



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 4, 2026

Administrator
WHITEWATER HEALTH SERVICES
525 BLUFF AVENUE
ST CHARLES, MN 55972

RE: CCN:245270

Cycle Start Date: April 16, 2026

Dear Administrator:

On April 16, 2026, 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor

St. Cloud A District Office

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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 **July 16, 2026** (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 **October 16, 2026** (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "H. Zahler". The signature is written in a cursive, slightly slanted style.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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May 4, 2026

Administrator
WHITEWATER HEALTH SERVICES
525 BLUFF AVENUE
ST CHARLES, MN 55972

Re: Event ID: 22EBF-H1

Dear Administrator:

The above facility survey was completed on April 16, 2026, 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,

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245270	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE , ST CHARLES, Minnesota, 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
F0000	<p>INITIAL COMMENTS</p> <p>On 4/15/26 through 4/16/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed. H52701237C (2980880). Incidental findings were discovered and cited at F655, F732, and F880.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F0000		05/20/2026
F0655 SS = D	<p>Baseline Care Plan</p> <p>CFR(s): 483.21(a)(1)-(3)</p> <p>§483.21 Comprehensive Person-Centered Care Planning</p> <p>§483.21(a) Baseline Care Plans</p> <p>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <p>(i) Be developed within 48 hours of a resident's admission.</p> <p>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-</p>	F0655	<p>R1 and R2 continue to reside at the facility. R1 and R2 had no identified adverse effects from this alleged deficient practice.</p> <p>Enhanced Barrier Precautions signage was put in place, supplies were provided, and care plans were developed with Enhanced Barrier Precautions interventions.</p> <p>Current residents that have indwelling catheters have the potential to be affected by this alleged deficient practice. An audit was conducted by the Director of Nursing/designee to review residents with indwelling catheters to ensure Enhanced Barrier Precaution Care plans were in place. No other residents were identified.</p> <p>Policy and procedures for Enhanced Barrier Precautions were reviewed by the IDT. Director of Nursing/designee will provide re-education to the IDT member and licensed nurses on the</p>	05/20/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245270</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 04/16/2026</p>	
<p>NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972</p>		
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<p>F0655 SS = D</p>	<p>Continued from page 1</p> <p>(A) Initial goals based on admission orders.</p> <p>(B) Physician orders.</p> <p>(C) Dietary orders.</p> <p>(D) Therapy services.</p> <p>(E) Social services.</p> <p>(F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission.</p> <p>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident.</p> <p>(ii) A summary of the resident's medications and dietary instructions.</p> <p>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review, the facility failed to develop a baseline care plan to ensure enhanced barrier precaution (EBP) needs were identified and addressed for 2 of 3 residents (R1 and R2) reviewed for indwelling catheters.</p> <p>Findings include:</p> <p>R1</p> <p>R1's admission record dated 3/31/26, indicated R1</p>	<p>F0655</p>	<p>Continued from page 1 development of baseline care plans and the policy and procedure for Enhanced Barrier Precautions.</p> <p>Executive Director/designee will conduct audits to validate baseline care plans are being initiated within 48 hours of admission to ensure Enhanced Barrier Precautions are implemented as appropriate. Audits will be conducted three times per week for four weeks or until substantial compliance is achieved. Results of the audits will be brought to QAPI for review and further recommendations.</p> <p>Facility will be in compliance by May 20th, 2026.</p>	<p>05/20/2026</p>

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<p>F0655 SS = D</p>	<p>Continued from page 2 had benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms.</p> <p>R1's order summary report dated 3/31/26, indicated R1 had an indwelling urinary catheter.</p> <p>R1's care plan dated 4/14/26, indicated R1 had an indwelling foley catheter. R1's care plan failed to include R1's need for EBPs as well as interventions related to this need.</p> <p>R1's medical record lacked evidence to ensure staff were knowledgeable in R1's need for EBPs.</p> <p>During an observation on 4/15/26 at 10:12 a.m., R1 was observed sleeping in his recliner. The door to the room was open and R1's foley catheter leg bag was visible attached to R1's leg. R1 did not have any signage or supplies for EBPs at his room door.</p> <p>R2</p> <p>R2's admission record dated 3/27/26, indicated R2 had benign prostatic hyperplasia with lower urinary tract symptoms.</p> <p>R2's order summary report dated 3/27/26, indicated R2 had an indwelling urinary catheter.</p> <p>R2's care plan dated 3/29/26, indicated R2 had an indwelling foley catheter. R2's care plan failed to include R1's need for EBPs as well as interventions related to this need.</p> <p>R2's medical record lacked evidence to ensure staff were knowledgeable in R2's need for EBPs.</p> <p>During an observation on 4/15/26 at 12:04 p.m., R2 was observed in his room in his wheelchair and R2's foley catheter bag was visibly attached under R2's wheelchair. R2 did not have signage or supplies for EBPs at his room door.</p> <p>During an observation on 4/15/26 at 1:24 p.m., the director of nursing (DON) was placing EBP signs on R1 and R2's doors and supplies next to the doors.</p> <p>During an interview on 4/15/26 at 1:25 p.m., DON stated both R1 and R2 should have been on EBPs since admission to the facility due to them having indwelling catheters. The DON was responsible for making sure the care plans reflected the need for EBPs. DON stated she was not sure why the signage was not in place and stated she forgot to put EBPs on R1 and R2's care plans.</p>	<p>F0655</p>		<p>05/20/2026</p>

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F0655 SS = D	Continued from page 3 The facility policy titled Baseline Care Plan revised 9/22/22, indicated the facility would develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care for the resident that would meet professional standards of quality of care within 48 hours of admission.	F0655		05/20/2026
F0732 SS = D	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F0732	No residents were identified as affected by this alleged deficient practice. The required nurse staffing information was immediately posted. Current residents and visitors have the potential to be affected by this alleged deficient practice. No adverse effects were noted. Policy and procedures for required nurse staffing information postings was reviewed by the IDT. The Vice President of Success conducted re-education for the Executive Director and Business Office Assistant on the proper process of posting the Nurse Staffing Information. Director of Nursing/designee will conduct audits to validate that the Nurse Staffing Information is posted five times per week (including weekends) for four weeks. Results of the audits will be brought to QAPI for review and further recommendations. Facility will be in compliance by May 20th, 2026.	05/20/2026

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F0732 SS = D	Continued from page 4 (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the required nurse staffing information was posted daily. This had the potential to affect all 33 residents residing in the facility and/or visitors who may wish to see the information. Findings include: During an observation on 4/15/26 at 9:59 a.m., the facility nurse staffing information was not observed on the administrator's office door. During an observation on 4/15/26 at 10:16 a.m., the primary areas, hallways, and entrance of the facility was observed, and no facility nurse staffing information was observed. On 4/15/26 at 11:23 a.m., the administrator stated she was responsible for posting nurse staffing information and it would have been located on her office door, but it was not because she had not printed or posted it. It was expected that the nurse staffing information is posted seven days a week. The facility policy titled Nurse Staffing Postage Information revised 10/13/22, indicated staffing information would be readily available in a readable format to residents and visitors at any given time and would be posted on a daily basis.	F0732		05/20/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880	R1 continues to reside at the facility. R1 had no identifiable adverse effects from this alleged deficient practice. Enhanced Barrier Precautions signage was put in place, and supplies were provided.	05/20/2026

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<p>F0880 SS = D</p>	<p>Continued from page 5 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p>	<p>F0880</p>	<p>Continued from page 5 Residents that have an indwelling foley catheter have the potential to be affected by this alleged deficient practice. An audit was conducted by the Director of Nursing/designee to review residents with indwelling catheters to ensure proper signage and supplies were in place. No other residents were identified. Policy and procedures for Enhanced Barrier Precautions were reviewed by the IDT. Director of Nursing/designee will provide re-education on Enhanced Barrier Precautions to facility staff. Director of Nursing/designee will conduct audits for residents requiring Enhanced Barrier Precautions to ensure staff remain compliant with Enhanced Barrier Precautions procedures and signage is posted. This audit will occur three times per week for four weeks or until substantial compliance is achieved. Results of the audits will be brought to QAPI for review and further recommendations. Facility will be in compliance by May 20th, 2026.</p>	<p>05/20/2026</p>

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<p>F0880 SS = D</p>	<p>Continued from page 6 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff consistently implemented enhanced barrier precautions (EBP) in accordance with Centers for Disease Control (CDC) guidelines to reduce the risk of infection spread for 1 of 3 residents (R1) reviewed for an indwelling catheter.</p> <p>Findings include: R1's admission record dated 3/31/26, indicated R1 had benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms. R1's order summary report dated 3/31/26, indicated R1 had an indwelling urinary catheter. R1's care plan dated 4/14/26, indicated R1 had an indwelling foley catheter. R1's medical record lacked evidence to ensure staff were knowledgeable in R1's need for EBPs. During an observation on 4/15/26 at 10:12 a.m., R1 was observed sleeping in his recliner. The door to the room was open and R1's foley catheter leg bag was visible attached to R1's leg. R1 did not have any signage or supplies for EBPs at his door. During an observation on 4/15/26 at 11:40 a.m., physical therapist (PT)-A was in R1's bathroom assisting him out of the bathroom with a gait belt. PT-A assisted R1 to his wheelchair and instructed him to sit as she held his gait belt. PT-A did not</p>	<p>F0880</p>		<p>05/20/2026</p>

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NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972	
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F0880 SS = D	<p>Continued from page 7 have the appropriate personal protective equipment (PPE) on, required when close contact care was provided for a resident who required EBPs.</p> <p>During an interview on 4/15/26 at 1:58 p.m., PT-A stated she would have known if someone was on EBPs by the signage on the door. PT-A did not use PPE when assisting R1 in the bathroom and with transfers because there was no signage on his door stating he was on EBPs.</p> <p>During an interview on 4/15/26 at 10:14 a.m., the director of nursing (DON) stated staff are expected to gown and glove when transferring and assisting someone who is on EBPs to the bathroom.</p> <p>The facility policy titled Enhanced Barrier Precautions revised 8/8/24, indicated EBPs would be initiated for residents who had urinary catheters. Use of personal protective equipment for EBPs would be necessary if staff performed high-contact care activities including transfers, assisting with toileting, and personal hygiene.</p>	F0880		05/20/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE , ST CHARLES, Minnesota, 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
20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On 4/15/26 through 4/16/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure.</p> <p>The following complaint was reviewed during the survey. H52701237C (2980880)</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.</p>	20000		05/20/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972	
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20000	Continued from page 1 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.	20000		05/20/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 27, 2026

Administrator
WHITEWATER HEALTH SERVICES
525 BLUFF AVENUE
ST CHARLES, MN 55972

RE: CCN: 245270

Cycle Start Date: April 16, 2026

Dear Administrator:

On May 22, 2026, the Minnesota Department 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.

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us