Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 12, 2024

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

RE: CCN: 245270
Cycle Start Date: June 12, 2024

Dear Administrator:

On July 10, 2024, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 12, 2024

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

Re: Reinspection Results
Event ID: XPUR12

Dear Administrator:

On July 10, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 12, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2024

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

RE: CCN: 245270
Cycle Start Date: June 12, 2024

Dear Administrator:

On June 12, 2024, 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:**

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

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 September 12, 2024 (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 December 12, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: XPUR11

Dear Administrator:

The above facility was surveyed on June 12, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00942	A. BUILDING: ______ B. WING ______	06/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/12/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00942	A. BUILDING: ______ B. WING ______	06/12/2024

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

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2 000	Continued From page 1 The following complaints were reviewed: H52704180C (MN00103681) with a licensing order issued at 1390. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 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.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced	21390		7/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	525 BLUFF AVENUE ST CHARLES, MN 55972

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21390	Continued From page 3 by: Based on observation, interview, and document review the facility failed to ensure proper hand hygiene after meal service and during personal cares for 3 of 3 resident (R1, R2, R4) observed for hand hygiene. Finding include: R1's quarterly minimum data set (MDS) dated 3/10/24, identified R1 was understood and understands both verbal and nonverbal expressions, had moderate cognitive impairment, and was dependent on staff for assistance with most to all dressing and grooming activities. R1's skin care plan dated 9/11/23, identified R1 had ongoing pressure ulcers and skin concerns, with goals to heal without complications. Intervention included report evidence of infections. R1's activities of daily living (ADL) care plan dated 7/10/23, indicated self-care deficit as evidenced by inability to complete independently related to cerebral vascular accident (CVA) and essential tremors. During an observation on 6/12/24 at 7:34 a.m., nursing assistant (NA)-A and NA-B assisted R1 with incontinent care before transferring with full body lift to wheelchair. NA-A applied gloves and cleaned peri-area and buttock before fully removing incontinent brief from underneath R1. Without removing gloves and performing hand hygiene NAs applied new clean brief, assisted to put lift sling in place on lift, and transferred R1 into wheelchair. After R1 was seated in the wheelchair, NA-A and NA-B removed gloves and disposed of them. Neither NA performed hand	21390	Date of compliance 7/8/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21390	Continued From page 4 hygiene after removing the gloves and NA-A pushed R1 into the dining area in his wheelchair. During an observation on 6/12/24 at 8:18 a.m., NA-A had gloves donned and proceeded to clear dining room tables with gloves on. NA-A was removing soiled trays and cups from the tables after breakfast. NA-A removed her gloves and put gloves in the trash bag, with her bare hands she walked back to the dining room table and grabbed 3 cups by the rims in her left hand and wiped the table down with a towel, brought the cups to the dirty cart. NA-A then asked an unidentified resident if she wanted help walking to her room. NA-A placed the resident's walker in front of her, then NA-A placed her hand on the resident's back and escorted her to her room. No hand hygiene noted. NA-A then returned to dining room and asked residents sitting at the dining tables if they wanted coffee refills. Residents agreed to coffee refills and NA-A proceeded to grab the coffee pot and fill the mugs of the 2 residents. R2's quarterly MDS dated 5/26/24, identified R1 was usually understood and usually could understand both verbal and nonverbal expressions, had severe cognitive impairment and was dependent on staff for all ADL's. R2's care plan dated 1/18/21, indicated R2 had a self care deficit related to cognitive deficits, weakness, impaired mobility as evidenced by her impaired ability to bath and groom self. During an observation on 6/12/24 at 10:36 a.m., NA-A and NA-B assisted R2 from wheelchair to bed. Staff both had put gloves on upon entering R2's room. NA-A and NA-B worked together to roll R2 back and forth the remove her pants and	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00942	A. BUILDING: ______ B. WING ______	06/12/2024

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

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21390	Continued From page 5 soiled brief. NA-A wiped R2 and applied barrier cream. NA-A and NA-B with same gloves on assisted R2 into bed, position her with pillows, pull blanket up and apply the call light. NA-A and NA-B removed gloves upon exiting the room however, did not perform hand hygiene. During an interview on 6/12/24 at 10:40 a.m., NA-A and NA-B stated hand hygiene should be done at the beginning of cares and at the end. NA-A stated hand hygiene should be completed when going from dirty to clean but she hadn't done it because she had her gloves on. NA-A stated she would have changed her gloves and done hand hygiene if the resident had a bowel movement. R4's quarterly MDS dated 3/26/24, identified R4 was understood and usually understands both verbal and nonverbal expressions, had moderate cognitive impairment, and was dependent on staff for assistance with most to all dressing and grooming activities. R4's activities of daily living (ADL) care plan dated 5/26/20, indicated self-care deficit related to cognitive deficits, impaired mobility as evidenced by her inability to groom and dress self. During an observation on 6/12/24 at 11:33 a.m., NA-A and registered nurse (RN)-A were in R4's room. Staff both had gloves donned and were assisting R4 in changing her incontinent brief. NA-A was cleaning R4's bottom when she noted a small amount of BM and removed it. NA-A proceeded to remove soiled gloves looked around the room and went over and put on a clean pair of gloves without performing hand hygiene. NA-A continued putting the mechanical lift sling in place and transferred R4 to her	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21390	Continued From page 6	21390		

Continued From page 6

wheelchair.

During an interview on 6/12/24 at 3:53 p.m., regional nurse consultant (NC), director of nursing (DON), and assistant director of nursing (ADON), stated they would expect staff to follow the hand hygiene policy, the facility was currently working on infection control and ways to improve hand hygiene in the facility.

Facility Policy titled Hand Hygiene, revised 11/2/2022, indicated,
All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Policy defines hand hygiene as a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR).
Policy indicates use of hand hygiene under the following conditions.
" Hands are visibly dirty
" Hands are visibly soiled with blood or other body fluids
" Before and after eating
" After using a restroom
" Exposure to Bacillus anthracis is suspected or proven
" Exposure to Clostridioides difficile is suspected or likely (i.e. isolation room for C. diff)
" After caring for a person with known or suspected infectious diarrhea
" When coming on duty
" Between resident contacts*
" After handling contaminated objects*
" Before performing invasive procedures
" Before applying and after removing personal protective equipment (PPE), including gloves

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00942	A. BUILDING: ______ B. WING ______	06/12/2024

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

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21390	Continued From page 7 " Before preparing or handling medications " Before and after handling clean or soiled dressings, linens, etc.* " Before performing resident care procedures " Before and after providing care to residents in isolation* " After handling items potentially contaminated with blood, body fluids, secretions, or excretions* " When, during resident care, moving from a contaminated body site to a clean body site* " After assistance with personal body functions (e.g., elimination, hair grooming, smoking) " After sneezing, coughing, and/or blowing or wiping nose " Before going off duty " When in doubt SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program including hand hygiene to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390		

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 06/12/2024

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

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F 000	INITIAL COMMENTS On 6/12/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H52704180C (MN00103681), with a deficiency issued at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. .	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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.	F 880		7/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/27/2024

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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	245270	A. BUILDING ______ B. WING ______	C 06/12/2024

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F 880

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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 §483.70(e) 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

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F 880	Continued From page 2 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper hand hygiene after meal service and during personal cares for 3 of 3 resident (R1, R2, R4) observed for hand hygiene. Finding include: R1's quarterly minimum data set (MDS) dated 3/10/24, identified R1 was understood and understands both verbal and nonverbal expressions, had moderate cognitive impairment, and was dependent on staff for assistance with most to all dressing and grooming activities. R1's skin care plan dated 9/11/23, identified R1 had ongoing pressure ulcers and skin concerns, with goals to heal without complications. Intervention included report evidence of infections. R1's activities of daily living (ADL) care plan dated	F 880	R1 and R2 have been free of s/s infection. Residents have the potential to be impacted by the alleged practice. Hand hygiene policy reviewed with no changes needed. Supply of pocket-sized hand sanitizer obtained to allow staff to carry this with them and additional hand sanitizer dispensers ordered to be placed in hallways and near rooms and dining rooms for easier access. Additional postings on hand hygiene were added to common areas and in hallways to provide visual reminders. The Director Nursing or designee provided re-education to facility staff on hand hygiene policies and completed Hand Hygiene Competencies with center staff. Re-education began on 6/26/24.	

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F 880	Continued From page 3 7/10/23, indicated self-care deficit as evidenced by inability to complete independently related to cerebral vascular accident (CVA) and essential tremors. During an observation on 6/12/24 at 7:34 a.m., nursing assistant (NA)-A and NA-B assisted R1 with incontinent care before transferring with full body lift to wheelchair. NA-A applied gloves and cleaned peri-area and buttock before fully removing incontinent brief from underneath R1. Without removing gloves and performing hand hygiene NAs applied new clean brief, assisted to put lift sling in place on lift, and transferred R1 into wheelchair. After R1 was seated in the wheelchair, NA-A and NA-B removed gloves and disposed of them. Neither NA performed hand hygiene after removing the gloves and NA-A pushed R1 into the dining area in his wheelchair. During an observation on 6/12/24 at 8:18 a.m., NA-A had gloves donned and proceeded to clear dining room tables with gloves on. NA-A was removing soiled trays and cups from the tables after breakfast. NA-A removed her gloves and put gloves in the trash bag, with her bare hands she walked back to the dining room table and grabbed 3 cups by the rims in her left hand and wiped the table down with a towel, brought the cups to the dirty cart. NA-A then asked an unidentified resident if she wanted help walking to her room. NA-A placed the resident's walker in front of her, then NA-A placed her hand on the resident's back and escorted her to her room. No hand hygiene noted. NA-A then returned to dining room and asked residents sitting at the dining tables if they wanted coffee refills. Residents agreed to coffee refills and NA-A proceeded to grab the coffee pot and fill the mugs of the 2	F 880	The Director of Nursing or designee will complete audits three times weekly for four weeks, then twice weekly for four weeks, then weekly for four weeks with ongoing random hand hygiene observations. Results of audits will be forwarded to the Quality Assurance Performance Improvement committee for review and recommendations.	

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residents.

R2's quarterly MDS dated 5/26/24, identified R1 was usually understood and usually could understand both verbal and nonverbal expressions, had severe cognitive impairment and was dependent on staff for all ADL's.

R2's care plan dated 1/18/21, indicated R2 had a self care deficit related to cognitive deficits, weakness, impaired mobility as evidenced by her impaired ability to bath and groom self.

During an observation on 6/12/24 at 10:36 a.m., NA-A and NA-B assisted R2 from wheelchair to bed. Staff both had put gloves on upon entering R2's room. NA-A and NA-B worked together to roll R2 back and forth the remove her pants and soiled brief. NA-A wiped R2 and applied barrier cream. NA-A and NA-B with same gloves on assisted R2 into bed, position her with pillows, pull blanket up and apply the call light. NA-A and NA-B removed gloves upon exiting the room however, did not perform hand hygiene.

During an interview on 6/12/24 at 10:40 a.m., NA-A and NA-B stated hand hygiene should be done at the beginning of cares and at the end. NA-A stated hand hygiene should be completed when going from dirty to clean but she hadn't done it because she had her gloves on. NA-A stated she would have changed her gloves and done hand hygiene if the resident had a bowel movement.

R4's quarterly MDS dated 3/26/24, identified R4 was understood and usually understands both verbal and nonverbal expressions, had moderate cognitive impairment, and was dependent on staff

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for assistance with most to all dressing and grooming activities.

R4's activities of daily living (ADL) care plan dated 5/26/20, indicated self-care deficit related to cognitive deficits, impaired mobility as evidenced by her inability to groom and dress self.

During an observation on 6/12/24 at 11:33 a.m., NA-A and registered nurse (RN)-A were in R4's room. Staff both had gloves donned and were assisting R4 in changing her incontinent brief. NA-A was cleaning R4's bottom when she noted a small amount of BM and removed it. NA-A proceeded to remove soiled gloves looked around the room and went over and put on a clean pair of gloves without performing hand hygiene. NA-A continued putting the mechanical lift sling in place and transferred R4 to her wheelchair.

During an interview on 6/12/24 at 3:53 p.m., regional nurse consultant (NC), director of nursing (DON), and assistant director of nursing (ADON), stated they would expect staff to follow the hand hygiene policy, the facility was currently working on infection control and ways to improve hand hygiene in the facility.

Facility Policy titled Hand Hygiene, revised 11/2/2022, indicated,
All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Policy defines hand hygiene as a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as

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alcohol-based hand rub (ABHR).
Policy indicates use of hand hygiene under the following conditions.
" Hands are visibly dirty
" Hands are visibly soiled with blood or other body fluids
" Before and after eating
" After using a restroom
" Exposure to Bacillus anthracis is suspected or proven
" Exposure to Clostridioides difficile is suspected or likely (i.e. isolation room for C. diff)
" After caring for a person with known or suspected infectious diarrhea
" When coming on duty
" Between resident contacts*
" After handling contaminated objects*
" Before performing invasive procedures
" Before applying and after removing personal protective equipment (PPE), including gloves
" Before preparing or handling medications
" Before and after handling clean or soiled dressings, linens, etc.*
" Before performing resident care procedures
" Before and after providing care to residents in isolation*
" After handling items potentially contaminated with blood, body fluids, secretions, or excretions*
" When, during resident care, moving from a contaminated body site to a clean body site*
" After assistance with personal body functions (e.g., elimination, hair grooming, smoking)
" After sneezing, coughing, and/or blowing or wiping nose
" Before going off duty
" When in doubt