STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitewater Health Services	525 Bluff Avenue St Charles, MN 55972

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on interview and record review, the facility failed to identify, comprehensively assess, implement interventions, and provide timely physician notification for a sudden change in condition for 1 of 3 residents (R1) reviewed for change in condition. This resulted in an immediate jeopardy (IJ) when R1 became unresponsive causing a delay in hospitalization . Immediate Jeopardy (IJ) began on [DATE] when the facility did not complete comprehensive assessments and communicate sudden change of condition to the physician when R1 became unresponsive and remained unresponsive for at least seven (7) hours before the ambulance arrived. The administrator and director of nursing (DON) were notified of the IJ on [DATE] at 4:58 p.m. The immediacy of the IJ was removed on [DATE] at 12:43 p.m. but noncompliance remained at the lower scope and severity level 2 (D), which indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include: R1's hospital after visit summary (AVS) [DATE], identified R1 had been hospitalized for a brain bleed, which caused right sided weakness and altered mentation. Mental status improved throughout hospitalization and R1 was discharged to facility. R1's face sheet identified R1 was admitted to the facility with nontraumatic intracerebral hemorrhage (brain bleed), mixed receptive-expressive language disorder, hemiplegia and hemiparesis affecting right dominant side, weakness, dysphagia-(swallowing disorder), compression of brain, encephalopathy-(brain dysfunction that causes altered mental state), and cerebral amyloid angiopathy-(myloid protein builds up in the blood vessels in the brain causing bleeding inside the brain). R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment and displayed symptoms of delirium that included inattention and disorganized thinking. R1 had adequate hearing and vision, and had clear speech. R1 required substantial assistance with activities of daily living and was frequently incontinent of bowel and bladder. R1's care plan dated [DATE], identified a focus of cognitive loss and delay in responding related to: effects of intracerebral hemorrhage. Interventions included to allow adequate time to respond. Do not rush or supply words. Provide cueing and prompting for such things as activities, personal care. Repeat communication using more that one method (words, gestures, facial expressions). (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's recorded vital signs sheet identified on [DATE], at 3:00 a.m. blood pressure ,d+[DATE] (BP normal , d+[DATE]), pulse 117 (P normal ,d+[DATE]), Temperature 100.7 (T normal ,d+[DATE] F), respirations 20 (R normal ,d+[DATE]), oxygen saturations 92% (O2 normal ,d+[DATE]%). There was no progress note or assessment that identified R1's condition or rational why vital signs were taken at 3:00 a.m. R1's recorded vital signs on [DATE] at 9:48 a.m., included: BP ,d+[DATE], P 100, T 101.6, Res 20, and 02 93%. R1's progress note on [DATE] at 10:16 a.m. identified, resident unresponsive this morning. Lung sounds clear. No cough. COVID test negative. Fever of 101.6., B/P ,d+[DATE], HR 100, R20 93% on room air. Cool rags applied. Notified MD [medical doctor] and RN [registered nurse] on call. At 10:25 a.m. the progress note identified the physician had responded with orders to collect a UA/UC. R1's medication administration record (MAR) identified LPN-A administered 650 milligrams Tylenol suppository at 10:17 a.m. and then at 10:18 a. m. documented the Tylenol was effective. On [DATE] at 12:48 p.m., R1's recorded vital signs included BP ,d+[DATE], P 117, T 98, Res 20, 02 95%. R1's progress note at 1:05 p.m. included, R1 had a fever, some difficulty breathing, and does not wake up or respond to stimuli. At 1:30 p.m. R1 had left via ambulance. R1's ambulance run report dated [DATE], identified Emergency Medical Services (EMS) crew arrived at 1:30 p.m. on scene and R1 was alone in room, no family or staff present. Initial assessment identified a Glasgow Coma Scale (GCS) of 3 (tool that measures a persons level of consciousness after a brain injury) the lowest possible score indicating deep coma or death. Sternal rub attempted with no response from R1. Rapid carotid pulse, skin diaphoretic (sweaty), warm to the touch, and pale. EMS applied cold packs bilaterally to neck, and axillary areas. Facility staff reported to EMS R1 had been in this condition since last night sometime. EMS requested intercept from secondary EMS crew due to R1's medical needs. R1's secondary EMS run on [DATE], identified EMS crew member from secondary EMS joined EMS crew from first ambulance at 1:41 p.m. and remained until arrived at the hospital at 2:05 p.m. EMS report R1 was unresponsive but breathing spontaneously with a steady pulse, GCS remained 3. During an interview on [DATE] at 1:16 p.m., nursing assistant (NA)-A and NA-B stated they were both familiar with R1. NA-A stated R1's normal routine was to get up in recliner during the morning and look outside. R1 was not usually difficult to arouse if she was sleeping. When NA's would reposition R1, she would wake up and talk to us. NA-A and NA-B both stated on [DATE] during the day shift, R1 went out of the facility for appointments and had been talking and drinking thickened liquids. Neither NA noticed any change in R1 since she was admitted to the facility. NA-A and NA-B both stated NA-C gave report to them on [DATE] at 6:00 a.m. and reported R1 had been unresponsive and limp. NA-A and NA-B went to R1's room at 6:30 a. m., performed morning cares, noted R1 was warm to touch. NA-B stated they reported R1's condition to LPN-A around 6:45 a.m. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] at 2:39 p.m., NA-C stated between 12:00 a.m.-1:30 a.m. on [DATE], R1 did not respond to her except in moans and she seemed very sleepy. NA-C just thought R1 was tired because she had out of the facility on [DATE] for quite awhile. NA-C explained when she went back to check on R1 between 2:30 to 3:30 a.m. she noticed R1 was very lethargic, warm, flushed, and weak. NA-C was concerned because that was not normal, so she reported the information to licensed practical nurse (LPN)-B. When she did shift report on [DATE] at 6:00 a.m., she explained all of R1's changes (very lethargic, warm, flushed, and weak) to NA-A and NA-B who were assigned to care for R1 for day shift. During a phone interview on [DATE] at 2:18 p.m., LPN-B stated between 2:,d+[DATE]:00 a.m. on [DATE], NA-C reported to her R1 was not answering her and would not wake up. LPN-B went to R1's room and took her vital signs which were within R1's normal limits. Although LPN-B stated when she collected R1's vital signs, R1 was not as responsive as she would have liked to have seen her, R1 was at her baseline and there was nothing unusual or different. LPN-B further explained she did not find R1's lack of responsiveness unusual because R1 would not always wake up for her during the night with light shoulder rubs or a quieter voice. LPN-B indicated she had not completed a neurological assessment and did not provide intervention to lower R1's temperature. During an interview on [DATE] at 2:56 p.m., LPN-A stated at the shift report on [DATE], at 6:00 a.m. LPN-B did not say anything unusual happened with R1 during the night. LPN-A stated NA-A and NA-B had come to her after they were done washing R1 up reporting they thought R1 had a fever just before 7:00 a.m However, LPN-A had started R1's tube feeding at 7:00 a.m. and did not notice a difference in R1 as the NA's reported. LPN-B did not take R1's vital signs despite NA's reporting of a fever nor complete a neurological assessment. During an interview on [DATE] at 1:16 p.m., NA-A and NA-B, NA-A stated after the 6:45 a.m. check they returned to R1's room sometime after 9:00 a.m. R1 was still unresponsive, limp, and warm to the touch during cares. NA's indicated they reported their concerns to LPN-A. During an interview on [DATE] at 2:56 p.m., LPN-A stated NA-A and NA-B reported they thought R1 had a fever around 9:00 a.m. or 10:00 a.m. LPN-A stated she then went to R1's room and took R1's vital signs; R1's temperature was 101.6. R1 was unresponsive. She would not wake up, I did a sternal rub and no response from that. I just figured she was kind of sleeping because of the fever. LPN-A performed a Covid test with negative results. LPN-B notified DON and medical doctor (MD)-A. LPN-A had reported to the DON and MD-A R1 had a fever and was really sleepy. LPN-A stated MD-A ordered a urine analysis/urine culture (UA/UC-test to determine presence of urinary tract infection/type of bacteria that is found in the urine) to be collected. LPN-A stated she did not tell the DON and MD-A she was not able to arouse R1 with a sternal rub. During the interview on [DATE] at 2:56 p.m., LPN-A stated R1 did not move, flinch, groan, or moan when she cathed R1 to collect urine for the UA/UC on [DATE]. LPN-A stated R1 just seemed to be sleeping really hard and had a fever. LPN-A did not perform a neurological assessment. During an interview on [DATE] at 1:16 p.m., NA-A and NA-B stated the next time they returned to R1's room sometime after lunch (12:,d+[DATE]:00 p.m) and changed R1's sheets because they were wet with perspiration. NA-A and NA-B noted R1 had sounded gurgly and was breathing heavily, remained unresponsive, and limp. NA's stated that is when LPN-A had called the ambulance. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] at 11:18 a.m., emergency medical system personal (EMS)-A indicated on [DATE], an ambulance was dispatched to the facility for a resident who was unresponsive. When they arrived onsite at approximately 1:30 p.m. R1 was unresponsive. Facility staff reported R1 had been in that state since the night before. R1's temperature was 100.2 when she was loaded her into the ambulance and never regained consciousness. During a phone interview on [DATE] at 12:16 p.m., MD-A stated LPN-A contacted her by message on [DATE]; the message said R1 was not as responsive and had a temperature of 102.9. Based on the information LPN-A gave to her she gave the order to get a UA/UC. MD-A stated it was not unusual for someone with a recent stroke to be a little more unarousable if they were to get an infection. However, at the time of the report from LPN-A, she was not aware LPN-A was not able to arouse R1 with a sternal rub. MD-A stated I would have sent her in [to the ED] then if I had known that. During an interview on [DATE] at 2:56 p.m., LPN-A explained around 12:30 p.m. she went into check on R1. R1's breathing became irregular; it was rapid, then calm, then rapid. LPN indicated she had described R1's condition to DON and MD as sleepiness because she was not sure R1's consciousness level had changed until right before we sent her to the hospital. R1's hospital records printed [DATE], identified a new large intraparenchymal hemorrhage (type of brain bleed) centered on the right parietal lobe as well as extension into the posterior right frontal and temporal lobes with extensive vasogenic edema (a type of brain swelling). Additionally, a second smaller intraparenchymal hemorrhage involving the inferior left occipital lobe with the associated vasogenic edema was found. R1 was intubated and mechanical ventilation began until family could arrive at bedside. R1 expired on [DATE] at 10:39 p.m. from nontraumatic Intracranial Hemorrhage. During an interview on [DATE] at 1:22 p.m., DON stated LPN-A called and said R1 had a fever and was not responding normally. DON verified LPN-A did not notify her that R1 was unresponsive to a sternal rub. DON indicated the physician should have been notified earlier when R1 was not responsive. Had she had more details she would have directed LPN to complete a neurological assessment. DON would expect staff to communicate efficiently so the physician could order the right treatments. DON expected complete assessments and evaluations as RN's or assist LPN's with what they are able to complete according to their scope. The facility Change in Condition of the Resident policy revised [DATE], identified the facility should immediately inform the resident; consult with the resident's physician; and notify the resident representative(s) when there is . a significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications. When a resident presents with a change in condition: 2. assess/evaluate the resident. This assessment/evaluation could include but is not limited to: a. VS. oxygen saturations, blood glucose level f. alteration in level of consciousness, ability to respond 6. Ensure change in condition is included on the 24-hour report to be reviewed later by interdisciplinary team. (continued on next page)

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