions were Kardex (abbreviate any changes to the communicated in sisheet. NA-B stated 10/16/2020, when It to his room to help, the room, thought It table, "I think he was the toilet, he was in think he was weak, started declining, hook, but he was unsistated R1 was som NA-B indicated R1 because he didn't liit off causing his ox NA-B stated R1 wo sporadically, however button, he would pund NA-B indicated R1 use the call light whowever would forgfall interventions aff. During an interview family member (FM his memory, had rethe type of person to needed it. FM-1 stated Fm and him have to gand he would have half hour. FM-1 stated Fm and been hard for FM-1 stated for FM-1 stated for FM-1 stated him have to gand he would have half hour. FM-1 stated Fm and been hard for FM-1 stated for FM-1 s	on 11/4/2020, at 10:14 a.m.	F6	89			

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

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F 689	he was diagnoses of that they had been did not recall the fainterventions, and to communicated about and indicated that of the communicated that of the communicated about and indicated that of the communicated about and indicated that of the communicated after filled out, supposed fall, and implement more falls. LPN-C refrom 10/16/2020, a who is confused to appropriate. Putting hard time seeing so right either." During an interview director of nursing of when nurses fill of thorough as possib occurred, where in was the resident try interventions to prefall. DON stated aft assessment was exconfirmed post fall completed after R1 reports were review the 8/31/2020, fall refollowing: had no id occurred, R1 was to not know why he was could not ascertain was related to toiled enough information.	ge 6 ne last couple of weeks after with pneumonia. FM-1 stated notified after R1's falls. FM-1 cility discussing further fall here was "nothing ever ut a toileting schedule or plan" could have been why he fell. on 11/4/2020, at 11:59 a.m. a fall, an incident report was to figure out what caused the an intervention to prevent eviewed R1's fall interventions and stated "reminding someone remember something is not a signs in his room; he had a country that would not have been on 11/4/2020, at 12:14 p.m. (DON) stated the expectation out the fall report they be as the which includes the time fall the room it occurred, what ring to do, and immediate event/reduce risk of another er a fall post fall risk expected to be completed. DON risk assessments were not a falls. R1's fall incident event were the DON stated the ea what time the fall actually rying to stand up however did as trying to stand up, and if R1's self-transfer attempt ing. DON stated there was not in the fall report to determine was a toileting issue then we	F6	89			

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

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	COM	C C		
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F 689	would want to know intervention was to the wall. DON conf written until 9/18, hevery morning and although the intervention was to the wall. DON R1's record the intervention was to identify. In regreport the DON stanot identify the time falls are not indicated identify, unknown wroom, and unknown DON indicated if the issue, it would be instated R1's last blabeen completed sire last assessment was tated the care plant the interventions and Facility policy and plucidents dated 3/6 and incidents involvisitors, vendors, epremises shall be inthe administrator. 1. Residents will be accidents upon adrequarterly, with sign after each fall. 2. Complete an incident report meeting. 3. Complete a fall in the staff is are that an each incident report meeting.	w that. DON stated the move R1's recliner up against irmed that IDT note was not owever IDT meetings were the note was entered late ention was implemented verified it was not evident in ervention was implemented pards to the 10/16/2020, fall sted the following: the report did to of the fall, if the time of the ed a trend was difficult to where he was found lying in his in what he was trying to do. It is fall was a toileting related in mortant to know that. DON in was not revised to include the fall of the fall. In was not revised to include the the 10/16/2020 fall. In orocedure Accidents and in the facility in the facility investigated and reported to the assessed for falls and other mission, readmission, if if cant change in condition, and ident/accident report when incident occurred. Review it at morning or daily clinical investigation after every fall.		9			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
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F 689	Facility policy Fall I Guidelines dated 2 a fall prevention and much as it is in the will prevent and/or falls. Fall Prevention and Objectives: -Appropriate fall mareducing falls, mini improving the qualitation of assessments and falls and intervention Assessments that fall risk and/or interincluded; Clinical a assessment, contingain assessment, contingain assessment and lentify level of risk assessments and phynamic Treatmer are based on resul individual resident's directed what should evaluation: 1. Comcomplete required	Prevention and Management /2017, The facility will maintain and management program. In as power of the facility, the facility manage the resident's risk for d Management Guideline anagement needs to result in mizing injuries, and ultimately ity of lift of residents and the occurrence of falls within at can be controlled through an interventions. The detailed different types the assuments a detailed different types are used to determine risk for the occurrence of falls within the occurrence of falls within and assessment, rehabilitation of the residents of the fall assessment and review, assessment. The based on collective professional judgment. The fall assessments and as preferences; the section and the fall assessments and the plete a post fall evaluation and notifications after every fall,	F 689		· ·	
	fall risk and/or interincluded; Clinical areassessment, conting pain assessment, of falls, pharmacologicand environment are lidentify level of risk assessments and proposed individual residentify directed what should be a complete required near miss fall or as	rventions to prevent falls ssessment, rehabilitation nence protocol, mental status, diagnosis that increase risk for ical assessment and review, ssessment. To based on collective professional judgment. It Plan 1. Specific interventions at softhe fall assessments and as preferences; the section and be addressed.				

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> 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

Whitewater Health Services November 18, 2020 Page 2

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

M. Paig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00942	B. WING		C 11/05/202	20
	PROVIDER OR SUPPLIER	ICFS 525 BLUF	DRESS, CITY, S F AVENUE LES, MN 559	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE CON	X5) IPLETE IATE
2 000	Initial Comments	NTION*****	2 000			
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section order has been issued y. If, upon reinspection, it is iency or deficiencies cited octed, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag le number indicated below. It is several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	survey was conduct with State Licensure be NOT in compliar Licensure. Please in of correction that you	TS: 15/2020, an abbreviated ted to determine compliance e. Your facility was found to note with the MN State ndicate in your electronic plan but have reviewed these the date when they will be				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 12/03/20

STATE FORM 6899 If continuation sheet 1 of 11 MSJS11

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00942	B. WING		C 11/05/2020	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	10	0.2020
WHITEW	ATER HEALTH SERV	ICES	F AVENUE LES, MN 55	972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From page 1		2 000			
	completed.					
	SUBSTANTIATED: H5270019C with a H5270020C was su H5270022C was su	deficiency cited at F689 ubstantiated with no deficiency ubstantiated with no deficiency ubstantiated with no deficiency				
		ed in ePOC and therefore a uired at the bottom of the first				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			12/7/20
	receive nursing car custodial care, and individual needs and the comprehensive plan of care as des and 4658.0405. A be out of bed as muis a written order from the custodial from the cu	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 nursing home resident must uch as possible unless there om the attending physician ust remain in bed or the remain in bed.				
	by: Based on observative review the facility far analysis of resident review of appropria	ent is not met as evidenced fon, interview and record alled to conduct a thorough the falls in a timely manner, the patient-centered evaluate the effectiveness of		POC for F689 will be used to rem state licensure tag.	edy	

Minnesota Department of Health

STATE FORM 6899 MSJS11 If continuation sheet 2 of 11

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COMP	LETED
		00942	B. WING		11/0	5/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WHITEW	ATER HEALTH SERV	ICES 525 BLUF	F AVENUE			
***************************************	AIER HEAEITI OERV	ST CHAR	LES, MN 55	972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From page 2		2 830			
	current interventions to prevent and/or reduce the likelihood of future falls for 1 of 2 residents (R1) reviewed for accidents.					
	Finding include:					
	moderate cognitive behaviors that occu assessment period impaired vision. The occasional urinary since the last assest 5/8/2020. R1's Transfer/Disch 10/20/2020, included disease, atrial fibrill characterized by irrheartbeat) and chrodisease (A group of the occasional urinary).	8/7/2020, indicated R1 had impairment, rejection of care arred on 1 to 3 days during the , and R1 had severely e MDS also indicated R1 was incontinence and no falls assment completed on				
	low risk for falls, ha had severely impai incontinent of urine	esment dated 8/7/2020, was at d no falls in the last 6 months, red vision, was occasionally, and was administered ensive, narcotic, and eations.				
	4/9/2019, R1 was lofalls dated 4/9/2019 injury; fall risk related drugs and impaired forgetting to use as interventions include	rision care plan dated egally blind. R1's care plan for 0, included "Potential for ed to use of psychotropic I vision as evidenced by sistive devices." Fall led:				

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Minnesota Department of Health STATE FORM

MSJS11 If continuation sheet 3 of 11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00942	B. WING		11/0	5/2020
	PROVIDER OR SUPPLIER	ICFS 525 BLUF	DRESS, CITY, S F AVENUE LES, MN 559	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	to always call for as-educate the reside measures. Assure not a bother (4/9/2019-Ensure that the reside footwear (4/9/2019-Place call light or creach. Answer light R1's activity of daily 5/18/2020, identifie extensive assist of independent, for toi assist of one hower but incontinent, and independent to extegait belt. R1's record review 8/31/2020 included 10/16/2020. 1. R1's fall incident indicated R1 had an injuries. The time of the report. Nursing crashing noise comfupon entry, tray tab bathroom door and and the resident was Resident stated "I will chair and the chair balance." The immediate collection of vital signal transferred to bed. marked on the report and diuretic administransfers. R1's record cause analysis, and	esistance (4/9/2019), and on fall prevention resident that calling for help is (19) sident is wearing appropriate (19) si	2 830			

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE \$25 BLUF AVENUE \$1 CHARLES, MN 55972 [KA) ID SUMMARY STATEMENT OF DEFICIENCIES I (EACH CONRECTIVE ACTION SHOULD BE INCOME. TAG REGULATORY OR LSC DENTIFYING INFORMATION) 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 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/vexoriation to face. 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, nanctoic and diuretic administration, anticoagulant, confused, incontinent, and ambulating without assist. Immediate action taken included, "Found on the floor". The record lacked evidence of on the floor on his right side with bright red blood on the floor. The record lacked evidence of roct cause analysis	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES SES BLUFF AVENUE ST CHARLES, MN 55972 CAUTION SUMMARY STATEMENT OF DEFICIENCIES (EACH ECRIFICH WILST SE PRECEDED BY PULL) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION CRACH CORRECTIVE ACTION SHOULD BE CROSS-REPERBUCED TO THE APPROPRIATE				A. BUILDING.			,	
SUMMARY STATEMENT OF DEFICIENCY ST CHARLES, MN 55972	00942		B. WING					
XA1 ID PROVIDER'S PLAN OF CORRECTION PREPIX TAGE TAGE PREPIX	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE			
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PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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, narrotic and diuretic administration, anticoagulant, confused, incontinent, and ambulating without assist. Immediate action taken included, "Found on the floor". The			ST CHAR	LES, MN 55	972			
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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	2 830	According to the re (IDT) review of the 9/18/2020, "Reside up from the chair at ask for (sic) when he that chair is sturdy. Noted that the chair wall." The report did attempted self-trans. R1's care plan lack that were identified. R1's record lacked post-fall risk assess and procedures. 2. R1's fall incident indicated R1 had at laceration to back of scratch/excoriation identify the time of resident had falling lying on floor on his he lost his balance. Why R1 had attempted in low position, condition, narcotic anticoagulant, confiambulating without taken included, "For side with bright red record lacked evide and immediate fall and implemented. A IDT review of the factors of the side with the factors of the factors	port, the interdisciplinary team fall was not completed until nt states he was trying to get and slid. Reminded resident to be wants to transfer. Ensured and not able to slip around. It was placed up against the donot identify why R1 sfer. Bed revision of fall interventions on the fall report. Bevidence of a completed sment per the facility's policy of head and to face. The report did not the fall. "Call to room due to for stand position and was a right side." Resident stated. The report did not identify sted self-transfer. Predisposing arked on the report included: furniture, recent change in and diuretic administration, used, incontinent, and assist. Immediate action and on the floor on his right blood on the floor". The ence of root cause analysis interventions were developed according to the report, the all was not completed until	2 830				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00942		B. WING		11/0	5/2020
	PROVIDER OR SUPPLIER	ICFS 525 BLUF	DRESS, CITY, S F AVENUE LES, MN 559	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	transferring. [R1] st light but didn't. A caplace as a reminde Resident did have of cleared. Resident at medical attention for with post fall followfor treatment of pair. R1's care plan lack interventions that wincident report. R1's record lacked post-fall risk assess and procedures. During an interview licensed practical nicensed	ated he knew to push his call all before you fall sign will be in for him to call for help. Clutter in his room which was not family did not want any or this fall. Staff will continue up. Orders received from MD	2 830			

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Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED			
					С			
		00942	B. WING			5/2020		
		00342			11/0	312020		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
WHIIEW	ATER HEALTH SERV	ICES ST CHAR	LES, MN 55	972				
(V4) ID	STIMMARV STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)		
(X4) ID PREFIX	_	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE		
				DEFICIENCY)				
2 830	Continued From pa	ane 6	2 830					
2 000	Continued From pa	ige o	2 000					
	During an interview	on 11/4/2020, at 10:14 a.m.						
	nursing assistant (N							
	interventions were	listed on the care plan or						
	Kardex (abbreviate	d care plan). NA-B indicated						
	any changes to the	care plan would be						
	communicated in sl	hift 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							
		NA-B stated the nurse was in						
	the room, thought R1 had fallen onto his tray							
		as trying to stand up and got to						
		dependent with toileting but I						
		" NA-B stated R1 had just						
		owever he still could transfer						
		table when he walked. NA-B						
		etimes incontinent of urine.						
		was checked on frequently						
		ke his oxygen and would take						
		ygen saturations to decrease.						
		uld use his call light						
		er, he would not push the						
		all the cord out of the wall.						
		was always encouraged to						
		nen staff left the room,						
		get. NA-B did not recall new						
		ter R1 fell on 10/16/2020.						
	ian interventions an	.G. 13 1611 011 10/10/2020.						
	During an interview	on 11/4/2020 of 11:15 a.m.						
		on 11/4/2020, at 11:15 a.m.						
		l)-1 stated R1 had trouble with						
		ally bad vision, and was not						
		to ask for help when he						
		ited R1 had started using						
		gust, however would not keep						
		R1 was on "water pills" that						
		go to the bathroom "right now"						
		to go sometimes almost						
		I-1 stated the last couple of						
	months had been h	ard for R1 and he started						

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					`	
		00942	B. WING			5/2020
		00042			1 11/0	3/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WHITEW	ATER HEALTH SERV	ICES 525 BLUF	F AVENUE			
*****	ALLK HEALIH SEKV	ST CHAR	LES, MN 55	972		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DAIL
				,		
2 830	Continued From pa	ige 7	2 830			
	giving up. FM-1 ind	icated R1 required more				
		aff especially in the last couple				
	of weeks after he w					
		stated that they had been				
		alls. FM-1 did not recall the				
		urther fall interventions, and				
		ever communicated about a				
		or plan" and indicated that				
	could have been wi					
		,				
	During an interview	on 11/4/2020, at 11:59 a.m.				
		a fall, an incident report was				
		I to figure out what caused the				
		an intervention to prevent				
		eviewed R1's fall interventions				
	from 10/16/2020, a	nd stated "reminding someone				
		remember something is not				
		g signs in his room; he had a				
		that would not have been				
	right either."					
	3					
	During an interview	on 11/4/2020, at 12:14 p.m.				
		(DON) stated the expectation				
		out the fall report they be as				
		le which includes the time fall				
	occurred, where in	the room it occurred, what				
	was the resident try	ring to do, and immediate				
		vent/reduce risk of another				
		er a fall post fall risk				
		spected to be completed. DON				
		risk assessments were not				
		's falls. R1's fall incident				
		ved with DON. In regards to				
		report the DON stated the				
		lea what time the fall actually				
		rying to stand up however did				
		as trying to stand up, and				
		if R1's self-transfer attempt				
		ting. DON stated there was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PLUI DINC.	SURVEY PLETED
A. BUILDING:	LLILD
	5/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
WHITEWATER HEALTH SERVICES 525 BLUFF AVENUE ST CHARLES, MN 55972	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830 Continued From page 8 2 830	
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. 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 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.	

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00942		B. WING		11/0	; 5/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 11/0	5/2020
		525 BI UF	F AVENUE	STATE, ZIF CODE		
WHITEW	ATER HEALTH SERV	ICES	LES, MN 55	972		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 9	2 830			
	•	ian and responsible party as				
	Guidelines dated 2, a fall prevention and much as it is in the facility will prevent a risk for falls. Fall Prevention and Objectives: -Appropriate fall mareducing falls, minimis improving the qualitimit and/or prevention and Details of Key Elem of assessments are falls and intervention Assessments that in fall risk and/or interincluded; Clinical assessment, continuous assessment and pulle individual resident's directed what shou Evaluation: 1. Com complete required in near miss fall or as and a fall risk assessment need to include the continuous and a fall risk assessment and a	may assist with identification of ventions to prevent falls assessment, rehabilitation ence protocol, mental status, liagnosis that increase risk for cal assessment and review, assessment. based on collective professional judgment. It Plan 1. Specific interventions as of the fall assessments and a preferences; the section				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		00942	B. WING		11/0) 5/2020				
		00942			11/0	15/2020				
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
WHITEW	ATER HEALTH SERV	ICES	F AVENUE LES, MN 55	972						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE				
2 830	DON or designee of program policies are licensed staff on endocumentation, ensincident reports, de and implementation interventions to preferesident falls. The Edevelop an auditing compliance as part assurance program	ould review the facility's fall and procedures and reeducate suring complete fall suring completion of fall termination of root cause, an of appropriate immediate event/reduce the risk of DON/designee could then a system to ensure ongoing of the facility's quality	2 830							

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