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	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitewater Health Services	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to maintain a clean, homelike environment when it was identified a refrigerator used to supply resident supplement drinks were not cleaned. In addition, during dining, meals were served on trays. This failure had an opportunity to affect all residents who received supplemental drinks and who received meals in the dining rooms.Findings include:During the initial kitchen tour on 6/29/2026 at 10:35 a.m., with cook (C)-A verified the refrigerator in the dining room where the residents house supplement is kept had a large amount of ice built up on the top freezer part with an unknown item within the ice. C-A indicated uncertain who was in charge to clean, monitor or who to report it to. During an interview on 7/01/2026 at 11:45 a.m., maintenance-B said when staff have things that need to be looked at, they are to place a ticket in the TELS. Maintenance-B indicated the TELS is where we would get notified of something needing fixed.During an observation and interview on 7/01/2026 5:50 p.m., administrator verified the ice buildup in the dining room refrigerator.During an interview on 7/01/2026 at 5:55 p.m., administrator, vice president of success (VPS)-A and B verified a TELS request should have been placed for maintenance to review the ice buildup. Administer reviewed the TELS report history and verified it was not reported regarding the ice buildup in the dining refrigerator.TraysDuring an observation on 6/29/2026 at 11:59 a.m., during noon meal, staff bring food to the resident on a tray. The tray includes drinks, dishes with miscellaneous items, and hot plate. The staff place the tray in front of the resident and leave it in front of them. During an observation on 6/29/2026 at 5:34 p.m., supper meals served to residents on trays.During an observation on 6/30/2026 at 12:32 p.m., noon meal was served to residents and left on trays.During an observation and interview on 7/1/01/2026 at 12:00 p.m., registered nurse (RN)-A verified the noon meal was served and food left on the trays and placed in front of the resident. RN-A indicated she recalled this occurring for some time at least two years.During an interview on 7/01/2026 at 7:24 p.m., VPS-A verified the meals are served on trays and left in front of the residents. VPS-A felt it has been like that since before thecurrent administrator. VPS-A confirmed it is not homelike.Facility policy tilted, Safe and Homelike Environment dated 6/16/2022 includes Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean. The facility will create and maintain, to the extent possible, a homelike environment that deemphasizes the institutional character of the setting. General considerations, eliminate the use of meal trays during dining service, unless otherwise requested by the resident.

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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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview and record review the facility failed to maintain equipment in good working order for 1 kitchen dishwashing system and surrounding area.Findings include:During the initial kitchen tour on 6/29/2026 at 10:35 a.m., [NAME] (C)-A identified dishwater and off to the left underneath counter a metal device with a large amount of water flowing from it. surrounding the device the tile floor was buckled and the trim around the perimeter of the wall was peeled back. C-A indicated maintenance has known of the water leak for about a month.During an observation and interview on 7/01/2026 at 11:45 a.m., maintenance (M)-B was asked to review the leak in the kitchen. After walking in the kitchen, M-B quickly went to the area and turned the water off. M-B was made aware on 6/30/26 from M-A. M-B indicated staff are to use the TELS system (a systems to give updates to maintenance of things needing attention). He reviewed TELS and verified staff did not report. M-B confirmed the damage was not new and should have been reported sooner. M-B indicated a plumber will be coming to assess.During an interview on 7/01/2026 at 5:55 p.m., administrator, vice president of success (VPS)-A and B, indicated the expectation would be staff to report things needing fixed to use the TELS system. Administrator indicated being updated of the plumber called to review the leak in the kitchen and confirmed did not observe the damage themselves.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review the facility failed to maintain dignity when it was identified a brace was not cleaned regularly for 1 of 1 resident (R1) reviewed for dignity.Findings include:R1's quarterly Minimum Data Set (MDS) assessment, dated 4/11/26, indicated R1 was not cognitively impaired. In addition, needed partial to moderate assistance to dress upper body.R1's care plan includes a focus for ADL (activity of daily living) assist of one staff for dressing, related to recurrent dislocation of right shoulder, and at risk for loss of range of motion and to apply device (specify-immobilizer) per physician orders.R1's orders include, the immobilizer should be removed twice daily, including for showers, to check underlying skin to ensure no rubbing. The immobilizer should be on at all times, otherwise.During an observation on 6/29/2026 at 4:57 p.m. R1 had a brace on right shoulder which wrapped around his trunk. The brace is dirty and or stained.During an observation and interview on 7/01/2026 at 12:03 p.m., registered nurse (RN)-A indicated there is an order to check the skin under the brace for R1 and R1 often removes the brace himself. At times when off it has been washed, although not recently and we try to complete it once a month. R1 was sitting in the dining room eating lunch and RN-A verified the brace was dirty and confirmed it needed to be washed. RN-A indicated it looks to be food from eating and wiping his hands on the brace.During an interview on 7/01/2026 at 12:11 p.m., environmental services (ES)-A indicated they are the ones who wash the braces for the residents but do not dry them. ES-A verified being familiar with R1's brace and said, o' yes, but we have not washed that for a while. During an interview on 7/01/2026 7:22 p.m. vice president of success (VPS)-A and B, verified resident's devices should be washed when identified dirty by staff as it could be an infection control concern.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review facility failed to notify the physician with a change of condition for 1 of 1 resident (R31) reviewed for discharge.Findings include:R31's Quarterly Minimum Data Set (MDS) assessment, dated 5/7/26 includes intact cognition with no mood or behaviors. R31's focus care plan indicates residents shows potential for discharge, will be discharged to home when clinical and rehabilitation goals are met.R31's physician encounter visit dated 3/24/26, indicates Nursing home discharge. Discharge preparation time spent with patient 40 minutes including the following tasks, reviewed the electronic medical record, updating epic problem list, medication,. time electronically signed 4:35 p.m., with another date and time of 3/27/26 at 2:25 p.m.R31's patient message dated 3/24/26 at 4:36 p.m., indicates discharge recommendation faxed to facility on 3/24/26 at 4:50 p.m.R31's record lacked communication with the provider R31 remained in the facility after signed discharged orders were received.R31's physician became aware R31 remained in the facility on 4/15/26 when R31 was sent to the emergency room (ED).R31's progress note dated 4/16/26 from nurse practitioner reads, does not appear on-call provider was notified of acute change in condition and ED transfer, acknowledged. Note he was seen for SNF (skilled nursing facility) discharge visit by MD (medical doctor) on 3/24/26R31 record revealed they were discharged on 6/6/26.During an interview on 7/01/2026 at 6:13 p.m., administrator, vice president of success (VPS)-A and B verified the order was received to discharge R31. When asked why, they indicated there was a snag in the payor source. Although confirmed they should have updated the physician of the change.During an interview on 7/07/2026 at 2:19 p.m., medical providers social services indicated the facility did not update the medical doctor of the change in condition, admission to the ED or that the resident remained in the nursing home after orders were given to discharge the resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to appropriately assess and reevaluate interventions discussed in a timely manner to help prevent future falls for 1 of 4 residents (R1) reviewed for accidents who had 23 falls.Findings include:R1 admitted to the facility 1/20/2026R1's care plan focus area dated 1/21/26 indicated R1 is at increased risk for actual fall related to history of (h/o) falls, impaired decision making, failure to recognize physical limitations, impaired safety awareness, and attempts to self-transfer. R1's goal is to minimize risk of falls. Original interventions included; ensure R1 is wearing appropriate footwear (gripper socks or shoes), have commonly used articles within easy reach, provide assist to transfer and ambulate as needed, reinforce wheelchair safety as needed such as locking brakes, report development of pain, bruises, change in mental status, ADL function, appetite, or neurological status post fall, and therapy to work on transfer, walking, strengthen.R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], includes mild cognition, no mood or behavior concerns. Requires substantial to max assist where a helper does more than half the effort for toileting, bathing, dressing, and personal hygiene. R1 is dependent on others for putting on and off footwear.During an interview on 6/29/2026 at 12:52 p.m., R1 said staff have told him he has fallen some 17 times since admission. When asked what he was trying to do R1 stated, he dropped glasses, trying to do things for himself instead of calling staff. R1 said the reason he is in the nursing home is due to a fall at home.R1's medical record identified 23 falls with the first one documented on his admission of 1/20/26 through 6/13/26. 21 falls were un-witnessed.R1's first 10 falls lacked a post fall assessment. The first one was not completed until 2/28/26. The assessment included new immediate intervention; would be to keep in common area when up in wheelchair, place slide strips, locking bed, moving bed against the wall, reminders frequently, hourly checks. Education given of the importance to wait for staff members. R1's record revealed interdisciplinary team (IDT) met on 4/28/26 to discuss the 4/28/26 fall. IDT note read the resident fell using the urinal at bedside, 18th fall since admit, and several of them were R1 using the urinal, IDT feels R1 will need to demonstrate the use of the urinal at bedside safely where he doesn't need to stand up. IDT will ask therapy for ideas. Care plan to be updated.R1's therapy note 4/30/26 reads co-treatment details: PT/OT (Physical/Occupational Therapy) cotreat for urinal use and ambulation. R1 stood for 3 minutes to utilize urinal.R1 record lack any further update and R1 continued to fall using his urinal on 5/8/26, and when using the toilet on 6/13/26.During an interview on 7/02/2026 at 12:26 p.m., administrator and vice president of success (VPS)-A and B would expect interventions spoke about at IDT are followed and reviewed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow care plan interventions requested by the resident for 1 of 1 resident (R5) reviewed for bladder incontinence.Findings include:R5 Quarterly Minimum Data Set (MDS) assessment dated [DATE], included intact cognition, no mood or behaviors, frequently incontinent with no toileting program.R5's care plan focus area for urinary incontinence related to functional incontinence with an intervention of a toileting plan: check and change every 2 hours starting in the am, between meals and at 10:30 p.m., then at 2-3 a.m., last check at 5a.m.During an observation and interview on 6/29/2026 at 3:52 p.m., R5 lying in bed when asked about going to the bathroom, R5 said, she does not make it to the restroom all the time. Staff are to check and change her or go to the bathroom every two hours. R5 continues and said it does not happen all the time and added some staff are better than others. R5's care conference summary dated 4/2/26 reads resident requested care conference to discuss having more input in her cares. R5 felt staff were not listening to her when R5 was telling staff she had a urinary tract infection. Intervention in place was to check on resident every 2 hours to see if she needs to be changed.R5's quarterly Clinical Review Bladder and Bowel assessment dated [DATE] reads bladder incontinent and is wet 1-2 times daily.An email communication provided, including R5, involved the regional ombudsman regarding her cares. The ombudsman attended R5's April care conference where it was discussed R5's toileting and check and change every 2 hours.R5 checks and change at night and every 2-hour, check list was provided for the following dates 6/29/26 through 7/2/26 indicating on 7/1/26 R5 was checked and changed at 6am, 8am, 10am, and noon.During an interview on 7/01/2026 at 8:45 a.m., nursing assistant (NA)-A said R5 had not gotten up for the day yet. When asked the last time R5 was checked and changed, NA-A indicated the night shift at 6am.During an observation on 7/01/2026 at 8:49 a.m., NA-A entered R5's room and walked right out.During an observation on 7/01/2026 at 9:26 a.m., activity staff knocked on the door open, walked in and out then closed door.During an observation and interview on 7/01/2026 at 11:50 a.m., NA-A indicated R5 is up and in her chair. R5 was sitting in her chair. When asked when staff got her up R5 said staff got her up about half hour ago. During an interview on 7/01/2026 at 12:13 p.m., NA-A was asked if R5 was wet with urine when she got her ready for the day. NA-A said yes and R5 was taken to the toilet where she continued to urinate and had a bowel movement. During an interview on 7/01/2026 at 2:04 p.m. NA-A verified she did not check on R5 until 10:30 a.m., NA-A indicated she did go in the room once but, R5 was having breakfast. NA-A confirmed R5's care plan includes check and change every 2 hours. NA-A confirmed she did not follow R5's care plan to check and change her every 2 hours. NA-A indicated they do not chart in real time and must complete at the end of the day. During an interview on 7/01/2026 at 6:05 p.m., administrator vice president of success (VPS)-A and B said they would expect staff to follow the care plan for checking and changing.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain a medical record that was complete, accurate and readily accessible for 1 of 1 resident (R29) reviewed for death record.Findings include:R29's Hospital Discharge summary revealed being discharged to the nursing home on [DATE] in stable condition.R29's Provider Orders for Life-Sustaining Treatment (POLST) dated [DATE] reads attempt CPR.R29's death record reads date of death [DATE]R29's Minimum Data Set assessment dated [DATE] indicates death in facility.R29's progress lacked documentation of R29 death in the facility or what had happened.R29's encounter date [DATE] at 9:58 a.m., received call R29 passed away this morning, CPR started, 911 called.State agency asked for R29's incident report and or medical record to include items that would have anything to do with the day of R29's death. Upon follow of request, it was brought to the attention there was no incident report or progress note of what occurred the day of R29's death.During an interview on [DATE] at 6:52 p.m., administrator, [NAME] president of success (VPS) A and B verified the facility did not have documents of what occurred the morning of [DATE] regarding R29 death. VPS-A offered to review a notebook of notes taken during an interdisciplinary team meeting (IDT) discussed the death in facility.