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	04/16/2026

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview and document review, the facility failed to develop a baseline care plan to ensure enhanced barrier precaution (EBP) needs were identified and addressed for 2 of 3 residents (R1 and R2) reviewed for indwelling catheters.Findings include:R1R1's admission record dated 3/31/26, indicated R1 had benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms. R1's order summary report dated 3/31/26, indicated R1 had an indwelling urinary catheter.R1's care plan dated 4/14/26, indicated R1 had an indwelling foley catheter. R1's care plan failed to include R1's need for EBPs as well as interventions related to this need.R1's medical record lacked evidence to ensure staff were knowledgeable in R1's need for EBPs. During an observation on 4/15/26 at 10:12 a.m., R1 was observed sleeping in his recliner. The door to the room was open and R1's foley catheter leg bag was visible attached to R1's leg. R1 did not have any signage or supplies for EBPs at his room door.R2R2's admission record dated 3/27/26, indicated R2 had benign prostatic hyperplasia with lower urinary tract symptoms.R2's order summary report dated 3/27/26, indicated R2 had an indwelling urinary catheter.R2's care plan dated 3/29/26, indicated R2 had an indwelling foley catheter. R2's care plan failed to include R1's need for EBPs as well as interventions related to this need.R2's medical record lacked evidence to ensure staff were knowledgeable in R2's need for EBPs.During an observation on 4/15/26 at 12:04 p.m., R2 was observed in his room in his wheelchair and R2's foley catheter bag was visibly attached under R2's wheelchair. R2 did not have signage or supplies for EBPs at his room door.During an observation on 4/15/26 at 1:24 p.m., the director of nursing (DON) was placing EBP signs on R1 and R2's doors and supplies next to the doors.During an interview on 4/15/26 at 1:25 p.m., DON stated both R1 and R2 should have been on EBPs since admission to the facility due to them having indwelling catheters. The DON was responsible for making sure the care plans reflected the need for EBPs. DON stated she was not sure why the signage was not in place and stated she forgot to put EBPs on R1 and R2's care plans.The facility policy titled Baseline Care Plan revised 9/22/22, indicated the facility would develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care for the resident that would meet professional standards of quality of care within 48 hours of admission.

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

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 04/16/2026

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the required nurse staffing information was posted daily. This had the potential to affect all 33 residents residing in the facility and/or visitors who may wish to see the information.Findings include:During an observation on 4/15/26 at 9:59 a.m., the facility nurse staffing information was not observed on the administrator's office door.During an observation on 4/15/26 at 10:16 a.m., the primary areas, hallways, and entrance of the facility was observed, and no facility nurse staffing information was observed.On 4/15/26 at 11:23 a.m., the administrator stated she was responsible for posting nurse staffing information and it would have been located on her office door, but it was not because she had not printed or posted it. It was expected that the nurse staffing information is posted seven days a week.The facility policy titled Nurse Staffing Postage Information revised 10/13/22, indicated staffing information would be readily available in a readable format to residents and visitors at any given time and would be posted on a daily basis.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and document review, the facility failed to ensure staff consistently implemented enhanced barrier precautions (EBP) in accordance with Centers for Disease Control (CDC) guidelines to reduce the risk of infection spread for 1 of 3 residents (R1) reviewed for an indwelling catheter.Findings include:R1's admission record dated 3/31/26, indicated R1 had benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms.R1's order summary report dated 3/31/26, indicated R1 had an indwelling urinary catheter.R1's care plan dated 4/14/26, indicated R1 had an indwelling foley catheter. R1's medical record lacked evidence to ensure staff were knowledgeable in R1's need for EBPs.During an observation on 4/15/26 at 10:12 a.m., R1 was observed sleeping in his recliner. The door to the room was open and R1's foley catheter leg bag was visible attached to R1's leg. R1 did not have any signage or supplies for EBPs at his door.During an observation on 4/15/26 at 11:40 a.m., physical therapist (PT)-A was in R1's bathroom assisting him out of the bathroom with a gait belt. PT-A assisted R1 to his wheelchair and instructed him to sit as she held his gait belt. PT-A did not have the appropriate personal protective equipment (PPE) on, required when close contact care was provided for a resident who required EBPs.During an interview on 4/15/26 at 1:58 p.m., PT-A stated she would have known if someone was on EBPs by the signage on the door. PT-A did not use PPE when assisting R1 in the bathroom and with transfers because there was no signage on his door stating he was on EBPs.During an interview on 4/15/26 at 10:14 a.m., the director of nursing (DON) stated staff are expected to gown and glove when transferring and assisting someone who is on EBPs to the bathroom.The facility policy titled Enhanced Barrier Precautions revised 8/8/24, indicated EBPs would be initiated for residents who had urinary catheters. Use of personal protective equipment for EBPs would be necessary if staff preformed high-contact care activities including transfers, assisting with toileting, and personal hygiene.