Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2024

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

Re: Reinspection Results
Event ID: UZ6C12

Dear Administrator:

On August 29, 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 August 6, 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
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
September 6, 2024

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

RE: CCN: 245270
Cycle Start Date: August 6, 2024

Dear Administrator:

On August 14, 2024, we notified you a remedy was imposed.

On August 29, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 27, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 29, 2024, did not go into effect. (42 CFR 488.417 (b))

In our letter of August 14, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 6, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed 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
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
August 14, 2024

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

RE: CCN: 245270
Cycle Start Date: August 6, 2024

Dear Administrator:

On August 6, 2024, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On August 2, 2024, the situation of immediate jeopardy to potential health and safety cited at **F684 - Quality of Care** was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 29, 2024.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 29, 2024, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 29, 2024, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Whitewater Health Services is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 6, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "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
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 6, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

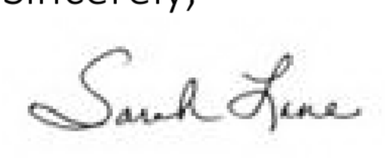
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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 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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 14, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: UZ6C11

Dear Administrator:

The above facility was surveyed on July 31, 2024 through August 6, 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.

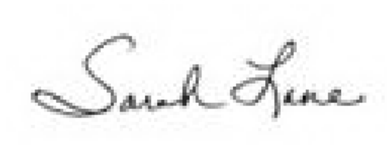
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 08/06/2024

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) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/31/24, 8/1/24, 8/6/24, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F684 began on 7/26/24, when when the facility failed to complete comprehensive assessments and communicate sudden change of condition to the physician when R1 became unresponsive and remained unresponsive at the facility until the ambulance removed R1 from the facility at 1:25 p.m. on 7/26/24. The administrator, and director of nursing (DON) were notified of the IJ on 8/1/24 at 4:58 p.m. The IJ was removed on 8/2/24 at 12:43 p.m. . The above findings constituted Substandard Quality of Care and an extended survey was conducted on 8/6/24. The following complaints were reviewed: H52706344C (MN00105277) with a deficiency cited at F684. 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/22/2024

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.

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 08/06/2024

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) COMPLETION DATE
F 000	Continued From page 1 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 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify, comprehensively assess, implement interventions, and provide timely physician notification for a sudden change in condition for 1 of 3 residents (R1) reviewed for change in condition. This resulted in an immediate jeopardy (IJ) when R1 became unresponsive causing a delay in hospitalization. Immediate Jeopardy (IJ) began on 7/26/24 when the facility did not complete comprehensive assessments and communicate sudden change of condition to the physician when R1 became unresponsive and remained unresponsive for at least seven (7) hours before the ambulance arrived. The administrator and director of nursing (DON) were notified of the IJ on 8/1/24 at 4:58 p.m. The immediacy of the IJ was removed on 8/2/24 at 12:43 p.m. but noncompliance remained at the lower scope and severity level 2 (D), which	F 684	R1 no longer resides at the facility. Residents who experience a change of condition have the potential to be impacted by the alleged practice. Facility documented progress notes for current residents were reviewed by the Director of Nursing to identify any change of condition or vital sign changes to ensure resident has been assessed and medical provider has been updated on change in condition- completed 8/1/2024 at 8:30 p.m. On 08/01/2024, the Medical Director was updated on the survey concern. Change in Condition of The Resident Policy was reviewed by the VPS, ED, DON, and Medical Director. Policy addresses guidance related to assessment, communication, and documentation. No changes to the policy	8/27/24

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 08/06/2024

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 684	Continued From page 2 indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include: R1's hospital after visit summary (AVS) 7/16/24, identified R1 had been hospitalized for a brain bleed, which caused right sided weakness and altered mentation. Mental status improved throughout hospitalization and R1 was discharged to facility. R1's face sheet identified R1 was admitted to the facility with nontraumatic intracerebral hemorrhage (brain bleed), mixed receptive-expressive language disorder, hemiplegia and hemiparesis affecting right dominant side, weakness, dysphagia-(swallowing disorder), compression of brain, encephalopathy-(brain dysfunction that causes altered mental state), and cerebral amyloid angiopathy-(myloid protein builds up in the blood vessels in the brain causing bleeding inside the brain). R1's admission Minimum Data Set (MDS) dated 7/26/24, indicated R1 had severe cognitive impairment and displayed symptoms of delirium that included inattention and disorganized thinking. R1 had adequate hearing and vision, and had clear speech. R1 required substantial assistance with activities of daily living and was frequently incontinent of bowel and bladder. R1's care plan dated 7/26/24, identified a focus of cognitive loss and delay in responding related to: effects of intracerebral hemorrhage. Interventions included to allow adequate time to respond. Do not rush or supply words. Provide cueing and prompting for such things as activities, personal	F 684	were recommended. The center will revise their shift-to-shift reporting process which includes communicating to the on-coming shift any changes in resident condition. With use of PCC 24-hour report, nursing staff re-educated to review with shift to shift for updates, change of condition and care of residents. Nursing staff re-educated prior to next scheduled shift on this process with Director of Nursing/Designee audit of process. Re-education was initiated 8/1/2024 and will be on-going prior to the next scheduled shift. Notification via email/text to nursing through payroll application on re-education prior to next scheduled shift along with text/phone calls to staff to ensure re-education completed. Nursing staff (including CNAs and Licensed Nurses) were re-educated on our Stop and Watch system in PCC. Nursing staff will be re-educated on hand-off of information accurately using the SBAR process in order for the physician to prescribe/recommend appropriate treatment. Licensed nursing staff were re-educated on the Change of Condition of the Resident policy. This policy included the following re-education: ¿ Change of condition refers to a deviation from the patient/resident's baseline in physical, cognitive, behavioral, or functional domains. The change of condition may be short lived or extend for a period of time and presents as a shift from the norm for that patient/resident.	

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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F 684	Continued From page 3 care. Repeat communication using more that one method (words, gestures, facial expressions). R1's recorded vital signs sheet identified on 7/26/24, at 3:00 a.m. blood pressure 121/66 (BP normal 120/80), pulse 117 (P normal 60-100), Temperature 100.7 (T normal 97-99 F), respirations 20 (R normal 12-20), oxygen saturations 92% (O2 normal 95-100%). There was no progress note or assessment that identified R1's condition or rational why vital signs were taken at 3:00 a.m. R1's recorded vital signs on 7/26/24 at 9:48 a.m., included: BP 133/60, P 100, T 101.6, Res 20, and 02 93%. R1's progress note on 7/26/24 at 10:16 a.m. identified, "resident unresponsive this morning. Lung sounds clear. No cough. COVID test negative. Fever of 101.6., B/P 133/60, HR 100, R20 93% on room air. Cool rags applied. Notified MD [medical doctor] and RN [registered nurse] on call." At 10:25 a.m. the progress note identified the physician had responded with orders to collect a UA/UC. R1's medication administration record (MAR) identified LPN-A administered 650 milligrams Tylenol suppository at 10:17 a.m. and then at 10:18 a.m. documented the Tylenol was effective. On 7/26/24 at 12:48 p.m., R1's recorded vital signs included BP 140/64, P 117, T 98, Res 20, 02 95%. R1's progress note at 1:05 p.m. included, R1 had a fever, some difficulty breathing, and does not wake up or respond to stimuli. At 1:30 p.m. R1 had left via ambulance.	F 684	¿ When a resident presents with a change in condition - Example □ change in cognition, difficulty breathing, etc. - the nurse will assess and complete vital signs on the resident and notify the attending practitioner of the resident's condition. ¿ Documentation needs to include: o Date and time of incident (if applicable), time of condition change - Example □ new onset of difficulty engaging in conversation with caregiver noted at 11:45 a.m. o Observation or assessment findings including pertinent vital signs, baseline function, and noted change in usual status. o Notification of practitioner - include date, time, what was communicated, and any orders received. Director of Nursing and/or designee will audit documentation for changes in condition and validate assessment, notifications, and monitoring are in place. DON or designee will share significant findings regarding condition changes and MD notification through the morning meeting held Mondays-Fridays x 8 weeks, then weekly x 4 weeks, then monthly x 3 months. The center will revise their shift-to-shift reporting process which includes communicating to the on-coming shift any changes in resident condition. With use of PCC 24-hour report, nursing staff re-educated to review with shift to	

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F 684	Continued From page 4 R1's ambulance run report dated 7/26/24, identified Emergency Medical Services (EMS) crew arrived at 1:30 p.m. on scene and R1 was alone in room, no family or staff present. Initial assessment identified a Glasgow Coma Scale (GCS) of 3 (tool that measures a persons level of consciousness after a brain injury) the lowest possible score indicating deep coma or death. Sternal rub attempted with no response from R1. Rapid carotid pulse, skin diaphoretic (sweaty), warm to the touch, and pale. EMS applied cold packs bilaterally to neck, and axillary areas. Facility staff reported to EMS R1 had been in this condition since "last night sometime." EMS requested intercept from secondary EMS crew due to R1's medical needs. R1's secondary EMS run on 7/26/24, identified EMS crew member from secondary EMS joined EMS crew from first ambulance at 1:41 p.m. and remained until arrived at the hospital at 2:05 p.m. EMS report R1 was unresponsive but breathing spontaneously with a steady pulse, GCS remained 3. During an interview on 7/31/24 at 1:16 p.m., nursing assistant (NA)-A and NA-B stated they were both familiar with R1. NA-A stated R1's normal routine was to get up in recliner during the morning and look outside. R1 was not usually difficult to arouse if she was sleeping. When NA's would reposition R1, "she would wake up and talk to us." NA-A and NA-B both stated on 7/25/24 during the day shift, R1 went out of the facility for appointments and had been talking and drinking thickened liquids. Neither NA noticed any change in R1 since she was admitted to the facility. NA-A and NA-B both stated NA-C gave report to them on 7/26/24 at 6:00 a.m. and reported R1 had	F 684	shift for updates, change of condition and care of residents. Nursing staff re-educated prior to next scheduled shift on this process with Director of Nursing/Designee audit of process. Results of the audits will be reviewed by the QAPI committee for further recommendations.	

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F 684	Continued From page 5 been unresponsive and limp. NA-A and NA-B went to R1's room at 6:30 a.m., performed morning cares, noted R1 was warm to touch. NA-B stated they reported R1's condition to LPN-A around 6:45 a.m. During a phone interview on 7/31/24 at 2:39 p.m., NA-C stated between 12:00 a.m.-1:30 a.m. on 7/26/24, R1 did not respond to her except in moans and she seemed very sleepy. NA-C just thought R1 was tired because she had out of the facility on 7/25/24 for quite awhile. NA-C explained when she went back to check on R1 between 2:30 to 3:30 a.m. she noticed R1 was very lethargic, warm, flushed, and weak. NA-C was concerned because that was not normal, so she reported the information to licensed practical nurse (LPN)-B. When she did shift report on 7/26/24 at 6:00 a.m., she explained all of R1's changes (very lethargic, warm, flushed, and weak) to NA-A and NA-B who were assigned to care for R1 for day shift. During a phone interview on 7/31/24 at 2:18 p.m., LPN-B stated between 2:30-3:00 a.m. on 7/26/24, NA-C reported to her R1 was not answering her and would not wake up. LPN-B went to R1's room and took her vital signs which were within R1's normal limits. Although LPN-B stated when she collected R1's vital signs, R1 was not as responsive as she would have liked to have seen her, R1 was at her baseline and there was nothing unusual or different. LPN-B further explained she did not find R1's lack of responsiveness unusual because R1 would not always wake up for her during the night with light shoulder rubs or a quieter voice. LPN-B indicated she had not completed a neurological assessment and did not provide intervention to	F 684		

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F 684	Continued From page 6 lower R1's temperature. During an interview on 7/31/24 at 2:56 p.m., LPN-A stated at the shift report on 7/26/24, at 6:00 a.m. LPN-B did not say anything unusual happened with R1 during the night. LPN-A stated NA-A and NA-B had come to her after they were done washing R1 up reporting they thought R1 had a fever just before 7:00 a.m.. However, LPN-A had started R1's tube feeding at 7:00 a.m. and did not notice a difference in R1 as the NA's reported. LPN-B did not take R1's vital signs despite NA's reporting of a fever nor complete a neurological assessment. During an interview on 7/31/24 at 1:16 p.m., NA-A and NA-B, NA-A stated after the 6:45 a.m. check they returned to R1's room sometime after 9:00 a.m. R1 was still unresponsive, limp, and warm to the touch during cares. NA's indicated they reported their concerns to LPN-A. During an interview on 7/31/24 at 2:56 p.m., LPN-A stated NA-A and NA-B reported they thought R1 had a fever around 9:00 a.m. or 10:00 a.m. LPN-A stated she then went to R1's room and took R1's vital signs; R1's temperature was 101.6. "R1 was unresponsive. She would not wake up, I did a sternal rub and no response from that. I just figured she was kind of sleeping because of the fever." LPN-A performed a Covid test with negative results. LPN-B notified DON and medical doctor (MD)-A. LPN-A had reported to the DON and MD-A R1 had a fever and was really sleepy. LPN-A stated MD-A ordered a urine analysis/urine culture (UA/UC-test to determine presence of urinary tract infection/type of bacteria that is found in the urine) to be collected. LPN-A stated she did not tell the DON and MD-A she	F 684		

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F 684	Continued From page 7 was not able to arouse R1 with a sternal rub. During the interview on 7/31/24 at 2:56 p.m., LPN-A stated R1 did not move, flinch, groan, or moan when she cathed R1 to collect urine for the UA/UC on 7/26/24. LPN-A stated R1 just seemed to be sleeping really hard and had a fever. LPN-A did not perform a neurological assessment. During an interview on 7/31/24 at 1:16 p.m., NA-A and NA-B stated the next time they returned to R1's room sometime after lunch (12:00-1:00 p.m) and changed R1's sheets because they were wet with perspiration. NA-A and NA-B noted R1 had sounded gurgly and was breathing heavily, remained unresponsive, and limp. NA's stated that is when LPN-A had called the ambulance. During a phone interview on 7/31/24 at 11:18 a.m., emergency medical system personal (EMS)-A indicated on 7/26/24, an ambulance was dispatched to the facility for a resident who was unresponsive. When they arrived onsite at approximately 1:30 p.m. R1 was unresponsive. Facility staff reported R1 had been in that state since the night before. R1's temperature was 100.2 when she was loaded her into the ambulance and never regained consciousness. During a phone interview on 8/1/24 at 12:16 p.m., MD-A stated LPN-A contacted her by message on 7/26/24; the message said R1 was not as responsive and had a temperature of 102.9. Based on the information LPN-A gave to her she gave the order to get a UA/UC. MD-A stated it was not unusual for someone with a recent stroke to be a little more unarousable if they were to get an infection. However, at the time of the report from LPN-A, she was not aware LPN-A was not	F 684		

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F 684	Continued From page 8 able to arouse R1 with a sternal rub. MD-A stated "I would have sent her in [to the ED] then if I had known that." During an interview on 7/31/24 at 2:56 p.m., LPN-A explained around 12:30 p.m. she went into check on R1. R1's breathing became irregular; it was rapid, then calm, then rapid. LPN indicated she had described R1's condition to DON and MD as "sleepiness" because she was not sure R1's consciousness level had changed "until right before we sent her to the hospital". R1's hospital records printed 7/31/24, identified a new large intraparenchymal hemorrhage (type of brain bleed) centered on the right parietal lobe as well as extension into the posterior right frontal and temporal lobes with extensive vasogenic edema (a type of brain swelling). Additionally, a second smaller intraparenchymal hemorrhage involving the inferior left occipital lobe with the associated vasogenic edema was found. R1 was intubated and mechanical ventilation began until family could arrive at bedside. R1 expired on 7/28/24 at 10:39 p.m. from nontraumatic Intracranial Hemorrhage. During an interview on 8/1/24 at 1:22 p.m., DON stated LPN-A called and said R1 had a fever and was not responding normally. DON verified LPN-A did not notify her that R1 was unresponsive to a sternal rub. DON indicated the physician should have been notified earlier when R1 was not responsive. Had she had more details she would have directed LPN to complete a neurological assessment. DON would expect staff to communicate efficiently so the physician could order the right treatments. DON expected complete assessments and evaluations as RN's	F 684		

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F 684	Continued From page 9 or assist LPN's with what they are able to complete according to their scope. The facility Change in Condition of the Resident policy revised 9/20/22, identified the facility should immediately inform the resident; consult with the resident's physician; and notify the resident representative(s) when there is ... ...a significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications. When a resident presents with a change in condition: 2. assess/evaluate the resident. This assessment/evaluation could include but is not limited to: a. VS. oxygen saturations, blood glucose level f. alteration in level of consciousness, ability to respond 6. Ensure change in condition is included on the 24-hour report to be reviewed later by interdisciplinary team. Documentation needs to include, but is not limited to the following: 1. Description of change in condition and assessment or observation findings. The IJ that began on 7/26/24 was removed on 8/2/24 at 12:43 p.m. when it was verified the facility implemented the following: -DON reviewed all resident progress notes for change of condition on 8/1/24. -Medical Director and VP of Success, Executive Director, DON reviewed change of condition policy with no changes recommended -staff education re: -deviation from baseline such as a shift from normal -change of condition such as difficulty breathing	F 684		

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F 684	Continued From page 10 nurse will complete VS, assess, notify MD of residents condition with documentation to include: date and time of incident, time of condition onset, observation and assessment findings including VS, baseline function and change in usual status, include in note what was communicated and what orders were rec'd. -education on the Stop and Watch system through PointClickCare -shift report changed to include nurse and nursing assistants together	F 684		

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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 7/31/24, 8/1/24, 8/6/24, 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, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H52706344C (MN00105277) with a licensing order issued at 0830. 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		

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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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to identify, comprehensively assess, implement interventions, and provide timely physician notification for a sudden change in condition for 1 of 3 residents (R1) reviewed for change in condition. This resulted in an immediate jeopardy (IJ) when R1 became unresponsive causing a delay in hospitalization for further evaluation. Immediate Jeopardy (IJ) began on 7/26/24 when the facility did not complete comprehensive	2 830	See tag F 0684 above	8/27/24

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2 830	Continued From page 3 assessments and communicate sudden change of condition to the physician when R1 became unresponsive and remained unresponsive for at least seven (7) hours before the ambulance arrived. The administrator and director of nursing (DON) were notified of the IJ on 8/1/24 at 4:58 p.m. The immediacy of the IJ was removed on 8/2/24 at 12:43 p.m. but noncompliance remained at the lower scope and severity level 2 (D), which indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include: R1's hospital after visit summary (AVS) 7/16/24, identified R1 had been hospitalized for a brain bleed, which caused right sided weakness and altered mentation. Mental status improved throughout hospitalization and R1 was discharged to facility. R1's face sheet identified R1 was admitted to the facility with nontraumatic intracerebral hemorrhage (brain bleed), mixed receptive-expressive language disorder, hemiplegia and hemiparesis affecting right dominant side, weakness, dysphagia-(swallowing disorder), compression of brain, encephalopathy-(brain dysfunction that causes altered mental state), and cerebral amyloid angiopathy-(myloid protein builds up in the blood vessels in the brain causing bleeding inside the brain). R1's admission Minimum Data Set (MDS) dated 7/26/24, indicated R1 had severe cognitive impairment and displayed symptoms of delirium that included inattention and disorganized thinking. R1 had adequate hearing and vision, and had clear speech. R1 required substantial assistance with activities of daily living and was	2 830		

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2 830	Continued From page 4 frequently incontinent of bowel and bladder. R1's care plan dated 7/26/24, identified a focus of cognitive loss and delay in responding related to: effects of intracerebral hemorrhage. Interventions included to allow adequate time to respond. Do not rush or supply words. Provide cueing and prompting for such things as activities, personal care. Repeat communication using more that one method (words, gestures, facial expressions). R1's recorded vital signs sheet identified on 7/26/24, at 3:00 a.m. blood pressure 121/66 (BP normal 120/80), pulse 117 (P normal 60-100), Temperature 100.7 (T normal 97-99 F), respirations 20 (R normal 12-20), oxygen saturations 92% (O2 normal 95-100%). There was no progress note or assessment that identified R1's condition or rational why vital signs were taken at 3:00 a.m. R1's recorded vital signs on 7/26/24 at 9:48 a.m., included: BP 133/60, P 100, T 101.6, Res 20, and 02 93%. R1's progress note on 7/26/24 at 10:16 a.m. identified, "resident unresponsive this morning. Lung sounds clear. No cough. COVID test negative. Fever of 101.6., B/P 133/60, HR 100, R20 93% on room air. Cool rags applied. Notified MD [medical doctor] and RN [registered nurse] on call." At 10:25 a.m. the progress note identified the physician had responded with orders to collect a UA/UC. R1's medication administration record (MAR) identified LPN-A administered 650 milligrams Tylenol suppository at 10:17 a.m. and then at 10:18 a.m. documented the Tylenol was effective.	2 830		

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2 830	Continued From page 5 On 7/26/24 at 12:48 p.m., R1's recorded vital signs included BP 140/64, P 117, T 98, Res 20, 02 95%. R1's progress note at 1:05 p.m. included, R1 had a fever, some difficulty breathing, and does not wake up or respond to stimuli. At 1:30 p.m. R1 had left via ambulance. R1's ambulance run report dated 7/26/24, identified Emergency Medical Services (EMS) crew arrived at 1:30 p.m. on scene and R1 was alone in room, no family or staff present. Initial assessment identified a Glasgow Coma Scale (GCS) of 3 (tool that measures a persons level of consciousness after a brain injury) the lowest possible score indicating deep coma or death. Sternal rub attempted with no response from R1. Rapid carotid pulse, skin diaphoretic (sweaty), warm to the touch, and pale. EMS applied cold packs bilaterally to neck, and axillary areas. Facility staff reported to EMS R1 had been in this condition since "last night sometime." EMS requested intercept from secondary EMS crew due to R1's medical needs. R1's secondary EMS run on 7/26/24, identified EMS crew member from secondary EMS joined EMS crew from first ambulance at 1:41 p.m. and remained until arrived at the hospital at 2:05 p.m. EMS report R1 was unresponsive but breathing spontaneously with a steady pulse, GCS remained 3. During an interview on 7/31/24 at 1:16 p.m., nursing assistant (NA)-A and NA-B stated they were both familiar with R1. NA-A stated R1's normal routine was to get up in recliner during the morning and look outside. R1 was not usually difficult to arouse if she was sleeping. When NA's would reposition R1, "she would wake up and talk to us." NA-A and NA-B both stated on 7/25/24	2 830		

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2 830	Continued From page 6 during the day shift, R1 went out of the facility for appointments and had been talking and drinking thickened liquids. Neither NA noticed any change in R1 since she was admitted to the facility. NA-A and NA-B both stated NA-C gave report to them on 7/26/24 at 6:00 a.m. and reported R1 had been unresponsive and limp. NA-A and NA-B went to R1's room at 6:30 a.m., performed morning cares, noted R1 was warm to touch. NA-B stated they reported R1's condition to LPN-A around 6:45 a.m. During a phone interview on 7/31/24 at 2:39 p.m., NA-C stated between 12:00 a.m.-1:30 a.m. on 7/26/24, R1 did not respond to her except in moans and she seemed very sleepy. NA-C just thought R1 was tired because she had out of the facility on 7/25/24 for quite awhile. NA-C explained when she went back to check on R1 between 2:30 to 3:30 a.m. she noticed R1 was very lethargic, warm, flushed, and weak. NA-C was concerned because that was not normal, so she reported the information to licensed practical nurse (LPN)-B. When she did shift report on 7/26/24 at 6:00 a.m., she explained all of R1's changes (very lethargic, warm, flushed, and weak) to NA-A and NA-B who were assigned to care for R1 for day shift. During a phone interview on 7/31/24 at 2:18 p.m., LPN-B stated between 2:30-3:00 a.m. on 7/26/24, NA-C reported to her R1 was not answering her and would not wake up. LPN-B went to R1's room and took her vital signs which were within R1's normal limits. Although LPN-B stated when she collected R1's vital signs, R1 was not as responsive as she would have liked to have seen her, R1 was at her baseline and there was nothing unusual or different. LPN-B further explained she did not find R1's lack of	2 830		

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2 830	Continued From page 7 responsiveness unusual because R1 would not always wake up for her during the night with light shoulder rubs or a quieter voice. LPN-B indicated she had not completed a neurological assessment and did not provide intervention to lower R1's temperature. During an interview on 7/31/24 at 2:56 p.m., LPN-A stated at the shift report on 7/26/24, at 6:00 a.m. LPN-B did not say anything unusual happened with R1 during the night. LPN-A stated NA-A and NA-B had come to her after they were done washing R1 up reporting they thought R1 had a fever just before 7:00 a.m.. However, LPN-A had started R1's tube feeding at 7:00 a.m. and did not notice a difference in R1 as the NA's reported. LPN-B did not take R1's vital signs despite NA's reporting of a fever nor complete a neurological assessment. During an interview on 7/31/24 at 1:16 p.m., NA-A and NA-B, NA-A stated after the 6:45 a.m. check they returned to R1's room sometime after 9:00 a.m. R1 was still unresponsive, limp, and warm to the touch during cares. NA's indicated they reported their concerns to LPN-A. During an interview on 7/31/24 at 2:56 p.m., LPN-A stated NA-A and NA-B reported they thought R1 had a fever around 9:00 a.m. or 10:00 a.m. LPN-A stated she then went to R1's room and took R1's vital signs; R1's temperature was 101.6. "R1 was unresponsive. She would not wake up, I did a sternal rub and no response from that. I just figured she was kind of sleeping because of the fever." LPN-A performed a Covid test with negative results. LPN-B notified DON and medical doctor (MD)-A. LPN-A had reported to the DON and MD-A R1 had a fever and was really sleepy. LPN-A stated MD-A ordered a urine	2 830		

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2 830	Continued From page 8 analysis/urine culture (UA/UC-test to determine presence of urinary tract infection/type of bacteria that is found in the urine) to be collected. LPN-A stated she did not tell the DON and MD-A she was not able to arouse R1 with a sternal rub. During the interview on 7/31/24 at 2:56 p.m., LPN-A stated R1 did not move, flinch, groan, or moan when she cathed R1 to collect urine for the UA/UC on 7/26/24. LPN-A stated R1 just seemed to be sleeping really hard and had a fever. LPN-A did not perform a neurological assessment. During an interview on 7/31/24 at 1:16 p.m., NA-A and NA-B stated the next time they returned to R1's room sometime after lunch (12:00-1:00 p.m) and changed R1's sheets because they were wet with perspiration. NA-A and NA-B noted R1 had sounded gurgly and was breathing heavily, remained unresponsive, and limp. NA's stated that is when LPN-A had called the ambulance. During a phone interview on 7/31/24 at 11:18 a.m., emergency medical system personal (EMS)-A indicated on 7/26/24, an ambulance was dispatched to the facility for a resident who was unresponsive. When they arrived onsite at approximately 1:30 p.m. R1 was unresponsive. Facility staff reported R1 had been in that state since the night before. R1's temperature was 100.2 when she was loaded her into the ambulance and never regained consciousness. During a phone interview on 8/1/24 at 12:16 p.m., MD-A stated LPN-A contacted her by message on 7/26/24; the message said R1 was not as responsive and had a temperature of 102.9. Based on the information LPN-A gave to her she gave the order to get a UA/UC. MD-A stated it was not unusual for someone with a recent stroke	2 830		

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2 830	Continued From page 9 to be a little more unarousable if they were to get an infection. However, at the time of the report from LPN-A, she was not aware LPN-A was not able to arouse R1 with a sternal rub. MD-A stated "I would have sent her in [to the ED] then if I had known that." During an interview on 7/31/24 at 2:56 p.m., LPN-A explained around 12:30 p.m. she went into check on R1. R1's breathing became irregular; it was rapid, then calm, then rapid. LPN indicated she had described R1's condition to DON and MD as "sleepiness" because she was not sure R1's consciousness level had changed "until right before we sent her to the hospital". R1's hospital records printed 7/31/24, identified a new large intraparenchymal hemorrhage (type of brain bleed) centered on the right parietal lobe as well as extension into the posterior right frontal and temporal lobes with extensive vasogenic edema (a type of brain swelling). Additionally, a second smaller intraparenchymal hemorrhage involving the inferior left occipital lobe with the associated vasogenic edema was found. R1 was intubated and mechanical ventilation began until family could arrive at bedside. R1 expired on 7/28/24 at 10:39 p.m. from nontraumatic Intracranial Hemorrhage. During an interview on 8/1/24 at 1:22 p.m., DON stated LPN-A called and said R1 had a fever and was not responding normally. DON verified LPN-A did not notify her that R1 was unresponsive to a sternal rub. DON indicated the physician should have been notified earlier when R1 was not responsive. Had she had more details she would have directed LPN to complete a neurological assessment. DON would expect staff to communicate efficiently so the physician	2 830		

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2 830	Continued From page 10 could order the right treatments. DON expected complete assessments and evaluations as RN's or assist LPN's with what they are able to complete according to their scope. The facility Change in Condition of the Resident policy revised 9/20/22, identified the facility should immediately inform the resident; consult with the resident's physician; and notify the resident representative(s) when there is ... ...a significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications. When a resident presents with a change in condition: 2. assess/evaluate the resident. This assessment/evaluation could include but is not limited to: a. VS. oxygen saturations, blood glucose level f. alteration in level of consciousness, ability to respond 6. Ensure change in condition is included on the 24-hour report to be reviewed later by interdisciplinary team. Documentation needs to include, but is not limited to the following: 1. Description of change in condition and assessment or observation findings. The IJ that began on 7/26/24 was removed on 8/2/24 at 12:43 p.m. when it was verified the facility implemented the following: -DON reviewed all resident progress notes for change of condition on 8/1/24. -Medical Director and VP of Success, Executive Director, DON reviewed change of condition policy with no changes recommended -staff education re: -deviation from baseline such as a shift from normal	2 830		

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2 830	Continued From page 11 -change of condition such as difficulty breathing nurse will complete VS, assess, notify MD of residents condition with documentation to include: date and time of incident, time of condition onset, observation and assessment findings including VS, baseline function and change in usual status, include in note what was communicated and what orders were rec'd. -education on the Stop and Watch system through PointClickCare -shift report changed to include nurse and nursing assistants together Suggested Method of Correction: The Directior of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent or improve areas from occuring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		