

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 05/14/2025
NAME OF PROVIDER OR SUPPLIER Whitewater Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379</p> <p>Based on observation, interview and record review, the facility failed to ensure a self-administration of medication (SAM) assessment was completed for 1 of 1 resident's (R16) reviewed for medication administration.</p> <p>Findings include:</p> <p>R16's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R16 was cognitively intact.</p> <p>R16's provider orders, included an order for Nystatin antifungal powder to both breasts and groin folds every 12 hours as needed .</p> <p>During observation on 5/14/25 at 7:17 a.m., registered nurse (RN)-A dispensed antifungal powder in a medication cup, walked to R16's room, and handed the medication cup to the director of nursing (DON) who was already in the room. The DON then placed the cup of powder on R16's bedside table and left the room. The DON stated R16 was getting ready for the day and would apply the powder herself when she is ready.</p> <p>During interview on 5/14/25 at 10:55 a.m., RN-A stated she did not think any current residents had a SAM assessment. RN-A stated a SAM assessment is needed to determine if a resident is safe to administer prescribed medications. Once a resident is deemed safe, a provider order is required for medications to be left at bedside. RN-A stated the SAM assessment is important to make sure the resident does not forget to take the medication. RN-A indicate all prescribed medications required a SAM assessment prior to leaving the medication at the bedside. RN-A confirmed R16 did not have a SAM assessment on file.</p> <p>During an interview on 5/14/25 at 11:20 a.m., the assistant director of nursing (ADON) stated residents who chose to have medications left at bedside would require an assessment for safety and a provider order to leave the medication at bedside. The ADON stated there are currently no residents who require a SAM assessment. The ADON stated narcotics are not allowed to be administered independently however all other medications are evaluated on a case by case basis. The ADON stated medications cannot be left with residents unless a SAM is performed to ensure residents are deemed safe to administer the medication properly. Self-administration assessments are reviewed every 3 months for safety and is documented .</p> <p>(continued on next page)</p>		

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
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility policy titled Medication Administration General-Guidelines dated 1/2023, included Residents are allowed to self-administer medications when specifically authorized by the prescriber, the nursing care center's Interdisciplinary Team (IDT), and in accordance with procedures for self-administration of medications and state regulations.</p>		

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<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379</p> <p>Based on observation, interview, and document review, the facility failed to ensure the facility's state survey results were kept in a location readily accessible to all residents and/or visitors. This had the potential to affect all 22 residents and/or visitors who could wish to review the information.</p> <p>Findings include:</p> <p>R16's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R16 had intact cognition.</p> <p>During resident council meeting on 5/12/25 at 10:50 a.m., R16 (resident council president) stated she did not know the state survey results were available to be read and confirmed she would be interested in seeing them.</p> <p>During observation and interview on 5/12/25 at 11:21 a.m., social worker (SW) said the facility had a survey binder and was unsure where the binder was located. SW walked out to main atrium and could not readily find the survey results binder.</p> <p>During observation and interview on 5/12/25 at 12:00 p.m., assistant director of nursing (ADON) and corporate vice president of success (VP) had located the survey binder stacked amongst other facility binders, out of sight of residents and others who may want to review. ADON confirmed the survey binder should be in a visible location and easily accessible .</p> <p>A policy regarding posting survey results was requested and not received.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379</p> <p>Based on interview and document review, the facility failed to complete and implement a baseline care plan within 48 hours of admission for 1 of 2 residents (R125) reviewed for new admissions.</p> <p>Findings include:</p> <p>R125's face sheet, indicated R125 admitted on [DATE]; diagnosis include, heart failure, respiratory disease, right lower leg pressure ulcer (reduce blood pressure to body area, leading to skin and tissue damage), left lower leg pressure ulcer, right hip pressure ulcer, perineum (area of sensitive skin between genitals and anus) wound, spinal vertebrae pain, lumbar pain, adult failure to thrive and a new diagnosis of urinary retention requiring a urinary catheter to drain bladder.</p> <p>R125's resident admission Minimum Data Set (MDS) assessment was not completed at time of survey. R125's cognitive function was intact.</p> <p>R125's a baseline care plan had not been initiated at time of survey; pain management treatment and goals had not been assessed.</p> <p>During interview on 5/12/25 at 10:39 a.m., R125 stated she has been in pain all morning, stated she was given Tylenol (used to help relieve pain) and some other medication this morning but the medications are not helping her with her pain. R125 stated her pain is where the urinary catheter is, she described it as a burning pain. R125 stated she is miserable here and just wants the pain to subside even for just a little bit. R125 stated no one at the facility had asked her what her pain goals were; she stated her goal would be a pain score of less than 2/10.</p> <p>During interview on 5/13/25 at 11:43 a.m., assistant director of nursing (ADON) and director of nursing (DON) stated R125 experiences pain frequently, and her pain has been high since arriving to the facility. ADON stated the initial goal was to try non-pharmacological options first. DON stated facility staff would be able to locate resident-specific needs in the resident care plan. Upon review, ADON confirmed a resident-specific care plan focus on pain had not been completed at the time of this interview.</p> <p>A facility care plan policy was requested and not received.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379</p> <p>Based on observation, interview and document review, the facility failed to identify, treat, follow up on pain and offer non-pharmacological interventions for 1 of 1 resident (R125) reviewed for pain management who was newly admitted .</p> <p>Findings include:</p> <p>R125's resident admission Minimum Data Set (MDS) assessment was not completed at time of survey. R125's had intact cognitive.</p> <p>R125 was admitted on [DATE] following a hospital stay, R125's diagnosis include, heart failure, respiratory disease, right lower leg pressure ulcer (reduce blood pressure to body area, leading to skin and tissue damage), left lower leg pressure ulcer, right hip pressure ulcer, perineum (area of sensitive skin between genitals and anus) wound, spinal vertebrae pain, lumbar pain, adult failure to thrive and a new diagnosis of urinary retention requiring a urinary catheter to drain bladder.</p> <p>R125's record lacked a baseline care plan. R125's pain management, treatment and goals was not assessed upon admission.</p> <p>R125's orders included Lyrica (Pregabalin-an anticonvulsant that can be used for nerve pain) 50 milligrams (mg) two times a day for pain, acetaminophen (a pain medication) 1000 mg every 6 hours for pain. Pain level was to be assessed each time the scheduled acetaminophen medication was administered.</p> <p>R125's May treatment administration record (TAR), included document any non-pharmacological pain interventions attempted. Interventions-ice, relaxation/distraction, repositioning, re-medicating, notify MD, diversional activities, music, re-repositioning, warm blanket, stretching, massage, rest, reduce stimuli, and other. R125's TAR included, Resident pain level every shift, use PAINAD (is a five-item observational tool to measure pain in people with dementia. It evaluates breathing, vocalization, facial expression, body language, and consolability) if resident unable to verbalize pain.</p> <p>R125's TAR lacked non-pharmacological pain interventions attempted for the following dates 5/8/25, 5/9/25, 5/10/25, and 5/11/25.</p> <p>R125's Pain Interview with Pain Management Review dated 5/12/25, indicated R125 had pain almost constantly over the past five days with an intensity rating as high as nine out of ten at times. The review of progress notes indicated staff had noticed vocal complaints of pain from R125 daily. The review indicated R125 received scheduled pain medication, but pain assessment was not completed for one of the two pain medications.</p> <p>R125's record included:</p> <p>-5/10/25 at 6:00 p.m., 1000mg acetaminophen was administered with pain rated 8/10.</p> <p>-5/10/25 at 8:00 p.m., 50mg Lyrica</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-5/10/25 at 10:29 p.m., R125 was calling out in pain, stating her pain is 8/10.</p> <p>-5/11/25 at 12:00 a.m., 1000mg acetaminophen was administered with pain rated 6/10.</p> <p>-5/11/25 at 6:00 a.m., 1000mg acetaminophen was administered with pain rated 5/10.</p> <p>-5/11/25 at 6:09 a.m., resident calling out in pain, stating to staff her pain is 8/10.</p> <p>-5/11/25 at 8:00 a.m., 50mg Lyrica</p> <p>-5/11/25 at 9:47 p.m., resident calling out in pain, stating to staff her pain is unbearable</p> <p>-5/11/25 at 12:00 p.m., 1000mg acetaminophen was administered with pain rated 5/10.</p> <p>-5/11/25 at 2:09 p.m., resident calling out in pain, stating to staff her pain is 8/10.</p> <p>-5/11/25 at 6:00 p.m., 1000mg acetaminophen was administered with pain rated 8/10.</p> <p>-05/11/25 6:32 p.m., resident stated the catheter is unbearable pain</p> <p>-5/11/25 at 8:00 p.m., 50mg Lyrica</p> <p>-5/11/25 at 11:37 p.m., resident calling out in pain</p> <p>-5/12/25 at 12:00 a.m., 1000mg acetaminophen was administered with pain rated 2/10.</p> <p>-5/12/25 at 3:27 a.m., pain is rated 2/10 (bilateral lower extremities, urinary catheter pain (noted to be draining clear yellow urine)</p> <p>-5/12/25 at 6:00 a.m., 1000mg acetaminophen was administered with pain rated 2/10.</p> <p>-5/12/25 at 8:00 a.m., 50mg Lyrica</p> <p>During observation on 5/11/25 at 6:20 p.m.,R125's call was on, nursing assistant (NA)-C entered the room and, told R125 the registered nurse (RN) would be in shortly to help her. R125 could be heard crying out in pain, stated she can't take this pain much longer, shouting out she doesn't understand why her pain isn't being treated.</p> <p>During observation on 5/12/25 at 9:25 a.m., R125 crying out, oh, oh this pain is terrible and ahh, ahh, make it stop</p> <p>During observation on 5/12/25 at 10:02 a.m., R125 called out in pain, ahh, oh , oh , someone help me owwww, help it hurts so bad</p> <p>During observation on 5/12/25 at 10:29 a.m., R125 calling out in pain ahh, this hurts so bad, oh, please help me</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 5/12/25 at 10:39 a.m., R125 stated she has been in pain all morning, stated she was given acetaminophen and some other medication this morning but the medications are not helping her with her pain. R125 stated her pain is where the urinary catheter is, she described it as a burning pain. R125 stated she is miserable here and just wants the pain to subside even for just a little bit.</p> <p>During interview on 5/13/25 at 10:22 a.m., NA-C stated she will check on each resident as often as she is able. NA-C stated she will update the nurse right away when a resident complains of pain or sounds like the resident is in pain. NA-C stated if she answers the same resident call light again and the resident had not been seen by the nurse NA-C stated she would remind the nurse. In addition, NA-C would assist the resident with anything while waiting for the nurse to give pain medications. NA-C stated she would expect pain to be treated within 10-15 minutes of staff notification.</p> <p>During interview on 5/13/25 at 7:55 a.m., RN-A stated she was unsure how long R125 had her light on and knew R125 was having pain. RN-A stated pain should be treated within 15 minutes of the time the resident tells staff they are experiencing pain. RN-A stated if it was too soon to give pain medications, staff should offer things like ice or heat or other non-pharmacological options to manage the pain. RN-A confirmed if staff offered non-pharmacological options they were to chart and document in the residents record and said sometimes non-pharmacological interventions work better than giving medications.</p> <p>During interview on 5/13/25 at 11:43 a.m., assistant director of nursing (ADON) stated R125 experiences pain frequently, and her pain has been high since arriving to the facility. ADON stated the initial goal was to try non-pharmacological options first. ADON stated it is an expectation if the resident is offered a non-pharmacological option, it is charted, and a follow up assessment completed. ADON confirmed R125 did not have any non-pharmacological options charted as given since her arrival. ADON stated resident pain should be treated with 15-20 minutes of staff notification.</p> <p>Per facility policy titled Pain Management dated 8/9/22, stated staff will recognize when the resident is experiencing pain, evaluate the resident for pain and the cause, manage or prevent pain.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49893</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff followed proper infection control practices for 1 of 1 resident (R11) reviewed for urinary catheter. Staff failed to ensure a mechanical transfer lift was cleaned and disinfected after resident use for 1 of 1 resident (R125) observed for infection control. Furthermore, staff failed to ensure proper personal protective equipment (PPE) was used for 2 of 2 residents (R125, R126) observed for proper PPE.</p> <p>Findings include:</p> <p>R11</p> <p>R11's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R11 was cognitively intact with no behaviors, had range of motion limitations to both lower extremities, and was dependent on staff for lower body cares, bed mobility, and transfers. It also indicated R11 had a urinary catheter and colostomy, history of spina bifida (genetic neurologic condition), history of UTI, paraplegia (paralysis of lower extremities due to disorder of the nerves).</p> <p>R11's physician orders indicated R11 required enhanced barrier precautions, provide catheter care every shift, and change catheter system as needed.</p> <p>R11's diagnoses included spina bifida, paraplegia, heart failure, Ileal conduit (surgical opening in the abdomen to allow urine to drain from the kidneys), artificial opening of urinary tract status.</p> <p>R11's urostomy care plan indicated empty when half full, monitor skin around stoma for breakdown, provide ostomy care and change appliance as needed, report any changes in amount and color/odor of urine, use 2 1/4 inch ostomy supplies. R11's infection care plan indicated R11 was at risk for infection related to indwelling catheter and wounds requiring enhanced barrier precautions when performing high-contact care activities.</p> <p>R11's nursing assistant Kardex instructed staff to empty urostomy when half full, use enhanced barrier precautions when performing high contact care activities.</p> <p>During observation and interview on 5/11/25 at 2:07 p.m., R11 was lying in bed connected to a urinary drainage bag that was laying directly on the floor without a barrier preventing contact with the floor. A blue cloth privacy bag was attached to the bedframe next to the drainage bag. R11 indicated he has had a urostomy for a long time and has a history of recurrent kidney issues including infections.</p> <p>During observation on 5/11/25 at 4:47 p.m., R11's drainage bag was observed directly on the floor.</p> <p>R11's progress notes dated 5/13/25 at 1:15 a.m., indicated R11 was sent to the emergency room for an elevated temperature and swelling/redness to left hip. On 5/13/25 at 12:50 p.m., R11 returned from the emergency room with a diagnosis of cellulitis (infection under the surface of the skin) to the left hip and urinary tract infection and was started on a 7 day course of antibiotics.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observation 5/14/25 at 8:45 a.m., R11's catheter bag was observed directly on the floor without a barrier beneath it. Blue cloth privacy bag was tied to the bedframe next to the catheter bag.</p> <p>During interview on 5/14/25 at 9:20 a.m., nursing assistant (NA)-B stated urinary drainage bags should be placed in the cloth privacy bag and hung on the bedframe. NA-B stated placing the catheter bag directly on the floor would be an infection control issue and risk the bag getting run over and damaged.</p> <p>During interview on 5/14/25 at 9:22 a.m., NA-A stated urinary drainage bags should be placed in the cloth bag on the side of the bed and hung from the frame. NA-A stated catheter bags should not be placed directly on the floor due to risk for infection.</p> <p>During interview on 5/14/25 at 9:30 a.m., registered nurse (RN)-A stated catheter bags should be hung below the level of the bladder and in a blue bag on the frame, not directly on the floor. RN-A asked, are you referring to the gentleman in the middle room? and immediately went to R11's room to remove the catheter from the floor.</p> <p>During interview on 5/14/25 at 10:08 a.m., the infection preventionist (IP) stated R11 has a habit of pulling on the tubing of the catheter bag to remove it from the dignity bag and place the catheter bag directly on the floor. The IP stated R11's care plan was updated instructing staff to double check the room and make sure the catheter bag is protected.</p> <p>During interview on 5/14/25 at 10:27 a.m., the director of nursing (DON) and assistant director of nursing (ADON) stated R11 gets very angry when the catheter bag hanging from the bedframe stating he doesn't feel it drains properly unless it is on the floor. The ADON stated staff did compromise with R11 by at least placing the catheter bag in the cloth bag prior to it being placed on the floor. The next morning R11 was upset stating the catheter bag didn't drain properly in the dignity bag and the urine backed up.</p> <p>During observation and interview on 5/14/25 at 11:01 a.m., R11's catheter bag was in the cloth dignity bag attached to the bedframe. R11 stated his preference for the location of the catheter bag depends on the type of bag the facility uses. R11 stated some of the catheter bags the facility uses do not drain as well as he would like unless they are hanging low. R11 stated his catheter bag does not have to be directly on the floor, he just prefers it hang as low as possible. He does not like to use the dignity bag because he feels it doesn't allow proper drainage. R11 observed his catheter bag hanging from the bedframe in the dignity bag at the time of the interview and stated the current bag is draining well and he doesn't have an issue with it hanging from the bedframe.</p> <p>During interview on 5/14/25 at 12:45 p.m., the DON and ADON reiterated R11's wishes keeping the catheter bag on the floor. The corporate vice president of success (VP) stressed the need to have a barrier between the catheter bag and the floor.</p> <p>A policy titled Catheter Care dated 3/15/23 indicated privacy/dignity bags will be available and a catheter drainage bag should be covered or shielded at all times when in use.</p> <p>51379</p> <p>Disinfecting Equipment</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R125's resident admission MDS assessment was not completed at time of survey. R125's cognition was intact.</p> <p>R125 was admitted on [DATE] following hospital admission for acute respiratory failure with hypercapnia (too much carbon dioxide in the blood). R125's admission diagnosis include, heart failure, respiratory disease, right lower leg pressure ulcer (reduce blood pressure to body area, leading to skin and tissue damage), left lower leg pressure ulcer, right hip pressure ulcer, perineum (area of sensitive skin between genitals and anus) wound, spinal vertebrae pain, lumbar pain, adult failure to thrive and a new diagnosis of urinary retention requiring a urinary catheter to drain bladder.</p> <p>During an observation on 5/12/25 at 8:55 a.m., nursing assistant (NA)-D and NA-C answered R125's call light, taking mechanical transfer lift from the hallway without wiping it down, assisted resident to commode, then back to chair. NA-D placed the mechanical transfer lift into the hall without wiping it down or sanitizing.</p> <p>During observation on 5/12/25 at 9:23 a.m., NA-D and NA-C answered call light for another room, the same mechanical transfer lift was used for the 2nd resident without being wiped down or sanitized before or after the 2nd use.</p> <p>During interview on 5/12/25 at 9:33 a.m., NA-D stated facility equipment should be cleaned between residents, this is done to help prevent the spread of infection from resident to resident. NA-D confirmed she had not wiped the lift after using it with R125 and before using it with the 2nd resident.</p> <p>During interview on 5/13/25 at 11:43 a.m., director of nursing (DON) and assistant director of nursing (ADON) stated it is an expectation mechanical lifts are sanitized after use with each resident.</p> <p>Per facility policy titled Standard Precautions Infection Control dated 3/24/23, reusable resident equipment, such as mechanical lifts, should be cleaned and disinfected between residents.</p> <p>Appropriate PPE Donning/Doffing</p> <p>R125's resident admission MDS assessment was not completed at time of survey. R125's cognitive function was intact.</p> <p>R125 was admitted on [DATE] following hospital admission for acute respiratory failure with hypercapnia (too much carbon dioxide in the blood). R125's admission diagnosis include, heart failure, respiratory disease, right lower leg pressure ulcer (reduce blood pressure to body area, leading to skin and tissue damage), left lower leg pressure ulcer, right hip pressure ulcer, perineum (area of sensitive skin between genitals and anus) wound, spinal vertebrae pain, lumbar pain, adult failure to thrive, new diagnosis of urinary retention requiring a urinary catheter to drain bladder, and c-difficile (contagious pathogen in stool).</p> <p>R125 had an order to be placed in a room designated with contact precautions (used for residents with known or suspected infections that pose an increased risk for infection transmission). R125 was placed in a room with contact precautions implemented.</p> <p>R126's resident admission MDS assessment was not completed at time of survey. R126's cognitive function was intact.</p> <p>(continued on next page)</p>		

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 05/14/2025
NAME OF PROVIDER OR SUPPLIER Whitewater Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R126 was admitted on [DATE] following hospital admission after left knee surgery. R126's admission diagnosis includes, type 2 diabetes, chronic kidney disease requiring dialysis, heart failure, irregular heart rate, history of long-term antibiotic use, and known infection of left knee surgical site.</p> <p>R126 had an order to be placed in a room designated with contact precautions . R126 was placed in a room with contact precautions implemented.</p> <p>During observation on 5/12/25 at 1:09 p.m., housekeeping (H)-A donned gown and gloves upon entering room [ROOM NUMBER]. Upon exiting 304, H-A removed gloves, did not take off gown. H-A applied new gloves to clean room [ROOM NUMBER] and did not change gown from the previous room. Upon exiting 306, H-A removed gloves but did not take off gown before moving to clean the 3rd room. H-A applied new gloves to clean room [ROOM NUMBER] but did not change his gown from the previous 2 rooms. Upon exiting 308, H-A removed gown and gloves.</p> <p>During interview on 5/12/25 at 1:27 p.m., H-A stated the process for cleaning each room is the same when you are in the room (wipe stuff down, mop the floor, clean bathroom, empty trash, etc.). H-A stated the process for cleaning contact isolation rooms depends on the specific type of isolation pathogen, generally you need an isolation gown and gloves for cleaning these types of isolation rooms. H-A stated it is an acceptable practice to wear the same gown to clean multiple rooms; would just need to change gloves between rooms.</p> <p>During interview on 5/12/25 at 2:00 p.m., housekeeping supervisor (H)-B stated it is an expectation for housekeepers to change isolation gowns and gloves each time they enter a room to clean. Wearing the same gown for each room could spread different infections to residents.</p> <p>During interview on 5/12/25 at 2:09 p.m., assistant director of nursing (ADON) and corporate vice president of success (VP) stated it is an expectation and facility policy to remove gown and gloves after cleaning each room. This process is done to prevent the spread of infection between residents during the cleaning process.</p> <p>Per facility policy titled Transmission-Based (Isolation) Precautions, dated 9/24/24, donning PPE upon room entry and discarding before exiting the room is done to contain pathogens.</p>		