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	06/16/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the 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. Findings include: 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. R2's face sheet dated 6/12/25 indicated R2 was admitted to the facility on [DATE] 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. 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. R2's provider order dated 12/31/24, indicated R2 was prescribed levothyroxine sodium 25 micrograms (mcg) one time a day related to hypothyroidism. 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. 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. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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	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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's provider order dated 5/30/25 indicated R2's potassium chloride ER 20 mEq would be discontinued. R4's face sheet dated 6/12/25 indicated R4 was admitted to the facility on [DATE] 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. R4's provider order dated 2/28/25 indicated R4 was prescribed potassium chloride 20 mEq taking two tablets one time a day. 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. R5's face sheet dated 6/12/25 indicated R5 was admitted to the facility on [DATE] 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. 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. 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. 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. R5's clozapine 100 mg medication card dated 6/5/25 indicated pharmacy filled five tablets. R6's face sheet dated 6/12/25 indicated R6 was admitted to the facility on [DATE] 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. 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. 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. 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. (continued on next page)

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	06/16/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R8's face sheet dated 6/12/25 indicated R8 was admitted to the facility on [DATE] 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. R8's provider order dated 5/2/25 indicated R8 was prescribed pregabalin ten mL (200 mg total) by mouth twice a day. R3's face sheet dated 6/12/25 indicated R3 was admitted to the facility on [DATE] with a primary diagnosis of other fracture of lower end of right ulna. R3's additional diagnoses included paranoid schizophrenia and anxiety disorder. R3's provider order dated 6/1/25 indicated R3 prescribed clozapine 100 mg five tablets orally at bedtime for paranoid schizophrenia. 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. R7's face sheet dated 6/12/25 indicated R7 was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R7's additional diagnoses included hyperparathyroidism and hyperlipidemia. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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	06/16/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 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. 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. 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. 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. 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.

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	06/16/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings include: 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. R2's face sheet dated 6/12/25 indicated R2 was admitted to the facility on [DATE] 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. 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. R2's provider order dated 12/31/24, indicated R2 was prescribed levothyroxine sodium 25 micrograms (mcg) one time a day related to hypothyroidism. 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. 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. R2's provider order dated 5/30/25 indicated R2's potassium chloride ER 20 mEq would be discontinued. R4's face sheet dated 6/12/25 indicated R4 was admitted to the facility on [DATE] 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. (continued on next page)

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	06/16/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's provider order dated 2/28/25 indicated R4 was prescribed potassium chloride 20 mEq taking two tablets one time a day. 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. R5's face sheet dated 6/12/25 indicated R5 was admitted to the facility on [DATE] 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. 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. 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. 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. R5's clozapine 100 mg medication card dated 6/5/25 indicated pharmacy filled five tablets. R6's face sheet dated 6/12/25 indicated R6 was admitted to the facility on [DATE] 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. 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. 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. 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. R8's face sheet dated 6/12/25 indicated R8 was admitted to the facility on [DATE] 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. R8's provider order dated 5/2/25 indicated R8 was prescribed pregabalin ten mL (200 mg total) by mouth twice a day. (continued on next page)

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	06/16/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's face sheet dated 6/12/25 indicated R3 was admitted to the facility on [DATE] with a primary diagnosis of other fracture of lower end of right ulna. R3's additional diagnoses included paranoid schizophrenia and anxiety disorder. R3's provider order dated 6/1/25 indicated R3 prescribed clozapine 100 mg five tablets orally at bedtime for paranoid schizophrenia. 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. R7's face sheet dated 6/12/25 indicated R7 was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R7's additional diagnoses included hyperparathyroidism and hyperlipidemia. 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. 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. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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	06/16/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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	06/16/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 dod not result in serious bodily injury.

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	06/16/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings include: 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. R2's face sheet dated 6/12/25 indicated R2 was admitted to the facility on [DATE] 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. 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. R2's provider order dated 12/31/24, indicated R2 was prescribed levothyroxine sodium 25 micrograms (mcg) one time a day related to hypothyroidism. 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. 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. R2's provider order dated 5/30/25 indicated R2's potassium chloride ER 20 mEq would be discontinued. R4's face sheet dated 6/12/25 indicated R4 was admitted to the facility on [DATE] 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. R4's provider order dated 2/28/25 indicated R4 was prescribed potassium chloride 20 mEq taking two tablets one time a day. (continued on next page)

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	06/16/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. R5's face sheet dated 6/12/25 indicated R5 was admitted to the facility on [DATE] 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. 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. 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. 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. R5's clozapine 100 mg medication card dated 6/5/25 indicated pharmacy filled five tablets. R6's face sheet dated 6/12/25 indicated R6 was admitted to the facility on [DATE] 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. 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. 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. 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. R8's face sheet dated 6/12/25 indicated R8 was admitted to the facility on [DATE] 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. R8's provider order dated 5/2/25 indicated R8 was prescribed pregabalin ten mL (200 mg total) by mouth twice a day. (continued on next page)

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	06/16/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's face sheet dated 6/12/25 indicated R3 was admitted to the facility on [DATE] with a primary diagnosis of other fracture of lower end of right ulna. R3's additional diagnoses included paranoid schizophrenia and anxiety disorder. R3's provider order dated 6/1/25 indicated R3 prescribed clozapine 100 mg five tablets orally at bedtime for paranoid schizophrenia. 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. R7's face sheet dated 6/12/25 indicated R7 was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R7's additional diagnoses included hyperparathyroidism and hyperlipidemia. 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. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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	06/16/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 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 thought HR-A had completed the investigation. 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. 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. 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. 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.

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	06/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings include: 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. 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. R2's face sheet dated 6/12/25, indicated R2 was admitted to the facility on [DATE] 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. R2's brief interview for mental status (BIMS) dated 5/8/25, indicated a score of 14, which indicated R2 was cognitively intact. 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. R2's provider order dated 12/31/24, indicated R2 was prescribed levothyroxine sodium 25 mcg, one time a day related to hypothyroidism. 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. 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. (continued on next page)

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	06/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's progress note dated 5/30/25, indicated R2's potassium chloride, ER 20 mEq would be discontinued. R2's provider order dated 5/30/25, indicated R2's potassium chloride ER 20 mEq, would be discontinued. R4's face sheet dated 6/12/25, indicated R4 was admitted to the facility on [DATE] 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. R4's BIMS dated 5/22/25, indicated a score of 15, which indicated R4 was cognitively intact. R4's provider order dated 2/28/25, indicated R4 was prescribed potassium chloride, 20 mEq, take two tablets one time a day. 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. R5's face sheet dated 6/12/25, indicated R5 was admitted to the facility on [DATE] 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. R5's BIMS dated 3/17/25, indicated a score of three, which indicated R5 had severe cognitive impairment. 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. 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 was taken or for which resident. 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. R5's clozapine 100 mg medication card dated 6/5/25 indicated pharmacy filled five tablets. 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. R6's face sheet dated 6/12/25 indicated R6 was admitted to the facility on [DATE] 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. (continued on next page)

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	06/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. R6's BIMS dated 5/6/25, indicated a score of zero, which indicated R6 had severe cognitive impairment. 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. 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. R6's pharmacy receipts indicated since 1/2025 the 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. 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. R8's face sheet dated 6/12/25, indicated R8 was admitted to the facility on [DATE] 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. R8's provider order dated 5/2/25, indicated R8 was prescribed pregabalin ten mL (200 mg total) by mouth twice a day. R8's medication card was no longer in the facility as she had been discharged . R3's face sheet dated 6/12/25 indicated R3 was admitted to the facility on [DATE], with a primary diagnosis of other fracture of lower end of right ulna. R3's additional diagnoses included paranoid schizophrenia and anxiety disorder. R3's provider order dated 6/1/25, indicated R3 was prescribed clozapine, 100 mg, five tablets orally at bedtime for paranoid schizophrenia. R3's BIMS dated 6/5/25 indicated a score of 13, which indicated R3 was cognitively intact. (continued on next page)

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	06/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. R3's pharmacy receipts indicated since 1/2025 the pharmacy delivered 25 tablets of clozapine on 6/6/25. R7's face sheet dated 6/12/25 indicated R7 was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R7's additional diagnoses included hyperparathyroidism and hyperlipidemia. R7's BIMS dated 4/24/25 indicated a score of zero, which indicated R7 had severe cognitive impairment. 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. 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. 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. 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. R9's face sheet dated 6/12/25 indicated R9 was admitted to the facility on [DATE] with a primary diagnosis of 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. 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. R9's BIMS dated 6/6/25 indicated a score of eight, which indicated R9 had moderate cognitive impairment. 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. (continued on next page)

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	06/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 fax the order to the pharmacy. 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. 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. 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. 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. 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. (continued on next page)

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	06/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. 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. 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. 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. 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. 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. 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 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. (continued on next page)

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	06/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (continued on next page)

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	06/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. 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. (continued on next page)

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	06/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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 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. 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. 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. 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. 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. (continued on next page)

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	06/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ordering and Receiving Non-Controlled Medications 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. 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. 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. 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.