



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 28, 2025

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

RE: CCN: 245270

Cycle Start Date: May 14, 2025

Dear Administrator:

On June 30, 2025, and July 2, 2025, we notified you a remedy was imposed.

On August 14, 2025, the Minnesota Departments of Health and Public Safety 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 July 23, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 14, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of July 2, 2025, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 17, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 23, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

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

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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July 2, 2025

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

RE: CCN: 245270
Cycle Start Date: May 14, 2025

Dear Administrator:

On May 30, 2025, we informed you that we may impose enforcement remedies.

On June 30, 2025, we informed you of imposed enforcement remedies.

On June 16, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

K0346, K0354, K0541

In addition, at the time of this survey, we identified the following deficiencies:

F602, F609, F610, and F755

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:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 14, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective August 14, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 14, 2025.

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.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 17, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Whitewater Health Services will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 17, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. 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 an "E"tag), i.e., the plan of correction should be directed to:

Annette Winters, Regional Supervisor, Federal Rapid Response

Health Regulation Division

Minnesota Department of Health

625 Robert Street N

P.O. Box 64975

Saint Paul, Minnesota 55164-0975

Email: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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 - Health Regulation Division 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 November 14, 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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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:

tamika.brown@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

Whitewater Health Services

July 2, 2025

Page 5

(312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,



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



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July 2, 2025

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

Re: Event ID: XMCL11

Dear Administrator:

The above facility survey was completed on June 16, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245270 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 06/16/2025 |
|---|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F0000 | <p>INITIAL COMMENTS</p> <p>On 6/11/25-6/16/25, 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.</p> <p>The following complaints were reviewed. H52706887C (MN00113754)</p> <p>The following complaints were reviewed. H52707007C (MN00113777 and MN00113732) with a deficiency issued at (F602, F609, F610, and F755)</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p> | F0000 | | |
| F0602 SS = E | <p>Free from Misappropriation/Exploitation</p> <p>CFR(s): 483.12</p> <p>§483.12</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and record review, the</p> | F0602 | <p>R2, R4 and R5 had no identified affects from this alleged deficient practice. R6 and R8 no longer reside at the facility. Director of Nursing or designee validated that residents have their medications available to prevent the alleged practice concerns. R2, R4 and R5 care plans were reviewed and remain current.</p> <p>Residents who require prescription medications have the potential to be affected by this alleged deficient practice. Policy and procedures were reviewed regarding abuse, neglect, misappropriation of resident property, and exploitation. No changes were required.</p> <p>Director of Nursing or designee provided re-education to licensed nursing staff on the rationale for not sharing prescription medication and process for reordering medication from pharmacy prior to running</p> | 07/23/2025 |

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

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

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| F0602 SS = E | <p>Continued from page 1 facility failed to ensure residents were free from misappropriation of property for five of eight residents (R2, R4, R5, R6, R8) reviewed when multiple nursing staff took medication belonging to one resident to administer to another resident when their medication supply ran out.</p> <p>Findings include:</p> <p>During an observation on 6/11/25 at 9:53 a.m. R2's levothyroxine 50 micrograms (mcg) medication card had doses, 30 through 17 removed and tablets one and two were removed. There was nothing written on the doses one and two. R4's potassium chloride 20 milliequivalent (mEq) medication card had doses 30 through five removed and doses one and two were removed. Written on the medication card was "5/18 for resident J.J (R7)". R5's glipizide five milligram (mg) medication card had doses 30 through seven removed and dose one was removed at the bottom of the medication card and was initialed "LM". R5's clozapine 100 mg medication card had doses 30 through 25 removed and doses five through one were removed. Written on the card was "6/6 D.L. for resident M.T. (R3)". Held by a rubber binder was a second medication card with five tablets that was delivered by pharmacy. R6's oxycodone five mg medication card had two doses removed on 6/5 at 11:45 a.m., two tablets that were removed on 6/7 at 1:58 p.m., and two tablets removed on 6/8 at 12:11 a.m. There was no indication as to why two tablets were removed at a time.</p> <p>R2's face sheet dated 6/12/25 indicated R2 was admitted to the facility on 11/20/16 with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R2's additional diagnoses included hypothyroidism, hyperlipidemia, and type 2 diabetes mellitus without complications.</p> <p>R2's provider order dated 12/31/24, indicated R2 was prescribed potassium chloride ER tablet extended release 20 milliequivalent (mEq) two tablets in the morning for low potassium levels.</p> <p>R2's provider order dated 12/31/24, indicated R2 was prescribed levothyroxine sodium 25 micrograms (mcg) one time a day related to hypothyroidism.</p> | F0602 | <p>Continued from page 1 out of medications. Licensed nurses also re-educated on the definition of misappropriation.</p> <p>Director of Nursing or designee will complete audits to validate medications have not been shared and nursing staff understand process to reorder medications. Audit will be completed two times per week for six weeks. Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.</p> <p>Facility will be in compliance by July 23rd, 2025.</p> | |

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| F0602 SS = E | <p>Continued from page 2</p> <p>R2's potassium chloride medication card dated 4/28/25, indicated doses nine through seven were removed on 6/5/25 and written on the medication card, the medication was removed for R7.</p> <p>R2's levothyroxine medication card dated 5/18/25 indicated dose 30 through 16 were removed as well as dose two and one. There was no indication as to why dose two and one were removed.</p> <p>R2's provider order dated 5/30/25 indicated R2's potassium chloride ER 20 mEq would be discontinued.</p> <p>R4's face sheet dated 6/12/25 indicated R4 was admitted to the facility on 10/22/24 with a primary diagnosis of lumbar spina bifida without hydrocephalus. R4's additional diagnoses included calculus of kidney, chronic kidney disease stage 3A, hypokalemia, and hypercalcemia.</p> <p>R4's provider order dated 2/28/25 indicated R4 was prescribed potassium chloride 20 mEq taking two tablets one time a day.</p> <p>R4's potassium chloride medication card dated 4/19/25 indicated doses 30 through five were removed. Doses two and one were removed on 5/18/25 for R7.</p> <p>R5's face sheet dated 6/12/25 indicated R5 was admitted to the facility on 2/26/21 with a primary diagnosis of schizoaffective disorder. R5's additional diagnoses included type 2 diabetes mellitus with other diabetic kidney complications and major depressive disorder.</p> <p>R5's provider orders dated 4/1/25 indicated R5 was prescribed clozapine 100 milligrams (mg) at bedtime released to schizoaffective disorder bipolar type. R5 was prescribed glipizide five mg by mouth in the morning related to type 2 diabetes mellitus without complications.</p> <p>R5's glipizide five mg medication card dated 5/3/25 indicated doses 30 through seven were removed. Dose one was taken with initials LW. It is unknown whose initials LW is. It is unknown what date the glipizide was removed for the unknown resident.</p> | F0602 | | |

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| F0602 SS = E | <p>Continued from page 3</p> <p>R5's clozapine 100 mg medication card dated 5/22/25 indicated doses 30 through 25 were removed. Doses five through one were removed on 6/6/25 for R3.</p> <p>R5's clozapine 100 mg medication card dated 6/5/25 indicated pharmacy filled five tablets.</p> <p>R6's face sheet dated 6/12/25 indicated R6 was admitted to the facility on 5/2/25 with a primary diagnosis of displaced fracture of lesser trochanter of left femur. R6's additional diagnoses included difficulty walking and age-related osteoporosis without current pathological fracture.</p> <p>R6's provider order dated 4/28/25 indicated R6 was prescribed oxycodone two-point five mg every four hours as needed for a pain score of four through six out of ten. R6 was prescribed five mg every four hours as needed for severe pain with a pain score of seven through ten out of ten. Oxycodone was prescribed for prolonged acute pain and traumatic injury.</p> <p>R6's oxycodone 5 mg medication card dated 5/18/25 indicated there were two tablets removed on 6/7/25 at 1:58 p.m. and two tablets were removed on 6/8/25 at 12:11 a.m.</p> <p>R6's medication administration record (MAR) dated 6/2025 indicated R6 was to be given oxycodone five mg, a half of a tablet (two-point five mg) every four hours as needed for pain. One dose of oxycodone two-point five mg was given on 6/7/25 at 1:57 p.m. by registered nurse (RN)-E. R6 was to be given oxycodone five mg one tablet every four hours as needed for pain. One dose of oxycodone five mg was given on 6/8/25 at 12:28 a.m. by licensed practical nurse (LPN)-A.</p> <p>R8's face sheet dated 6/12/25 indicated R8 was admitted to the facility on 5/2/25 with a primary diagnosis of encounter or orthopedic aftercare following surgical amputation. R8's additional diagnoses included osteomyelitis of vertebra in the lumbar region, polyneuropathy, and restless legs syndrome. R8 was discharged from the facility on 6/3/25.</p> | F0602 | | |

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| <p>F0602 SS = E</p> | <p>Continued from page 4 R8's provider order dated 5/2/25 indicated R8 was prescribed pregabalin ten mL (200 mg total) by mouth twice a day.</p> <p>R3's face sheet dated 6/12/25 indicated R3 was admitted to the facility on 6/5/25 with a primary diagnosis of other fracture of lower end of right ulna. R3's additional diagnoses included paranoid schizophrenia and anxiety disorder.</p> <p>R3's provider order dated 6/1/25 indicated R3 prescribed clozapine 100 mg five tablets orally at bedtime for paranoid schizophrenia.</p> <p>R3's MAR dated 6/2025 indicated R3 was to take clozapine 100 mg five tablets by mouth at bedtime. R3's clozapine was given on 6/6/25 by LPN-B.</p> <p>R7's face sheet dated 6/12/25 indicated R7 was admitted to the facility on 5/22/21 with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R7's additional diagnoses included hyperparathyroidism and hyperlipidemia.</p> <p>R7's progress note dated 5/5/25 indicated R7 was prescribed potassium chloride ER 20 mEq taking two tablets by mouth in the morning.</p> <p>R7's MAR dated 5/2025 indicated R7 was to take potassium chloride ER oral tablet extended release 40 mEq in the morning. R7's potassium chloride was given on 5/18/25 by RN-A.</p> <p>R7's MAR dated 6/2025 indicated R7 was to take potassium chloride ER oral tablet extended release 40 mEq by mouth in the morning. R7's potassium chloride was given on 6/5/25 by (RN)-A.</p> <p>During an interview on 6/11/25 at 9:53 a.m., RN-A stated director of nursing (DON)-A directed RN-A several times to "borrow" medications from other residents to give to another resident. All nurses were given education "recently" by DON-A about how to "borrow" medications from residents to give to another resident but could not recall the date that education</p> | <p>F0602</p> | | |

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| F0602 SS = E | <p>Continued from page 5 was.</p> <p>During an interview on 6/11/25 at 11:09 a.m., R2 stated the nurses had not asked if they could "borrow" any of her medications to give to other residents. R2 was unsure whether she has run out of medications or missed any doses of her medications.</p> <p>During an interview on 6/11/25 at 11:11 a.m., R3 stated the nurses had not asked if they could "borrow" any of her medications to give to other residents. R3 stated she was unsure whether she had missed any doses of her medications.</p> <p>During an interview on 6/11/25 at 11:16 a.m., R4 stated the nurses had not asked if they could "borrow" any of his medications to give to other residents. R4 has not ran out of medications that he knows of.</p> <p>During an interview on 6/11/25 at 11:24 a.m., family member (FM)-A stated the nurses had not called him to ask if they could "borrow" any of R5's medications to give to other residents. FM-A was unsure whether R5 has gone without any medications or ran out of medications.</p> <p>During an interview on 6/11/25 at 12:24 p.m., LPN-A stated if a resident were out of a medication, they would call either the RN on call, the DON-A, or RN-C and get direction. The RN on call, DON-A, or RN-C would direct her to "borrow" medications from another resident to give to that resident.</p> <p>During an interview on 6/11/25 at 12:43 p.m., LPN-B stated when she would run out of a medication for a resident, she would contact the RN on call, and they would give her direction to "borrow" medications from one resident to give to another resident. LPN-B stated, "this happens a lot." The last time LPN-B "borrowed" medications was "about a week ago." R9 had ran out of Pregabalin and R8 would be discharging the next day. DON-A gave direction to "borrow" R8's medication to give to R9.</p> <p>During an interview on 6/11/25 at 2:08 p.m., RN-C stated she had given direction to several of the nurses to "borrow" medications from residents to give to other residents if they did not have the medication that</p> | F0602 | | |

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| F0602 SS = E | <p>Continued from page 6 needed to be administered. RN-C stated that this practice would happen "every other day".</p> <p>During an interview on 6/11/25 at 5:44 p.m., RN-E stated DON-A and RN-C had told him to "borrow" medications from residents to give to other residents but could not recall the last time this happened.</p> <p>During an interview on 6/12/25 at 10:44 a.m., RN-A stated she has "borrowed" medications "several" times from residents to give to other residents but could not recall what medications she "borrowed" or what residents she took the medications from or what residents she gave the medications to. When a resident does not have a medication in the facility that needed to be administered, RN-A would call DON-A or RN-C, and they would give direction to "borrow" a resident's medication to give to that resident. When she would "borrow" medications from other residents, she would take the tablet from bottom of the medication card, initial with the nurses initial, date, time, and the initials of the resident to whom she gave the medication.</p> <p>During an interview on 6/12/25 at 2:24 p.m., DON-B stated he was unsure how long the "borrowing" of medications had been going on.</p> <p>Attempts to contact DON-A on 6/11/25 at 1:32 p.m., 6/12/25 at 9:28 a.m., and 6/16/25 at 9:35 a.m. without success.</p> <p>The facility policy titled Abuse, Neglect and Exploitation indicated misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belonging or money without the resident's consent.</p> | F0602 | | |
| F0609 SS = E | <p>Reporting of Alleged Violations</p> <p>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(1) Ensure that all alleged violations</p> | F0609 | <p>R2, R4, and R5 had no recognized affects from this alleged deficient practice. R6 and R8 no longer reside at the facility. Director of Nursing or designee confirmed that residents have their medications available to avoid this alleged practice concerns. R2, R4 and R5 care plans were reviewed and remain current.</p> <p>Current residents in the facility could have the potential to be impacted by this alleged deficient practice.</p> | 07/23/2025 |

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| F0609 SS = E | <p>Continued from page 7 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and record review the facility failed to ensure that alleged violations involving misappropriation of resident medications were reported to the state agency not later than 24 hours of the incidents for five of eight residents (R2, R4, R5, R6, and R8). The facility knew about the misappropriation of resident medications on 6/9/25 and did not report to the state agency.</p> <p>Findings include:</p> <p>During an observation on 6/11/25 at 9:53 a.m. R2's levothyroxine 50 micrograms (mcg) medication card had doses, 30 through 17 removed and tablets one and two were removed. There was nothing written on the doses one and two. R4's potassium chloride 20 milliequivalent (mEq) medication card had doses 30 through five removed and doses one and two were removed. Written on the medication card was "5/18 for resident J.J (R7)". R5's glipizide five milligram (mg) medication card had doses 30 through seven removed and dose one was removed at the bottom of the medication card and was initialed "LM". R5's clozapine 100 mg medication card had doses 30 through 25 removed and doses five through one were removed. Written on the card was "6/6 D.L. for resident M.T. (R3)". Held by a rubber binder was a second</p> | F0609 | <p>Continued from page 7</p> <p>Executive Director or designee re-educated staff on identifying potential abuse, misappropriation, neglect and exploitation; the timeframe for reporting any alleged violations, and the availability of the facility's compliance hotline to report any suspected violations anonymously.</p> <p>New hire and agency employees will receive education related to identifying potential abuse, misappropriation, neglect and exploitation; the timeframe for reporting any alleged violations, and the facility's compliance hotline during general orientation.</p> <p>Executive Director or designee will conduct random staff audits twice a week for six weeks to validate staff's understanding related to identifying potential abuse, neglect and exploitation, as well as the timeframe for reporting allegations.</p> <p>Facility will be in compliance by July 23rd, 2025.</p> | |

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| F0609 SS = E | <p>Continued from page 8 medication card with five tablets that was delivered by pharmacy. R6's oxycodone five mg medication card had two doses removed on 6/5 at 11:45 a.m., two tablets that were removed on 6/7 at 1:58 p.m., and two tablets removed on 6/8 at 12:11 a.m. There was no indication as to why two tablets were removed at a time.</p> <p>R2's face sheet dated 6/12/25 indicated R2 was admitted to the facility on 11/20/16 with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R2's additional diagnoses included hypothyroidism, hyperlipidemia, and type 2 diabetes mellitus without complications.</p> <p>R2's provider order dated 12/31/24, indicated R2 was prescribed potassium chloride ER tablet extended release 20 milliequivalent (mEq) two tablets in the morning for low potassium levels.</p> <p>R2's provider order dated 12/31/24, indicated R2 was prescribed levothyroxine sodium 25 micrograms (mcg) one time a day related to hypothyroidism.</p> <p>R2's potassium chloride medication card dated 4/28/25, indicated doses nine through seven were removed on 6/5/25 and written on the medication card, the medication was removed for R7.</p> <p>R2's levothyroxine medication card dated 5/18/25 indicated dose 30 through 16 were removed as well as dose two and one. There was no indication as to why dose two and one were removed.</p> <p>R2's provider order dated 5/30/25 indicated R2's potassium chloride ER 20 mEq would be discontinued.</p> <p>R4's face sheet dated 6/12/25 indicated R4 was admitted to the facility on 10/22/24 with a primary diagnosis of lumbar spina bifida without hydrocephalus. R4's additional diagnoses included calculus of kidney, chronic kidney disease stage 3A, hypokalemia, and hypercalcemia.</p> <p>R4's provider order dated 2/28/25 indicated R4 was prescribed potassium chloride 20 mEq taking two tablets</p> | F0609 | | |

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| F0609 SS = E | <p>Continued from page 9 one time a day.</p> <p>R4's potassium chloride medication card dated 4/19/25 indicated doses 30 through five were removed. Doses two and one were removed on 5/18/25 for R7.</p> <p>R5's face sheet dated 6/12/25 indicated R5 was admitted to the facility on 2/26/21 with a primary diagnosis of schizoaffective disorder. R5's additional diagnoses included type 2 diabetes mellitus with other diabetic kidney complications and major depressive disorder.</p> <p>R5's provider orders dated 4/1/25 indicated R5 was prescribed clozapine 100 milligrams (mg) at bedtime released to schizoaffective disorder bipolar type. R5 was prescribed glipizide five mg by mouth in the morning related to type 2 diabetes mellitus without complications.</p> <p>R5's glipizide five mg medication card dated 5/3/25 indicated doses 30 through seven were removed. Dose one was taken with initials LW. It is unknown whose initials LW is. It is unknown what date the glipizide was removed for the unknown resident.</p> <p>R5's clozapine 100 mg medication card dated 5/22/25 indicated doses 30 through 25 were removed. Doses five through one were removed on 6/6/25 for R3.</p> <p>R5's clozapine 100 mg medication card dated 6/5/25 indicated pharmacy filled five tablets.</p> <p>R6's face sheet dated 6/12/25 indicated R6 was admitted to the facility on 5/2/25 with a primary diagnosis of displaced fracture of lesser trochanter of left femur. R6's additional diagnoses included difficulty walking and age-related osteoporosis without current pathological fracture.</p> <p>R6's provider order dated 4/28/25 indicated R6 was prescribed oxycodone two-point five mg every four hours as needed for a pain score of four through six out of ten. R6 was prescribed five mg every four hours as needed for severe pain with a pain score of seven through ten out of ten. Oxycodone was prescribed for prolonged acute pain and traumatic injury.</p> | F0609 | | |

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| F0609 SS = E | <p>Continued from page 10</p> <p>R6's oxycodone 5 mg medication card dated 5/18/25 indicated there were two tablets removed on 6/7/25 at 1:58 p.m. and two tablets were removed on 6/8/25 at 12:11 a.m.</p> <p>R6's medication administration record (MAR) dated 6/2025 indicated R6 was to be given oxycodone five mg, a half of a tablet (two-point five mg) every four hours as needed for pain. One dose of oxycodone two-point five mg was given on 6/7/25 at 1:57 p.m. by registered nurse (RN)-E. R6 was to be given oxycodone five mg one tablet every four hours as needed for pain. One dose of oxycodone five mg was given on 6/8/25 at 12:28 a.m. by licensed practical nurse (LPN)-A.</p> <p>R8's face sheet dated 6/12/25 indicated R8 was admitted to the facility on 5/2/25 with a primary diagnosis of encounter or orthopedic aftercare following surgical amputation. R8's additional diagnoses included osteomyelitis of vertebra in the lumbar region, polyneuropathy, and restless legs syndrome. R8 was discharged from the facility on 6/3/25.</p> <p>R8's provider order dated 5/2/25 indicated R8 was prescribed pregabalin ten mL (200 mg total) by mouth twice a day.</p> <p>R3's face sheet dated 6/12/25 indicated R3 was admitted to the facility on 6/5/25 with a primary diagnosis of other fracture of lower end of right ulna. R3's additional diagnoses included paranoid schizophrenia and anxiety disorder.</p> <p>R3's provider order dated 6/1/25 indicated R3 prescribed clozapine 100 mg five tablets orally at bedtime for paranoid schizophrenia.</p> <p>R3's MAR dated 6/2025 indicated R3 was to take clozapine 100 mg five tablets by mouth at bedtime. R3's clozapine was given on 6/6/25 by LPN-B.</p> <p>R7's face sheet dated 6/12/25 indicated R7 was admitted to the facility on 5/22/21 with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R7's</p> | F0609 | | |

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| F0609 SS = E | <p>Continued from page 11 additional diagnoses included hyperparathyroidism and hyperlipidemia.</p> <p>R7's progress note dated 5/5/25 indicated R7 was prescribed potassium chloride ER 20 mEq taking two tablets by mouth in the morning.</p> <p>R7's MAR dated 5/2025 indicated R7 was to take potassium chloride ER oral tablet extended release 40 mEq in the morning. R7's potassium chloride was given on 5/18/25 by RN-A.</p> <p>R7's MAR dated 6/2025 indicated R7 was to take potassium chloride ER oral tablet extended release 40 mEq by mouth in the morning. R7's potassium chloride was given on 6/5/25 by (RN)-A.</p> <p>During an interview on 6/11/25 at 9:53 a.m., RN-A stated director of nursing (DON)-A directed RN-A several times to "borrow" medications from other residents to give to another resident. All nurses were given education "recently" by DON-A about how to "borrow" medications from residents to give to another resident but could not recall the date that education was.</p> <p>During an interview on 6/11/25 at 11:09 a.m., R2 stated the nurses had not asked if they could "borrow" any of her medications to give to other residents. R2 was unsure whether she has run out of medications or missed any doses of her medications.</p> <p>During an interview on 6/11/25 at 11:11 a.m., R3 stated the nurses had not asked if they could "borrow" any of her medications to give to other residents. R3 stated she was unsure whether she had missed any doses of her medications.</p> <p>During an interview on 6/11/25 at 11:16 a.m., R4 stated the nurses had not asked if they could "borrow" any of his medications to give to other residents. R4 has not ran out of medications that he knows of.</p> <p>During an interview on 6/11/25 at 11:24 a.m., family member (FM)-A stated the nurses had not called him to ask if they could "borrow" any of R5's medications to</p> | F0609 | | |

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| F0609 SS = E | <p>Continued from page 12 give to other residents. FM-A was unsure whether R5 has gone without any medications or ran out of medications.</p> <p>During an interview on 6/11/25 at 12:24 p.m., LPN-A stated if a resident were out of a medication, they would call either the RN on call, the DON-A, or RN-C and get direction. The RN on call, DON-A, or RN-C would direct her to "borrow" medications from another resident to give to that resident.</p> <p>During an interview on 6/11/25 at 12:43 p.m., LPN-B stated when she would run out of a medication for a resident, she would contact the RN on call, and they would give her direction to "borrow" medications from one resident to give to another resident. LPN-B stated, "this happens a lot." The last time LPN-B "borrowed" medications was "about a week ago." R9 had ran out of Pregabalin and R8 would be discharging the next day. DON-A gave direction to "borrow" R8's medication to give to R9.</p> <p>During an interview on 6/11/25 at 2:08 p.m., RN-C stated she had given direction to several of the nurses to "borrow" medications from residents to give to other residents if they did not have the medication that needed to be administered. RN-C stated that this practice would happen "every other day".</p> <p>During an interview on 6/11/25 at 5:44 p.m., RN-E stated DON-A and RN-C had told him to "borrow" medications from residents to give to other residents but could not recall the last time this happened.</p> <p>During an interview on 6/12/25 at 10:44 a.m., RN-A stated she has "borrowed" medications "several" times from residents to give to other residents but could not recall what medications she "borrowed" or what residents she took the medications from or what residents she gave the medications to. When a resident does not have a medication in the facility that needed to be administered, RN-A would call DON-A or RN-C, and they would give direction to "borrow" a resident's medication to give to that resident. When she would "borrow" medications from other residents, she would take the tablet from bottom of the medication card, initial with the nurses initial, date, time, and the initials of the resident to whom she gave the medication.</p> | F0609 | | |

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| F0609 SS = E | <p>Continued from page 13</p> <p>During an interview on 6/12/25 at 2:24 p.m., DON-B stated to his knowledge, the misappropriation of medications was never reported, although it should have been. DON-B stated he was unsure how long the "borrowing" of medications had been going on.</p> <p>During an interview on 6/16/25 at 1:01 p.m., DON-D stated incidents of misappropriation of medications should be reported to the state agency.</p> <p>During an interview on 6/16/25 at 1:12 p.m., DON-C stated misappropriation of medications should be reported to the state agency, but he did not report.</p> <p>During an interview on 6/16/25 at 2:03 p.m., human resources (HR)-B stated she found out on 6/9/25 about the misappropriation of medications. HR-B did not report these incidents to the state agency because she did not have access and did not know how to report to the state agency. HR-B was unsure who would have been responsible for reporting these incidents to the state agency.</p> <p>During an interview on 6/16/25 at 2:40 p.m., HR-A stated he found out about the incident with misappropriation of medications on 6/9/25. HR-A did not report the misappropriation of medication because he was not involved in the investigation.</p> <p>Surveyor attempted to contact DON-A on 6/11/25 at 1:32 p.m., 6/12/25 at 9:28 a.m., and 6/16/25 at 9:35 a.m. without success.</p> <p>The facility policy titled Abuse, Neglect and Exploitation indicated misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belonging or money without the resident's consent. Employees would be educated on abuse, neglect, exploitation, and misappropriated of resident property on areas of definitions, preventing, identification, investigation, protection, and reporting not later than 24 hours if the events that cause the allegation do not involve abuse and did not result in serious bodily injury.</p> | F0609 | | |
| F0610 SS = E | Investigate/Prevent/Correct Alleged Violation | F0610 | R2, R4, and R5 had no identified affects from this | 07/23/2025 |

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| F0610 SS = E | <p>Continued from page 14</p> <p>CFR(s): 483.12(c)(2)-(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review, the facility failed to thoroughly investigate allegations of misappropriation of resident medications for five of eight residents (R2, R4, R5, R6, and R8) when the facility found out about these allegations on 6/9/25, placed DON-A on administrative leave pending an investigation.</p> <p>Findings include:</p> <p>During an observation on 6/11/25 at 9:53 a.m. R2's levothyroxine 50 micrograms (mcg) medication card had doses, 30 through 17 removed and tablets one and two were removed. There was nothing written on the doses one and two. R4's potassium chloride 20 milliequivalent (mEq) medication card had doses 30 through five removed and doses one and two were removed. Written on the medication card was "5/18 for resident J.J (R7)". R5's glipizide five milligram (mg) medication card had doses 30 through seven removed and dose one was removed at the bottom of the medication card and was initialed "LM". R5's clozapine 100 mg medication card had doses 30 through 25 removed and doses five through one were removed. Written on the card was "6/6 D.L. for resident M.T. (R3)". Held by a rubber binder was a second</p> | F0610 | <p>Continued from page 14</p> <p>alleged deficient practice. R6 and R8 no longer reside at the facility. DON-A was placed on administrative leave immediately pending internal investigation of this alleged deficient practice. Licensed staff were interviewed as to what their prior process was when medications were not available and then educated on the proper handling of medications when not available. R2, R4, and R5 care plans were reviewed and remain current.</p> <p>Management staff will receive education on the policy and procedure regarding internal investigation.</p> <p>Current residents have the potential to be impacted by this alleged deficient practice. Interviewable residents were interviewed to see if they have any allegations or concerns related to potential misappropriation that have not been resolved/investigated.</p> <p>New hire employees will receive education on the policy and procedure of internal investigation during general orientation, as well as new agency employees during their general orientation.</p> <p>Executive Director or designee will conduct random staff audits twice a week for six weeks related to the staff's understanding of the policy and procedure regarding internal investigations.</p> <p>Facility will be in compliance by July 23rd, 2025.</p> | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245270 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 06/16/2025 |
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| NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 | |
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| F0610 SS = E | <p>Continued from page 15 medication card with five tablets that was delivered by pharmacy. R6's oxycodone five mg medication card had two doses removed on 6/5 at 11:45 a.m., two tablets that were removed on 6/7 at 1:58 p.m., and two tablets removed on 6/8 at 12:11 a.m. There was no indication as to why two tablets were removed at a time.</p> <p>R2's face sheet dated 6/12/25 indicated R2 was admitted to the facility on 11/20/16 with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R2's additional diagnoses included hypothyroidism, hyperlipidemia, and type 2 diabetes mellitus without complications.</p> <p>R2's provider order dated 12/31/24, indicated R2 was prescribed potassium chloride ER tablet extended release 20 milliequivalent (mEq) two tablets in the morning for low potassium levels.</p> <p>R2's provider order dated 12/31/24, indicated R2 was prescribed levothyroxine sodium 25 micrograms (mcg) one time a day related to hypothyroidism.</p> <p>R2's potassium chloride medication card dated 4/28/25, indicated doses nine through seven were removed on 6/5/25 and written on the medication card, the medication was removed for R7.</p> <p>R2's levothyroxine medication card dated 5/18/25 indicated dose 30 through 16 were removed as well as dose two and one. There was no indication as to why dose two and one were removed.</p> <p>R2's provider order dated 5/30/25 indicated R2's potassium chloride ER 20 mEq would be discontinued.</p> <p>R4's face sheet dated 6/12/25 indicated R4 was admitted to the facility on 10/22/24 with a primary diagnosis of lumbar spina bifida without hydrocephalus. R4's additional diagnoses included calculus of kidney, chronic kidney disease stage 3A, hypokalemia, and hypercalcemia.</p> <p>R4's provider order dated 2/28/25 indicated R4 was prescribed potassium chloride 20 mEq taking two tablets</p> | F0610 | | |

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| F0610 SS = E | <p>Continued from page 16 one time a day.</p> <p>R4's potassium chloride medication card dated 4/19/25 indicated doses 30 through five were removed. Doses two and one were removed on 5/18/25 for R7.</p> <p>R5's face sheet dated 6/12/25 indicated R5 was admitted to the facility on 2/26/21 with a primary diagnosis of schizoaffective disorder. R5's additional diagnoses included type 2 diabetes mellitus with other diabetic kidney complications and major depressive disorder.</p> <p>R5's provider orders dated 4/1/25 indicated R5 was prescribed clozapine 100 milligrams (mg) at bedtime released to schizoaffective disorder bipolar type. R5 was prescribed glipizide five mg by mouth in the morning related to type 2 diabetes mellitus without complications.</p> <p>R5's glipizide five mg medication card dated 5/3/25 indicated doses 30 through seven were removed. Dose one was taken with initials LW. It is unknown whose initials LW is. It is unknown what date the glipizide was removed for the unknown resident.</p> <p>R5's clozapine 100 mg medication card dated 5/22/25 indicated doses 30 through 25 were removed. Doses five through one were removed on 6/6/25 for R3.</p> <p>R5's clozapine 100 mg medication card dated 6/5/25 indicated pharmacy filled five tablets.</p> <p>R6's face sheet dated 6/12/25 indicated R6 was admitted to the facility on 5/2/25 with a primary diagnosis of displaced fracture of lesser trochanter of left femur. R6's additional diagnoses included difficulty walking and age-related osteoporosis without current pathological fracture.</p> <p>R6's provider order dated 4/28/25 indicated R6 was prescribed oxycodone two-point five mg every four hours as needed for a pain score of four through six out of ten. R6 was prescribed five mg every four hours as needed for severe pain with a pain score of seven through ten out of ten. Oxycodone was prescribed for prolonged acute pain and traumatic injury.</p> | F0610 | | |

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| F0610 SS = E | <p>Continued from page 17</p> <p>R6's oxycodone 5 mg medication card dated 5/18/25 indicated there were two tablets removed on 6/7/25 at 1:58 p.m. and two tablets were removed on 6/8/25 at 12:11 a.m.</p> <p>R6's medication administration record (MAR) dated 6/2025 indicated R6 was to be given oxycodone five mg, a half of a tablet (two-point five mg) every four hours as needed for pain. One dose of oxycodone two-point five mg was given on 6/7/25 at 1:57 p.m. by registered nurse (RN)-E. R6 was to be given oxycodone five mg one tablet every four hours as needed for pain. One dose of oxycodone five mg was given on 6/8/25 at 12:28 a.m. by licensed practical nurse (LPN)-A.</p> <p>R8's face sheet dated 6/12/25 indicated R8 was admitted to the facility on 5/2/25 with a primary diagnosis of encounter or orthopedic aftercare following surgical amputation. R8's additional diagnoses included osteomyelitis of vertebra in the lumbar region, polyneuropathy, and restless legs syndrome. R8 was discharged from the facility on 6/3/25.</p> <p>R8's provider order dated 5/2/25 indicated R8 was prescribed pregabalin ten mL (200 mg total) by mouth twice a day.</p> <p>R3's face sheet dated 6/12/25 indicated R3 was admitted to the facility on 6/5/25 with a primary diagnosis of other fracture of lower end of right ulna. R3's additional diagnoses included paranoid schizophrenia and anxiety disorder.</p> <p>R3's provider order dated 6/1/25 indicated R3 prescribed clozapine 100 mg five tablets orally at bedtime for paranoid schizophrenia.</p> <p>R3's MAR dated 6/2025 indicated R3 was to take clozapine 100 mg five tablets by mouth at bedtime. R3's clozapine was given on 6/6/25 by LPN-B.</p> <p>R7's face sheet dated 6/12/25 indicated R7 was admitted to the facility on 5/22/21 with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R7's</p> | F0610 | | |

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| F0610 SS = E | <p>Continued from page 18 additional diagnoses included hyperparathyroidism and hyperlipidemia.</p> <p>R7's progress note dated 5/5/25 indicated R7 was prescribed potassium chloride ER 20 mEq taking two tablets by mouth in the morning.</p> <p>R7's MAR dated 5/2025 indicated R7 was to take potassium chloride ER oral tablet extended release 40 mEq in the morning. R7's potassium chloride was given on 5/18/25 by RN-A.</p> <p>R7's MAR dated 6/2025 indicated R7 was to take potassium chloride ER oral tablet extended release 40 mEq by mouth in the morning. R7's potassium chloride was given on 6/5/25 by (RN)-A.</p> <p>During an interview on 6/11/25 at 9:53 a.m., RN-A stated director of nursing (DON)-A directed RN-A several times to "borrow" medications from other residents to give to another resident. All nurses were given education "recently" by DON-A about how to "borrow" medications from residents to give to another resident but could not recall the date that education was.</p> <p>During an interview on 6/11/25 at 12:24 p.m., LPN-A stated if a resident were out of a medication, they would call either the RN on call, DON-A, or RN-C and get direction. The RN on call, DON-A, or RN-C would direct her to "borrow" medications from another resident to give to that resident.</p> <p>During an interview on 6/11/25 at 12:43 p.m., LPN-B stated when she would run out of a medication for a resident, she would contact the RN on call, and they would give her direction to "borrow" medications from one resident to give to another resident. LPN-B stated, "this happens a lot." The last time LPN-B "borrowed" medications was "about a week ago." R9 had ran out of Pregabalin and R8 would be discharging the next day. DON-A gave direction to "borrow" R8's medication to give to R9.</p> <p>During an interview on 6/11/25 at 2:08 p.m., RN-C stated she had given direction to several of the nurses to "borrow" medications from residents to give to other</p> | F0610 | | |

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| F0610 SS = E | <p>Continued from page 19 residents if they did not have the medication that needed to be administered. RN-C stated that this practice would happen "every other day."</p> <p>During an interview on 6/11/25 at 5:44 p.m., RN-E stated DON-A and RN-C had told him to "borrow" medications from residents to give to other residents but could not recall the last time this happened.</p> <p>During an interview on 6/12/25 at 10:44 a.m., RN-A stated she has "borrowed" medications "several" times from residents to give to other residents but could not recall what medications she "borrowed" or what residents she took the medications from or what residents she gave the medications to. When a resident does not have a medication in the facility that needed to be administered, RN-A would call DON-A or RN-C, and they would give direction to "borrow" a resident's medication to give to that resident. When she would "borrow" medications from other residents, she would take the tablet from bottom of the medication card, initial with the nurses initial, date, time, and the initials of the resident to whom she gave the medication.</p> <p>During an interview on 6/12/25 at 2:24 p.m., DON-B stated he was not part of the facility's investigation, so he was unfamiliar with what was happening in an investigation. DON-B stated human resources (HR)-A was investigating.</p> <p>During an interview on 6/12/25 at 2:40 p.m., HR-A stated he did not do an investigation. HR-A is aware that the facility had placed DON-A on administrative leave pending the investigation.</p> <p>During an email correspondence on 6/16/25 at 6:24 a.m., HR-A stated he had discussed with the facility and team internally and would not be releasing the investigation that the surveyor had requested. Parts of the investigation were still on going and the facility needed to protect themselves and employees as needed.</p> <p>During an interview on 6/16/25 at 1:12 p.m., DON-C stated he has educated some of the nurses about the polies and procedures around medication administration and what to do if they are out of a medication. DON-C stated he was not part of the investigation, but had</p> | F0610 | | |

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| F0610 SS = E | <p>Continued from page 20 thought HR-A had completed the investigation.</p> <p>During an interview on 6/16/25 at 1:40 p.m., HR-A stated when the facility found out about the allegation of misappropriation of resident medications, he was not part of the investigation, but HR-B was part of the investigation. HR-A was unaware of any education, corrective action plans, or audits being completed.</p> <p>During an interview on 6/16/25 at 2:03 p.m., HR-B stated she was part of an investigation. HR-B had placed DON-A on administrative leave pending the investigation but was unsure the results of the investigation. HR-B was unaware if the facility had done any education with the nurses.</p> <p>Attempts to contact DON-A on 6/11/25 at 1:32 p.m., 6/12/25 at 9:28 a.m., and 6/16/25 at 9:35 a.m. without success.</p> <p>The facility policy titled Abuse, Neglect and Exploitation indicated misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belonging or money without the resident's consent. Employees would be educated on abuse, neglect, exploitation, and misappropriated of resident property on areas of definitions, preventing, identification, investigation, protection, and reporting. Investigation included identify staff responsible for the investigation, identify and interview all persons involved including the alleged victim(s), alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s), determine if the allegation occurred, the extent, and cause, complete and thorough documentation of the investigation.</p> | F0610 | | |
| F0755 SS = E | <p>Pharmacy Srvcs/Procedures/Pharmacist/Records</p> <p>CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> | F0755 | <p>F755 Pharmacy Services/Procedures/pharmacist/Records.</p> <p>R2, R4 and R5 had no identified affects from this alleged deficient practice. R6 and R8 were discharged to the community and no longer reside at the facility. Director of Nursing or designee validated that residents have their medications available to prevent this alleged practice concerns. R2, R4 and R5 care plans were reviewed and remain appropriate.</p> <p>Residents who require prescription medications have the potential to be affected by this alleged deficient</p> | 08/04/2025 |

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| F0755 SS = E | <p>Continued from page 21</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to ensure residents medications were ordered in advanced and medications were administered as prescribed for five of eight residents (R2, R4, R5, R6, R8) reviewed when residents were administered other resident's medications when their supply ran out.</p> <p>Findings include:</p> <p>During an observation on 6/11/25 at 9:53 a.m. R2's levothyroxine 50 micrograms (mcg) medication card had doses, 30 through 17 removed and tablets one and two were removed. There was nothing written on the doses one and two. R4's potassium chloride 20 milliequivalent (mEq) medication card had doses 30 through five removed and doses one and two were removed. Written on the medication card was "5/18 for resident J.J (R7)". R5's glipizide five milligram (mg) medication card had doses 30 through seven removed and dose one was removed at the bottom of the medication card and was initialed "LM". R5's clozapine 100 mg medication card had doses</p> | F0755 | <p>Continued from page 21 practice. Policy and procedures were reviewed and remain appropriate regarding medication ordering and receiving from pharmacy and medication administration.</p> <p>Director of Nursing or designee provided re-education to licensed nursing staff on misappropriation of medication and pharmaceutical services; including procedures to ensure the accuracy of acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident. Education will be completed prior to their next shift.</p> <p>To ensure the proper protocol for returning medications, the facility obtained a return scanner from the pharmacy as an additional tool to aide with returning medications. Pharmacia provided education to licensed staff on procedures for re-ordering and returning medications.</p> <p>Upon receiving medication from pharmacy, receipt is obtained of delivered medication. Controlled substances are logged into the controlled substance book upon receiving. Reconciliation is done at time of administration of medication and at shift change. Pharmacy consultant completes random monthly controlled substance audits to ensure proper documentation.</p> <p>Licensed staff receive annual training related to medication administration and misappropriation of medication.</p> <p>Director of Nursing or designee will complete audits for compliance with medication standards two times per week for six weeks. Audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.</p> <p>Facility will be in compliance by July 23rd, 2025.</p> | |

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| F0755 SS = E | <p>Continued from page 22 30 through 25 removed and doses five through one were removed. Written on the card was "6/6 D.L. for resident M.T. (R3)". Held by a rubber binder was a second medication card with five tablets that was delivered by pharmacy. R6's oxycodone five mg medication card had two doses removed on 6/5 at 11:45 a.m., two tablets that were removed on 6/7 at 1:58 p.m., and two tablets removed on 6/8 at 12:11 a.m. There was no indication as to why two tablets were removed at a time.</p> <p>During an observation on 6/11/25 at 10:20 a.m. R2's potassium chloride 20 mEq medication card had two doses missing. Written next to the two doses missing included "6/5 for J.J."</p> <p>R2's face sheet dated 6/12/25, indicated R2 was admitted to the facility on 11/20/16 with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R2's additional diagnoses included hypothyroidism, hyperlipidemia, and type 2 diabetes mellitus without complications.</p> <p>R2's brief interview for mental status (BIMS) dated 5/8/25, indicated a score of 14, which indicated R2 was cognitively intact.</p> <p>R2's provider order dated 12/31/24, indicated R2 was prescribed potassium chloride ER tablet extended release, 20 mEq, two tablets in the morning for low potassium levels.</p> <p>R2's provider order dated 12/31/24, indicated R2 was prescribed levothyroxine sodium 25 mcg, one time a day related to hypothyroidism.</p> <p>R2's potassium chloride medication card dated 4/28/25, indicated doses nine through seven were removed on 6/5/25, and written on the medication card, the medication was taken for R7.</p> <p>R2's levothyroxine medication card dated 5/18/25, indicated dose 30 through 16 were removed as well as dose two and one. There was no indication as to why dose two and one was removed.</p> | F0755 | | |

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| F0755 SS = E | <p>Continued from page 23</p> <p>R2's progress note dated 5/30/25, indicated R2's potassium chloride, ER 20 mEq would be discontinued.</p> <p>R2's provider order dated 5/30/25, indicated R2's potassium chloride ER 20 mEq, would be discontinued.</p> <p>R4's face sheet dated 6/12/25, indicated R4 was admitted to the facility on 10/22/24 with a primary diagnosis of lumbar spina bifida without hydrocephalus. R4's additional diagnoses included calculus of kidney, chronic kidney disease stage 3A, hypokalemia, and hypercalcemia.</p> <p>R4's BIMS dated 5/22/25, indicated a score of 15, which indicated R4 was cognitively intact.</p> <p>R4's provider order dated 2/28/25, indicated R4 was prescribed potassium chloride, 20 mEq, take two tablets one time a day.</p> <p>R4's potassium chloride medication card dated 4/19/25, indicated doses 30 through five were removed. Doses two and one were removed on 5/18/25 for R7.</p> <p>R5's face sheet dated 6/12/25, indicated R5 was admitted to the facility on 2/26/21 with a primary diagnosis of schizoaffective disorder. R5's additional diagnoses included type 2 diabetes mellitus with other diabetic kidney complications and major depressive disorder.</p> <p>R5's BIMS dated 3/17/25, indicated a score of three, which indicated R5 had severe cognitive impairment.</p> <p>R5's provider orders dated 4/1/25, indicated R5 was prescribed clozapine, 100 mg, at bedtime related to schizoaffective disorder bipolar type. R5 was prescribed glipizide, five mg, by mouth in the morning related to type 2 diabetes mellitus without complications.</p> <p>R5's glipizide five mg medication card dated 5/3/25, indicated doses 30 through seven were removed. Dose one was removed with initials LW. It is unknown whose initials LW is. It is unknown what date the glipizide</p> | F0755 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245270 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 06/16/2025 |
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| NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 | |
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| F0755 SS = E | <p>Continued from page 24 was taken or for which resident.</p> <p>R5's clozapine 100 mg medication card dated 5/22/25 indicated doses 30 through twenty-five were removed. Doses five through one were removed on 6/6/25 for R3.</p> <p>R5's clozapine 100 mg medication card dated 6/5/25 indicated pharmacy filled five tablets.</p> <p>R5's pharmacy receipts indicated on 6/6/25 the pharmacy received a message from DON-A requesting to bill the facility for five tablets of the clozapine one-hundred mg tablets.</p> <p>R6's face sheet dated 6/12/25 indicated R6 was admitted to the facility on 5/2/25 with a primary diagnosis of displaced fracture of lesser trochanter of left femur. R6's additional diagnoses included difficulty walking and age-related osteoporosis without current pathological fracture.</p> <p>R6's provider order dated 4/28/25 indicated R6 was prescribed oxycodone, two-point five mg, every four hours as needed for a pain score of four through six out of ten. R6 was prescribed five mg every four hours as needed for severe pain with a pain score of seven through ten out of ten. Oxycodone was prescribed for prolonged acute pain and traumatic injury.</p> <p>R6's BIMS dated 5/6/25, indicated a score of zero, which indicated R6 had severe cognitive impairment.</p> <p>R6's oxycodone 5 mg medication card dated 5/18/25 indicated there were two tablets removed on 6/7/25 at 1:58 p.m. and two tablets were removed on 6/8/25 at 12:11 a.m.</p> <p>R6's medication administration record (MAR) dated 5/2025 indicated from 5/13/25 to 5/20/25 the facility used 15 half tablets of the five mg oxycodone tablets and five tablets of the oxycodone five mg tablets. This should have left the facility with two and a half tablets of the five mg tablets left.</p> <p>R6's pharmacy receipts indicated since 1/2025 the</p> | F0755 | | |

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| F0755 SS = E | <p>Continued from page 25 pharmacy delivered 15 tablets of oxycodone, five mg, on 5/3/25. On 5/13/25 the pharmacy delivered five mg, ten tablets. On 5/20/25 the pharmacy received a message stating the facility only had two tablets of the oxycodone five mg left. On 5/20/25 the pharmacy delivered oxycodone five mg 28 tablets.</p> <p>R6's MAR dated 6/2025 indicated R6 was to be given oxycodone five mg a half of a tablet (two-point five mg) every four hours as needed for pain. One dose of oxycodone two-point five mg was given on 6/7/25 at 1:57 p.m. by registered nurse (RN)-E. R6 was to be given oxycodone five mg one tablet every four hours as needed for pain. One dose of oxycodone five mg was given on 6/8/25 at 12:28 a.m. by licensed practical nurse (LPN)-A. The does was dependent on the pain scale. This should have left the facility with two and a half tablets of the five mg tablets.</p> <p>R8's face sheet dated 6/12/25, indicated R8 was admitted to the facility on 5/2/25 with a primary diagnosis of encounter or orthopedic aftercare following surgical amputation. R8's additional diagnoses included osteomyelitis of vertebra in the lumbar region, polyneuropathy, and restless legs syndrome. R8 was discharged from the facility on 6/3/25.</p> <p>R8's provider order dated 5/2/25, indicated R8 was prescribed pregabalin ten mL (200 mg total) by mouth twice a day.</p> <p>R8's medication card was no longer in the facility as she had been discharged.</p> <p>R3's face sheet dated 6/12/25 indicated R3 was admitted to the facility on 6/5/25, with a primary diagnosis of other fracture of lower end of right ulna. R3's additional diagnoses included paranoid schizophrenia and anxiety disorder.</p> <p>R3's provider order dated 6/1/25, indicated R3 was prescribed clozapine, 100 mg, five tablets orally at bedtime for paranoid schizophrenia.</p> <p>R3's BIMS dated 6/5/25 indicated a score of 13, which indicated R3 was cognitively intact.</p> | F0755 | | |

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| F0755 SS = E | <p>Continued from page 26</p> <p>R3's MAR dated 6/2025 indicated R3 was to take clozapine, 100 mg, five tablets by mouth at bedtime. R3's clozapine was given on 6/6/25 by LPN-B.</p> <p>R3's pharmacy receipts indicated since 1/2025 the pharmacy delivered 25 tablets of clozapine on 6/6/25.</p> <p>R7's face sheet dated 6/12/25 indicated R7 was admitted to the facility on 5/22/21 with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R7's additional diagnoses included hyperparathyroidism and hyperlipidemia.</p> <p>R7's BIMS dated 4/24/25 indicated a score of zero, which indicated R7 had severe cognitive impairment.</p> <p>R7's progress note dated 5/5/25 indicated R7 was prescribed potassium chloride ER 20 mEq taking two tablets by mouth in the morning.</p> <p>R7's MAR dated 5/2025 indicated R7 was to take potassium chloride ER oral tablet extended release 40 mEq in the morning. R7's potassium chloride was given on 5/18/25 by RN-A.</p> <p>R7's MAR dated 6/2025 indicated R7 was to take potassium chloride ER oral tablet extended release 40 mEq by mouth in the morning. R7's potassium chloride was given on 6/5/25 by (RN)-A.</p> <p>R7's pharmacy receipts indicated since 1/2025 the pharmacy delivered 946 milliliters (mL) of potassium chloride on 1/21/25. On 2/20/25 the pharmacy delivered 946 mL. On 3/27/25 the pharmacy delivered 946 mL. On 5/2/25 the pharmacy delivered 473 mL. On 5/2/25 the pharmacy received a message stating P7 was on hospice and requested a partial refill. On 5/3/25 the pharmacy delivered 30 tablets. On 5/20/25 the pharmacy delivered thirty tablets. On 6/6/25 the pharmacy delivered 30 tablets.</p> <p>R9's face sheet dated 6/12/25 indicated R9 was admitted to the facility on 7/10/23 with a primary diagnosis of</p> | F0755 | | |

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| F0755 SS = E | <p>Continued from page 27</p> <p>hypertensive heart and chronic kidney disease with heart failure and stage one through stage four chronic kidney disease. R9's additional diagnosis included type 2 diabetes.</p> <p>R9's provider order dated 10/17/24 indicated R9 was prescribed pregabalin 200 mg twice a day related to type 2 diabetes mellitus with diabetic neuropathy.</p> <p>R9's BIMS dated 6/6/25 indicated a score of eight, which indicated R9 had moderate cognitive impairment.</p> <p>R9's pharmacy receipts indicated since 1/2025 the pharmacy delivered 60 pregabalin tablets on 1/14/25. On 2/13/25 the pharmacy delivered 60 tablets. On 3/17/25 the pharmacy delivered 60 tablets. On 4/23/25 the pharmacy delivered 60 tablets. On 5/16/25 the pharmacy delivered 60 tablets.</p> <p>During an interview on 6/11/25 at 9:53 a.m., RN-A stated when a resident is out of a medication, they would re-order the medication once there is eight doses left. If the medication is not available at the time of medication administration, she would look in the emergency medication kit to see if the medication is available. RN-A would also call the pharmacy to check on the status of the medication. RN-A would call the on-call RN, RN-C or DON-A to get direction on the medication administration. RN-A stated she has been given direction by RN-C and DON-A to "borrow" medications from another resident when the medication is not available for that resident and not available in the emergency medication kit. RN-A has been given that direction "several" times. RN-A has received education about how to "properly" borrow medications from other residents but was unsure when this education was. The education was about taking a dose from the resident's medication card at the bottom. The nurse would then date, write the nurses initials, and then the initials of the resident who was given the medication. DON-A. provided this education.</p> <p>During an interview on 6/12/25 at 9:04 a.m., RN-A stated she would re-order a medication once there is eight doses left. The overnight nurses are responsible for re-ordering the medications. To order a medication, a nurse would click the "re-order" button in the electronic medical record (EMR). If a medication has been re-ordered but was not delivered yet, RN-A would</p> | F0755 | | |

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| F0755 SS = E | <p>Continued from page 28 fax the order to the pharmacy.</p> <p>During an interview on 6/11/25 at 11:09 a.m., R2 stated the nurses had not asked if they could "borrow" any of her medications to give to other residents. R2 was unsure whether she has run out of medications or missed any doses of her medications.</p> <p>During an interview on 6/11/25 at 11:11 a.m., R3 stated the nurses had not asked if they could "borrow" any of her medications to give to other residents. R3 stated she was unsure whether she had missed any doses of her medications.</p> <p>During an interview on 6/11/25 at 11:16 a.m., R4 stated the nurses had not asked if they could "borrow" any of his medications to give to other residents. R4 has not ran out of medications that he knows of.</p> <p>During an interview on 6/11/25 at 11:24 a.m., family member (FM)-A stated the nurses had not called him to ask if they could "borrow" any of R5's medications to give to other residents. FM-A was unsure whether R5 has gone without any medications or ran out of medications.</p> <p>During an interview on 6/11/25 at 12:24 p.m., LPN-A stated if she ran out of a resident medication, she would look in the backstock medication cart. If the medication is not in the backstock medication cart, she would call the pharmacy to check the status of delivery. LPN-A would ask for a stat delivery of the medication. If there is a medication that needs to be administered and the medication is not at the facility, she would consult with the RN-C or DON-A. On 6/6/25 she was to give R3 her clozapine dose. Since R3 was admitted to the day prior, R3's medications were not delivered yet. LPN-A consulted with the nurse practitioner (NP) who could not gain access into R3's EMR yet but would attempt to get into it the following day. The NP could not send the order to the pharmacy at that time. LPN-A consulted with RN-C who told LPN-A to "borrow" the medication from R5. LPN-A was aware this was a bad practice in nursing, but was following the direction of RN-C.</p> <p>During an interview on 6/11/25 at 12:43 p.m., LPN-B stated when she would run out of a medication for a resident, she would first call the provider. LPN-B</p> | F0755 | | |

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| F0755 SS = E | <p>Continued from page 29</p> <p>stated she has received direction from RN-C and DON-A to "borrow" medications from residents to give to other residents if they run out of medications. LPN-B stated, "this happens a lot." LPN-B stated the last time she "borrowed" a medication was "last week" when R9 ran out of his pregabalin and R8 was discharging the next day, so DON-A had told her to "borrow" the medication from R8 to give to R9. LPN-B stated the facility did not get the medication back to R8 because R8 had discharged that next day.</p> <p>During an interview on 6/11/25 at 12:49 p.m., LPN-C stated she has never "borrowed" a medication from one resident to give to another resident.</p> <p>During an interview on 6/11/25 at 1:07 p.m., RN-D stated if she ran out of a medication, she would call an on-call provider and the on-call nurse for direction. RN-D stated she had not been told to "borrow" medications from a resident to give to another resident is they ran out of that medication.</p> <p>During an interview on 6/11/25 at 1:36 p.m., guardian (G)-A stated the nurses had not asked if they could "borrow" any of R5's medications to give to other residents. G-A stated she is unsure whether R5 has gone without any medications or ran out of his medications.</p> <p>During an interview on 6/11/25 at 1:38 p.m., FM-B stated the nurses had not asked if they could "borrow" any of R6's medications to give to other residents. FM-B was unsure whether R6 had missed any medication doses.</p> <p>During an interview on 6/11/25 at 1:53 p.m., executive director (ED)-A stated DON-A gave nurses the direction to "borrow" medications from residents to give to other residents. ED-A stated "borrowing" medications from a resident to give to another resident has been a long-standing practice in the facility. DON-A had educated nurses on how to "properly borrow medications."</p> <p>During an interview on 6/11/25 at 2:08 p.m., RN-C stated DON-A educated the nurses on how to "properly borrow medications" from residents to give to other residents. The education was in an all-nurses meeting in April 2025. The education was for nurses to take a</p> | F0755 | | |

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| F0755 SS = E | <p>Continued from page 30</p> <p>dose from the bottom of a resident's medication card and dating and writing the initials of the resident who was given that dose of medication. RN-C stated DON-A did not want nurses taking a dose from the top of the medication because she did not want it to look like a medication error to other staff and the state agency. RN-C was unsure how the facility got the medications from the pharmacy to ensure the resident whose medications were "borrowed" was not short. LPN-A stated this practice has been going on for "so long." "Borrowing" medications from residents had become a common practice within the facility that nurses stopped asking DON-A or herself when there was not a medication in the facility. On 6/2/25, RN-C was informed by DON-A that DON-A had given direction to LPN-A to "borrow" R8's pregabalin dose to R9 since "R8 was discharging" soon. On 6/6/25, RN-C received a call from LPN-A that R3 was anxious. LPN-A had already called the provider who could not write the prescription yet and the pharmacy to get a status on the delivery. The pharmacy told LPN-A that the clozapine medication card would not be delivered in time for her next dose. LPN-A gave direction to LPN-A to "borrow" the clozapine from R5. RN-C relayed the message to DON-A that she gave the direction to LPN-A to "borrow" the clozapine from R5 to give to R3 and DON-A stated she would call the pharmacy on 6/7/25 stating she dropped the cup of the five tablets on the floor and ask if the pharmacy could replace those medications.</p> <p>During an interview on 6/11/25 at 5:44 p.m., RN-D stated if a resident is missing a medication, they would look in the backstock medication cart. If the medication is not in the backstock medication cart, he would "consider" looking in the emergency medication kit. RN-D stated RN-C and DON-A had told him to "borrow" medications from one resident to give to another resident before, but was unsure of the date, resident's name, or situation. RN-D stated he had been educated within the last six months about how to "properly borrow medications from other residents."</p> <p>During an interview on 6/12/25 at 9:21 a.m., physician assistant (PA)-A stated he was unaware the facility has been "borrowing" medications from one resident to give to another resident. PA-A stated the facility recently hired his company to provide medical care and he had only been in the facility two times. PA-A stated he would expect all residents' medications to be given to that resident only, and not "shared."</p> | F0755 | | |

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| F0755 SS = E | Continued from page 31 During an interview on 6/12/25 at 10:44 a.m., RN-A stated she has "borrowed" medications from residents to give to other residents "several times" but could not recall the medication name or the residents involved. Once a provider writes a new order, the provider can give the medication order to any of the nurses and that nurse is responsible for faxing the order to the pharmacy. After the order is faxed to the pharmacy, the nurse will write a progress note in the resident's chart about the medication change. Once the order is faxed, and if it were a hard copy order, the nurse would place that in the resident's chart. Once the pharmacy received the order, the pharmacy will process and deliver the order. The cut off time for same day delivery is 6:00 p.m. Monday through Saturday. If a medication is needed on a Sunday, the nurse would call the pharmacy and then the pharmacy will have the medication delivered from a backup pharmacy. If it is after 6:00 p.m. the medication would be delivered the next day. The pharmacy is open twenty-four hours a day. If a nurse needs a stat delivery on a medication, the nurse would check the emergency medication kit to see if the medication is in there, if not, the nurse would call the pharmacy requesting a stat delivery. If a medication cannot be delivered the same day and it needed to be started immediately, RN-A would check the emergency medication kit. If the medication is not in the emergency medication kit, the nurse would call the provider to ask if the medication can wait until the next day or if the provider wants to make a medication change. If a nurse has to use the emergency medication kit, and the medication is not a narcotic, the nurse would open the emergency medication kit, take the medication needed, and then fill out a form with the resident's name, the medication name, and how many tablets of the medication was taken, and then fax that form to pharmacy so they can replace the medication. If it is a narcotic, the nurse would call the pharmacy to get a code to open the narcotic emergency medication kit and then fill out a form with the resident's name, the medication name, and how many tablets of the medication was taken, and then fax the form to pharmacy so they can replace the medication. Nurse should only take from the emergency medication kit one dose at a time for a resident. Once a medication is delivered, a nurse will receive the medication and then compare the delivery receipt to the medications that were delivered. Once that is completed, the nurse would put the medication cards in the medication cart or the backstock medication cart. During administration if the nurse notices the medication is not in the medication cart and needs to be administered, the nurse would call the on-call RN, RN-C, or DON-A and they would give the nurse direction. RN-A stated "every time" she has | F0755 | | |

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| F0755 SS = E | <p>Continued from page 32 called the on-call RN, RN-C, or DON-A, they would give direction to "borrow" medications from another resident to give to that resident. Once the medication cards come in for that other resident, they would take however many doses out of the medication card to put back in the resident's medication card the nurse took from by placing the medication in the card and taping it shut. RN-A stated she does now know how the medications are replaced so that the medications are not short "all of the time." RN-A stated she "thought" the RN-C or DON-A calls the pharmacy to say they dropped the medications that they took from the resident so that pharmacy would replace how many doses were "borrowed."</p> <p>During an interview on 6/12/25 at 1:06 p.m., pharmacist (PH)-A stated she would receive orders from the facility either in the EMR or via fax. PH-A stated the facility has a daily medication delivery in the evening. PH-A stated the facility has an emergency medication kit that she expects the facility to use if they are out of a resident's medication or it is a new stat order for a medication. The facility's emergency medication kit includes narcotic and non-narcotic medications. PH-A stated she has not received a phone call from the facility stating they had dropped medications and needed replacement but says there are other pharmacists at the pharmacy that also take phone calls. PH-A stated "borrowing" medications to give to other residents is not a standard of practice that the pharmacy would have.</p> <p>During an interview on 6/12/25 at 2:24 p.m., DON-B stated "borrowing" of medications is not a standard of practice that the facility would follow as this is misappropriation of medications. It is expected of nursing staff when a resident is out of a medication, to check the emergency medication kit. If the medication is not in the emergency medication kit, the nurse should call the pharmacy and "troubleshoot" with the pharmacy.</p> <p>During an interview on 6/12/25 at 2:40 p.m. human resources (HR)-A stated he knew DON-A had been placed on administrative leave pending the investigation.</p> <p>During an interview on 6/16/25 at 11:07 a.m., RN-D stated once the provider writes a new order for a resident, the provider will give those orders to the nurse on the floor. The nurse on the floor is</p> | F0755 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245270 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 06/16/2025 |
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| NAME OF PROVIDER OR SUPPLIER WHITEWATER HEALTH SERVICES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 525 BLUFF AVENUE , ST CHARLES, Minnesota, 55972 | |
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| F0755 SS = E | <p>Continued from page 33 responsible for putting those orders in the resident's charts. When a resident is low on a medication, the nurse will order the medication when the resident has eight doses on a medication left. RN-D stated the pharmacy will deliver medications once a day, every day. If a medication is not in the facility when it is time for medication administration, RN-D would check the backstock medication cart. If the medication is not in the backstock medication cart, then RN-D would check the emergency medication kit. If the medication is not in the emergency medication kit, he will call the on-call nurse, RN-C or DON-A. RN-D stated DON-A has hold him previously to "borrow" medications from residents to give to other residents. RN-D could not recall what date, medications, resident names, or situation when he "borrowed" these medications.</p> <p>During an interview on 6/16/25 at 1:12 p.m., DON-C stated it is expected that when a nurse runs out of medications, the nurse would call the pharmacy and provider to ask for alternatives to the medication that the nurse may have in the emergency medication kit, the time the medication can be delivered, and if the medication is not going to be delivered, to make a medication error report. DON-C stated the "borrowing" of medications is considered misappropriation of medications.</p> <p>During an interview on 6/16/25 at 1:40 p.m., HR-A stated he found out on 6/9/25 that nurses were "borrowing" medications from residents to give to other residents if they ran out of the medications. HR-A stated there has not been any corrective action plans for any of the nurses involved other than placing DON-A on an administrative leave. HR-A stated DON-A has been terminated from the facility following the investigation.</p> <p>During an interview on 6/16/25 at 2:03 p.m. HR-B stated DON-A was placed on administrative leave pending the investigation. After the investigation was completed, DON-A was terminated from the facility. RN-C placed her resignation effective immediately on 6/8/25.</p> <p>Surveyor attempted to contact DON-A on 6/11/25 at 1:32 p.m., 6/12/25 at 9:28 a.m., and 6/16/25 at 9:35 a.m. with no success.</p> <p>Ordering and Receiving Non-Controlled Medications</p> | F0755 | | |

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| F0755 SS = E | <p>Continued from page 34</p> <p>policy dated 1/2025 indicated the facility would reorder medications in advance by writing the medication name and prescription number or applying the peel-off bar-coded label from the prescription label on the reorder sheet and faxing or otherwise transmitting the order to the pharmacy. All medication order changes would be communicated to the pharmacy, timely, to provide the correct quantities and accurate labeling when doses or administration frequencies are modified. If a medication is new, the facility would fax the order in and then inform the pharmacy of the need for prompt delivery. If a medication is a stat order, and if the medication is available in the emergency medication kit, the facility would remove the medication dose needed for administration prior to the next pharmacy delivery. If a medication is not in the emergency medication kit, a stat order is placed to the pharmacy and then the pharmacy is called by the facility requesting a stat delivery.</p> <p>The facility policy titled Medication Administration General Guidelines Section 7.1 dated 01/25 indicated medications supplied for one resident are never administered to another resident.</p> <p>The facility policy titled Medication Ordering and Receiving Form Pharmacy Provider and Ordering and Receiving Non-Controlled Medications Section 3.2 dated 01/25 indicated medications and related products are received from the provider pharmacy on a timely basis and the nursing care center maintain accurate records or medications ordered.</p> <p>The facility contracted pharmacy agreement effective 5/1/23 indicated the facility secured services that included up to eight (8) hours of nurse consulting services representative pharmacy visits quarterly, additional service charges apply. Nurse consulting services are only performed upon facility request. Available services include medication cart audits, documentation review to validate physician orders, medication administration record review, audits to assure accuracy among and between resident charts, treatment cart review, medication room audits and inspection, observation of medication passes, narcotic review, pre-survey audits, root cause analysis to determine process gaps with written solutions, and education training sessions for facility staff.</p> | F0755 | | |

Minnesota State Department of Health

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| 20000 | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 6/11/25-6/16/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure.</p> <p>The following complaints were reviewed: H52706887C (MN00113754), H52707007C (MN00113777 and MN00113732).</p> | 20000 | | |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| 20000 | Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 20000 | | |