Electronically delivered
January 10, 2021

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

RE: CCN: 245270
Cycle Start Date: December 23, 2020

Dear Administrator:

On December 23, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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 March 23, 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 June 23, 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 12/23/2020

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 12/23/2020 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5270023C The following complaint was found NOT substantiated: H5270024C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		1/22/21

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

Electronically Signed | 01/11/2021

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

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F 600	Continued From page 1 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to protect residents from verbal/mental abuse for 1 of 2 residents (R1) reviewed for allegations of abuse. Findings include: During an observation and interview on 12/23/2020, at 11:00 a.m. R1 sat on the edge of the bed. R1 looked down as he remembered that a few days ago licensed practical nurse (LPN)-A yelled at him which was very upsetting. R1 stated he just couldn't deal with it anymore that it had started wearing on him. R1 stated LPN-A was always cold and short to him. R1 stated LPN-A did treat not treat all residents that way, she had no time for him, and she had made him feel like he was not a person too. R1 indicated he had not witnessed LPN-A yelling at any other residents in the facility. R1 stated LPN-A was terminated, which made him feel very relieved he would not have to "put up" with her anymore, although did feel bad she lost her job. R1 stated he was grateful and satisfied with the facilities follow-up and actions taken as a result of LPN-A's actions. A facility Reported Incident (FRI) submitted to the State Agency on 12/17/2020, at 4:20 p.m. indicated the facility was reporting an allegation of	F 600	R1 has continued to demonstrate improved mood and has not had any further episodes of emotional distress related to treatment by staff. Residents are at risk for abuse while in a skilled facility. The facility will continue to screen employees, train employees, prevent, identify, investigate, protect and report and respond to abuse following the facility policy. Education was presented to staff interviewed following the incident that was reported. The executive director or designee will ensure that remaining employees receive education on abuse prevention, identification of potential abuse events, protection of residents, and reporting and responding to abuse. Education will be initiated for staff on January 15th, 2021. The executive director and director of nursing have a clear understanding of their role in investigating events as evidenced by the steps taken after the reported event. Audits will be completed by the executive director or designee three times weekly for four weeks by interviews of both residents and employees regarding their treatment by staff or co-workers. Results	

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F 600	Continued From page 2 emotional/mental abuse. The FRI identified licensed practical nurse (LPN)-A "Yelled at [R1] and told him to stop and to get out of the way, [R1] then began to raise his voice back at nurse. Nurse yelled at [R1] "go back to your room if that is the way you are going to act." [R1] began to cry." The report indicated facility staff intervened immediately and the nurse was suspended immediately pending investigation. R1's Admission Record provided by the facility on 12/23/2020, included diagnosis of anxiety and major depressive disorder. R1's quarterly Minimum Data Set (MDS) dated 12/11/2020, indicated R1 had moderate cognitive impairment and did not have signs and symptoms of delirium. The MDS identified R1 had verbal behaviors one to three days and did not have rejection of care behaviors. The MDS indicated R1 required extensive assistance from one staff member for bed mobility, transfers, toilet use, and personal hygiene. R1's care plan dated 11/20/2020, included, "[R1] is a vulnerable adult r/t [related to] age, nursing home placement, impaired hearing and impaired mobility, depression. He is able to report episodes of abuse/maltreatment. He is dependent on staff to remove him from potentially dangerous situations. Associated interventions directed staff to remove form potentially dangerous situations and report all episodes of abuse/maltreatment immediately. The care plan also indicated R1 could exhibit occasional behaviors of verbal aggression (yelling) towards staff and other residents and had tearful episodes at times. Associated interventions directed staff to remove from public area when behavior is	F 600	of audits will be forwarded to the quality assurance committee for review and recommendations.	

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F 600	Continued From page 3	F 600		

disruptive/unacceptable, and talk in a low pitch, calm voice to decrease/eliminate undesired behavior.

R1's progress note dated 12/17/2020, at 1:39 p.m. included "This writer heard yelling out side [sic] of my office door. I heard [R1] in dialogue with a nurse. They were both yelling in a loud voice. I immediately went to see what was happening. I heard the nurse tell [R1] "if you don't like it can go back to your room. I asked the nurse to stop arguing and I escorted [R1] to my office where he began to cry. [R1] stated I can't take this anymore, she's a bully. I cant [sic] take this much longer." Once [R1] was calm he proceeded to go to the activity of the day. The nurse who was caring for [R1] was sent home."

R1's progress note dated 12/18/2020, indicated the physician had ordered essential caregiver visits for R1 once weekly.

R1's progress note dated 12/23/2020, included "I have visited with [R1] everyday [sic] in my office regarding the incident with the nurse that happened last week. [R1] has voiced gratitude that we listened to him and took action. He says he is happy and has been in good spirits this week so far. [R1] continues to come to my office daily to speak about things of concerns and things that make him happy."

During an interview on 12/23/2020, at 9:30 a.m. social worker (SW), stated she was made aware of the incident between R1 and LPN-A. SW indicated R1 had a stronger personality and self-directed and made choices that were not the best in accordance with his care plan. SW indicated R1 could be sensitive at times and did

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F 600	Continued From page 4	F 600		

not like people telling him what to do. SW stated LPN-A should not have yelled at him and R1 did not deserve that.

During an interview on 12/23/2020, at 9:52 a.m. nursing assistant (NA)-A stated an awareness of the incident between R1 and LPN-A, however had not witnessed. NA-A stated LPN-A "wasn't warm all the time", "more businesslike, more cold, not personable with some residents.", "She didn't go out of her way her to do a job.", "she wasn't approachable". NA-A indicated an awareness of some staff fearing retaliation from LPN-A if they were to report her mannerisms to administration. NA-A stated he had not noticed any negative behavior changes in R1 since the incident. NA-A stated he was grateful to the new administrator for taking things seriously, because previous administration didn't seem to. NA-A stated he was interviewed as part of the investigation, had been provided with education, had not witnessed LPN-A abusing other residents, and did not have any concerns voiced by other residents.

During an interview on 12/23/2020, at 10:03 a.m. activities director (AD) stated an awareness of the incident, however not been a witness. AD indicated LPN-A seemed to not have patience with R1, R1 seemed to upset her, and she would get snotty with him. AD stated LPN-A made staff feel really uncomfortable and staff were scared of her. AD stated relief the administrator had terminated LPN-A. AD indicated it was not appropriate for LPN-A to treat R1 like that. AD stated she was interviewed by administration and has had abuse education.

During an interview on 12/23/2020, at 10:47 a.m.

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F 600	Continued From page 5	F 600		

medical records coordinator (MRC) stated she was aware of the incident between LPN-A and R1. MRC stated LPN-A was a hard person to be around and was aware of staff who had quit because of her however, had not witnessed LPN-A verbally abusing any residents. MRC indicated LPN-A's mannerisms toward R1 after time would probably be emotionally abusive.

During an interview on 12/23/2020, at 9:00 a.m. director of nursing (DON) and administrator, the administrator stated that the episode was witnessed, as it happened write outside the DON's and administrator's offices. Administrator stated LPN-A began the verbal altercation. Administrator stated, she could hear R1 stating, "I didn't do anything" then LPN-A stated, "if you don't like it, you can go back to your room!" DON then stated, she intervened by going out into the hallway, told them both to "stop arguing". DON stated she immediately removed R1 out of the situation by bringing him to her office where R1 was very visibly upset and crying; R1 reported to DON he was upset and stated, "I can't take this anymore." Administrator indicated while the DON was providing reassurance to R1, she suspended LPN-A and walked her out of the building. Administrator stated the facility stated after ensuring R1's safety, a report was filed with the State Agency and started the investigation. Administrator stated staff and residents were interviewed; the conclusion of the investigation revealed the other residents that were interviewed reported no concerns and felt safe, however staff indicated they felt LPN-A had more of a colder personality towards some residents and felt intimidated by her. Administrator indicated during the staff interview process abuse education was provided and reiterated. Administrator also

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F 600	Continued From page 6	F 600		

indicated as part of the investigation LPN-A's personnel record was reviewed; LPN-A had a similar allegation back in August. Administrator stated, at that time LPN-A was placed on a personal improvement plan for three months with direct supervision, provided education, weekly meetings, and was informed any further incidents would lead to termination. Administrator stated as a result of the investigation LPN-A's employment was terminated. DON stated when R1 was informed, he actually started crying when he found out. DON stated the physician and family was notified of the incident. DON stated since the incident she visited with R1 daily in order to monitor his mood or any effect the incident had; DON indicated R1's mood has seemed to actually improve since the incident.

The facility's investigation and ongoing abuse prevention plans included the following evidence of:
1) Immediate removal of LPN-A following incident to ensure safety of R1 and all the other residents residing in the facility.
2) Notification to the physician and R1's resident representative on 12/17/2020.
3) Immediate initiation of investigation which included staff members; residents were also interviewed in order to determine extent of the allegation. Interviews that were started on 12/17/2020, were completed on 12/28/2020.
4) Administrator provided re-education to all staff interviewed on 12/17 and 12/18/2020.
5) R1 was assessed following the incident, ongoing support services and assessments for any mood/behavioral changes as a result of incident.

The facility's Abuse Prevention Program dated

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F 600	Continued From page 7 2/2019, included: Our residents have the right to be free form abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom form corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Therefore, the facility has developed for screening and training employees for the protection of residents and for the prevention, identification, investigation, and reporting of abuse, mental abuse related to humiliating or demeaning photography and use of social media, neglect mistreatment, involuntary seclusion, misappropriation of property and exploitation of residents to include ... The facility's purpose is to assure that the facility is doing all that is within their control to prevent occurrences. These seven components listed below will give the facility guidance to assure the protection of all residents while they reside in the facility. The policy identified the seven components of abuse prevention: Screening, training, prevention, identification, investigation, protection and reporting/responding.	F 600		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 10, 2021

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

Re: Event ID: RFUI11

Dear Administrator:

The above facility survey was completed on December 23, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any 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

Minnesota Department of Health

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	00942	A. BUILDING: _____ B. WING _____	C 12/23/2020

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/23/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaint was found to be SUBSTANTIATED: H5270023C	2 000		

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

Electronically Signed | 01/11/21

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2 000	Continued From page 1 The following complaint was found to be UNSUBSTANTIATED: H5270024C NO licensing orders were issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		