DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 27, 2026

Administrator
St Gertrudes Health & Rehabilitation Center
1850 SARAZIN STREET
SHAKOPEE, MN 55379

RE: CCN: 245610
Cycle Start Date: December 18, 2025

Dear Administrator:

On January 6, 2026, we informed you that we may impose enforcement remedies.

On January 15, 2026, the Minnesota Departments of Health and Public Safety completed a revisit/survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 18, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 18, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 18, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed

care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 18, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Gertrudes Health & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 18, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E"tag), i.e., the plan of correction should be directed to:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 18, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare &

Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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January 27, 2026

Administrator
St Gertrudes Health & Rehabilitation Center
1850 SARAZIN STREET
SHAKOPEE, MN 55379

Re: State Nursing Home Licensing Orders
Event ID: 1DDFD3-H1

Dear Administrator:

The above facility survey was completed on January 15, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	1850 SARAZIN STREET , SHAKOPEE, Minnesota, 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 1/12/26- 1/15/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		02/18/2026
F0000	INITIAL COMMENTS On 1/12/26 to 1/15/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H56103123C (MN00107776) H56103122C (MN00108406) H56103120C (MN00110401) H56102083C (IQIES 2700198) H56103413C (IQIES 2714096) H56103121C (IQIES 1133928) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F0000		02/18/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

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F0000	Continued from page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure a resident was appropriately assessed and had an appropriate order in place to self-administer nebulizer medication for 1 of 1 resident (R80) reviewed for self-administration of medications. Findings include: R80's significant change Minimum Data Set (MDS), dated 11/16/25, indicated R80 was cognitively intact and required partial to moderate assistance with most activities of daily living. R80's active orders, printed 1/15/26, contained an order for albuterol sulfate for nebulization once a day in the morning and three times a day as needed for difficulty breathing, shortness of breath, wheezing and/or bronchospasm prevention. R80's care plan, dated 10/30/25, indicated, "I [R80] will independently administer respiratory treatments as ordered and I will receive assistance setting up, disassembling, and cleaning respiratory equipment from a licensed nurse." with interventions to include, "acquire physician's order for self-administration of respiratory treatments" and, "perform a self-administration medication assessment per facility protocol." R80's electronic medical record lacked an order and an assessment for self-administration of her respiratory treatments (i.e. albuterol sulfate via nebulization).During an interview on 1/14/26 at 10:30 a.m., licensed practical nurse (LPN)-A stated R80 administered her nebulizer independently. She indicated licensed staff would put the medication in the nebulizer and leave R80 with the medication who would turn off the nebulizer machine on her own when the medication was gone, stating he checked back with her	F0554	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F554 Resident Self-Admin Meds- Clinically Approp CITED RESIDENT(S): Resident R80 was evaluated for the appropriateness of self-administering a nebulizer following nursing set-up. Resident demonstrated the ability to safely self-administer the nebulizer after nurse set-up; order obtained from provider and care plan updated. LIKE RESIDENT(S): A facility-wide audit was conducted to identify other residents who self-administer nebulizers after nursing set-up. All residents identified have a completed self-administration evaluated, a provider order and care plan updated accordingly. EDUCATION: The Self-Administration of Medications policy was reviewed and remains current. Licensed nurses were re-educated that any resident with an order for a nebulizer will have a self-administration evaluation completed. If the resident is determined to be appropriate to self-administer medications, a provider order will be obtained, and the resident’s care plan will be updated accordingly. AUDITS: The Director of Nursing or designee will complete audits of five residents’ medical records to ensure that residents who self-administer nebulizers after nurse set-up have an appropriate assessment and provider order in place. Audits will be conducted weekly for four weeks, biweekly for one month, and then monthly for three months. Audit results will be presented monthly to the Quality Council, with additional actions taken as indicated. Date of Compliance: February 18th, 2026	02/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

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F0554 SS = D	Continued from page 2 in 10-15 minutes after starting the nebulizer. During observation on 1/14/26 at 11:45 a.m., LPN-A entered R80's room, handed her the hand-held nebulizer mouthpiece, already filled with the albuterol medication, turned on the nebulizer machine, and left R80 to self-administer the medication independently. During an interview on 1/15/26 at 9:08 a.m., the assistant director of nursing (ADON) confirmed there was not an order or assessment in place for R80 to self-administer her nebulizer medication and that it would be expected to have those in place prior to self-administration of any medications. A facility policy titled Self-Administration of Medications, revised 4/10/25, indicated each resident will be assessed for the ability to physically and mentally self-administer any medication and, if deemed appropriate, a physician order would be obtained to self-administer the assessed medications.	F0554		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to accommodate resident needs by ensuring the call light was accessible for 1 of 1 resident (R26) reviewed for call lights. Findings include: R26's quarterly Minimum Data Set (MDS) dated 1/12/26, identified R26 with impaired cognition, no rejection of cares or wandering, impairment in lower extremity range of motion, required a walker or wheelchair for mobility, and needed partial to moderate assistance with dressing, transfers, and hygiene. Diagnoses include heart failure, kidney disease, arthritis, depression and anxiety. During observation and interview with R26 on 1/12/26 at 5:01 p.m., R26 was lying in bed with call light out of reach on nightstand next to head of bed. R26 stated she could not see it and wanted assistance to get up out of bed to go to dinner. "Normally I use the call light if	F0558	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F558 Reasonable Accommodations Needs/Preferences CITED RESIDENT(S): Resident R26 was provided a pendant call light. LIKE RESIDENT(S): All other residents in long-term care were audited to ensure call lights were within reach. EDUCATION: Call Lights-Call System Activation and Response policy reviewed and remains current. Licensed nursing staff and nursing assistant were re-educated to ensure call lights are within reach while residents are in their room; specifically, when in their bed or other sleeping accommodation within the resident room. AUDITS: The Director of Nursing or designee will complete audits of five residents to confirm call lights are placed within in their room. Audits will be conducted weekly for four weeks, biweekly for one month, and then monthly for three months. Audit results will be presented monthly to the Quality Council, with	02/18/2026

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F0558 SS = D	Continued from page 3 I need help. If it is out of reach then I make noise to get attention to get [staff] to answer my pleas." During observation and interview with nursing assistant (NA)-B on 1/12/26 at 5:04 p.m., NA-B verified R26's call light was out of reach, "It should be in reach to ask for help". During interview with NA-D on 1/15/26 at 6:52 a.m., NA-D stated it was important to place the call light "next to patients at all times. If out of reach the residents can fall. For safety." During interview with registered nurse (RN)-G on 1/15/26 at 7:04 a.m., RN-B stated, "[staff] always make sure [call light] is in reach and [residents] know how to use it." During interview with director of nursing (DON) on 1/15/26 at 9:57 a.m., DON stated expectation of staff to place the call light call within reach at all times so residents can call for help if needed. Facility policy titled Call Lights-Call System Activation and Response dated 5/28/2024 identified:Each resident is provided with a means to call staff directly for assistance. The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room.	F0558	Continued from page 3 additional actions taken as indicated. Date of Compliance: February 18th, 2026	
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F0584	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F-584 – Safe/Clean/Comfortable/Homelike Environment CITED RESIDENT(S): Resident R57 room temperature was corrected and adjusted to within the acceptable range of 71 – 81 degrees. LIKE RESIDENT(S): No other concerns identified. Licensed nursing staff and nursing assistants were re-educated regarding resident room temperature standards of 71-81 degrees and recognizing signs of discomfort related to room temperature including what to do if room temperature is outside of acceptable	02/18/2026

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F0584 SS = D	Continued from page 4 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident rooms were maintained at a comfortable temperature between 71 and 81 degrees Fahrenheit for 1 of 1 residents (R57) reviewed who indicated their rooms were cold. Findings Include: R57's admission Minimum Data Set (MDS) assessment, dated 12/22/25, indicated a diagnosis of cerebral infarction (stroke) with intact cognition. During an interview on 1/12/26 at 5:19 p.m., R57 stated his room was cold. R57 was observed wearing a winter coat while sitting in a recliner chair in his room between the bed and the window which he reported was where he spent the majority of his time. R57 stated he had reported his concerns to staff and had been told "this room is always like this." R57 stated, "I am froze." The thermostat on the wall indicated 72.9 degrees Fahrenheit (F). At 5:50 p.m., surveyor obtained temperatures in the room: 66.2 degrees F by the tv, 68.3 degrees F around the chair R57 was sitting in, and	F0584	Continued from page 4 range. EDUCATION: Licensed nursing staff and nursing assistants were re-educated regarding resident room temperature standards of 71-81 degrees and recognizing signs of discomfort related to room temperature including what to do if room temperature is outside of acceptable range. AUDITS: The Plant Ops Director or designee will complete weekly audits of all thermostats and HVAC performance, and document findings and ensure corrective actions in place as deemed necessary. Audits will be conducted weekly for four weeks, biweekly for one month, and monthly for three months. Audit results will be presented monthly to the Quality Council, with additional actions taken as indicated. Date of Compliance: February 18th, 2026.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

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F0584 SS = D	Continued from page 5 67.7 degrees F between the chair and the wall. During an interview on 1/12/26 at 5:58 p.m., nursing assistant (NA)-C stated R57 had complained of his room being cold about a week or so ago. NA-C stated he thought a form had been filled out for maintenance to look at R57's room temperature. NA-C verified that R57 was wearing a winter coat due to being cold when he brought him to the bathroom this evening. During a follow up interview on 1/13/25 at 9:55 a.m., R57 stated he did not use his personal refrigerator as it was cold enough in the room to keep items on the counter to keep them cold. On 1/14/26 at 10:46 a.m., surveyor obtained temperatures in R57's room. It was 66.5 degrees F around R57's chair. During an interview on 1/14/26 at 12:20 p.m., director of maintenance (DOM) stated that he had received a complaint of R57's room being cold last week and had the vendor come out and look at his room. DOM stated after the vendor was out, the room was above 71 degrees F. The next day, DOM check the room temperature via computer as temperatures can be checked from the thermostats via computer without having to disrupt the residents. He stated the computer indicated the room was above 71 degrees F. DOM and surveyor obtained temperatures in R57's room: the area around R57 was 69.7 degrees F, and the middle of the room was 70.2 degrees. R57's thermostat indicated 72.3. DOM stated R57's room temperatures are not within the required 71-81 degrees F and would call the vendor out again. During an interview on 1/15/26 at 11:15 a.m., administrator stated temperatures are to be between 71-81 degrees F. Administrator stated the vendor came out yesterday for R57's room and switched the wires. Administrator stated the room was currently temping at 74 degrees F where the resident sits. A facility policy on room temperatures was requested and not received.	F0584		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F0605	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in	02/18/2026

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F0605 SS = D	Continued from page 6 §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An	F0605	Continued from page 6 accordance with federal and state law requirements. F0605 Right to be Free from Chemical Restraints CITED RESIDENT(S): Resident R100, Abilify was discontinued on 1/13/2026. Resident R49, orthostatic blood pressure monitoring was completed on 2/3/2026 and will be completed per protocol thereafter. LIKE RESIDENT(S): Residents currently prescribed antipsychotic medications will have their medical records reviewed to ensure an appropriate diagnosis is documented and that orthostatic blood pressure monitoring has been completed within the past 30 days. EDUCATION: The Psychotropic Medication Use policy was reviewed and remains current. Licensed nurses, Health Unit Coordinators, and Providers were re-educated on the requirement for appropriate diagnosis and documentation for antipsychotic medication use. Licensed nurses and Health Unit Coordinators were also re-educated to ensure orthostatic blood pressure monitoring is included in monthly orders for new admissions and completed as ordered. AUDITS: The Director of Nursing or designee will complete audits of five residents' medical records to verify appropriate antipsychotic diagnosis documentation and completion of orthostatic blood pressure monitoring. Audits will be conducted weekly for four weeks, biweekly for one month, and then monthly for three months. Audit results will be presented monthly to the Quality Council, with additional actions taken as indicated. Date of Compliance: February 18th, 2026	

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F0605 SS = D	Continued from page 7 unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner	F0605		

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F0605 SS = D	Continued from page 8 evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide and document an appropriate diagnosis for a prescribed psychotropic medication for 1 of 5 (R100) residents and failed to provide appropriate side effect monitoring (i.e., orthostatic blood pressure) with antipsychotic medication consumption for 1 of 3 (R49) residents reviewed for unnecessary medication use. Findings include: R100's quarterly Minimum Data Set (MDS), dated 10/30/25, indicated R100 was admitted to the care facility on 6/14/22 and was cognitively intact. The MDS further indicated R100 had no documented hallucinations or delusions during the look-back period. R100's Diagnoses List, indicated R100 had diagnoses including vascular dementia, history of stroke and adjustment order with anxiety. R100's Physician Order Report, dated 12/1/25 - 12/31/25, indicated an order, dated 9/11/25, for Abilify 5 milligrams (mg) once a day for bothersome and frightening hallucinations. R100's Consultant Pharmacist Recommendation to Physician, printed 12/29/25, indicated, "this resident [R100] is receiving antipsychotic agent Aripiprazole [Abilify] (currently listed on the MAR for hallucinations), but lacks an allowable diagnosis to support its use." R100's progress note, dated 1/13/26, indicated the nurse practitioner reviewed the pharmacist recommendation from December and due to R100 not having an appropriate diagnosis for antipsychotic medication the Abilify was discontinued. During an interview on 1/14/26 at 12:25 p.m., the assistant director of nursing (ADON) stated it would be expected that the nurse managers review psychotropic medications for an appropriate diagnosis when ordered,	F0605		

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F0605 SS = D	Continued from page 9 stating the pharmacist will also review medications and inform the facility staff if there is not an appropriate diagnosis attached to the medication order, confirming R100's Abilify, ordered 9/11/25, did not have an appropriate diagnosis. A facility policy titled Psychotropic Medication Use, reviewed 9/7/23 indicated "psychotropic medications are ordered by the medical provider to treat a specific condition as diagnosed and documented in the medical record." R49's admission Minimum Data Set (MDS) assessment, dated 10/20/25, indicated R49 had intact cognition with no hallucinations or delusions and no behavioral symptoms including physical or verbal behavioral symptoms directed at others, or behavioral symptoms not directed toward others. Further it indicted R49 received an antipsychotic medication. R49's January 2026 Medication and Treatment Administration Record (MAR)/TAR), printed 1/15/26, included the following orders: -aripiprazole (antipsychotic medication used to treat mental/mood disorder) 10 milligram (mg) tablet – give 10 mg by mouth at bedtime for moderate episode of recurrent major depressive disorder with a start date of 10/14/25. Medication was documented as administered every day in January. -orthostatic blood pressure related to antipsychotic use once a month on the 14th with a start date of 10/14/25. The MAR/TAR indicated a signature of completion. The document lacked documentation of the blood pressures. -per therapy recommendations: discontinue assist of 2 with sara steady assist of 1 with sara steady for all transfers. Knee brace as needed for comfort with a start date of 1/5/26. -per therapy recommendations: discontinue ceiling lift assist of 2 with sara steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26. R49's December 2025 MAR/TAR included the following orders:	F0605		

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F0605 SS = D	Continued from page 10 -aripiprazole (antipsychotic medication used to treat mental/mood disorder) 10 milligram (mg) tablet – give 10 mg by mouth at bedtime for moderate episode of recurrent major depressive disorder with a start date of 10/14/25. Medication was documented as administered every day in December. -orthostatic blood pressure related to antipsychotic use once a month on the 14th with a start date of 10/14/25. The MAR/TAR indicated a signature of completion. The document lacked documentation of the blood pressures. -per therapy recommendations: discontinue ceiling lift assist of 2 with sara steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26. -per therapy recommendations: discontinue ceiling lift. Assist of 2 staff with sara steady for all transfer.KI on right lower extremity at all times except skin checks. Please support right lower extremity to maintain right knee during extension during transfers. No ambulation at this time with a start date of 12/16/25 and discontinue date of 12/18/25. -per therapy recommendations: discontinue ceiling lift. Assist of 2 with sara steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26. R49's care plan, printed 1/15/26, identified the following: -Under Activities of Daily Living (ADL)s Functional category, the care plan identified R49 had a self-deficit with ambulation, transferring, mobility, oral cares, grooming and bathing and indicated "Resident has a tendency to self-transfer, self-ambulate, and not use her call button for assistance." -Under the Mood state category, the care plan identified R49 had a diagnosis of major depressive disorder and to "obtain monthly orthostatic blood pressure per pharmacy recommendations." R49's blood pressure and pulse logs for 12/1/25 to 1/15/26 were reviewed. The document lacked evidence of	F0605		

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F0605 SS = D	Continued from page 11 orthostatic blood pressure being completed and documented. R49's progress notes for 12/1/25 to 1/15/26 were reviewed. The document lacked evidence of orthostatic static pressures being completed and documented. During an interview on 1/15/26, R49 was observed sitting in her wheelchair. R49 stated things were going well, denied any concerns and engaged in the conversation. During an interview on 1/15/26 at 10:20 a.m., licensed practical nurse (LPN)-B stated if a resident needed to have orthostatic blood pressures taken then an order was put in the electronic medical record (EMR). LPN-B stated the orders would show up under the treatments and documented on the MAR/TAR, and the vital signs would flow over to the vital signs section of the EMR. LPN-B stated some residents who were on antipsychotic medications had orders for orthostatic blood pressures to be taken but not all residents. LPN-B was not sure how it was decided who needed to have orthostatic blood pressures taken when a resident was on antipsychotic medications and stated the health unit coordinator or nurse manager put the orders in. LPN-B verified R49 had an order to have orthostatic blood pressures taken monthly and verified it was signed off for 12/14/25 and 1/14/26 as completed. LPN-B verified there were not blood pressures on the MAR/TAR and no blood pressures entered in the vital signs section of the EMR on 12/14/25 or 1/14/26. LPN-B stated, "it looks like they weren't done." LPN-B stated R49 was able to stand with assist of 1 and EZ stand (device that assists person to stand). LPN-B stated there was a risk of orthostatic hypotension when a person took antipsychotic medication(s). During an interview on 1/15/26 at 11:04 a.m., director of nursing (DON) stated the expectation would be any resident on an antipsychotic medication should be getting orthostatic blood pressures done monthly. DON stated it's important to monitor orthostatic blood pressures as antipsychotic medications can affect blood pressures which can increase falls. DON could not find any orthostatic blood pressures documented for R49 the last few months. A facility policy titled Psychotropic Medication Use, reviewed 9/7/23, indicated "When psychotropic medications are ordered, the IDT identifies target behaviors, medication side effects to be monitored and	F0605		

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F0605 SS = D	Continued from page 12 implements a resident centered care plan with both non-pharmacologic and pharmacological interventions.”	F0605		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure a resident's preferences were care planned to ensure preferences were honored for 1 of 1 resident (R127) reviewed who preferred to have female only caregivers. Findings include: R127's admission Minimum Data Set (MDS), dated 1/10/26, indicated R127 was admitted to the care facility on 1/4/26 and was cognitively intact. The MDS further	F0657	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F657 Care Plan Timing and Revision CITED RESIDENT(S): Resident R127’s care plan was updated on 1/15/2026 to reflect a preference for female caregivers. Resident was discharged from the facility on 1/23/2026. LIKE RESIDENT(S): All newly admitted residents will have their personal preferences reviewed and discussed during the 48-hour care conference. Any new identified preferences will be communicated to nursing leadership and incorporated into the individualized care plan as appropriate. EDUCATION: Comprehensive Assessment and Care Planning policy was reviewed and remains current. Licensed nursing staff and nursing assistants were re-educated that any resident preference must be communicated to nursing leadership. Nursing will inquire about resident preferences during the 48-hour care conference for all new admissions. AUDITS: The Director of Nursing or designee will audit five residents’ medical records weekly for four weeks, biweekly for one month, and monthly for three months to ensure resident preferences are identified, communicated, and incorporated into care plans. Audit results will be presented to the Quality Council monthly, with additional actions implemented as indicated. Date of Compliance: February 18th, 2026	02/18/2026

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F0657 SS = D	Continued from page 13 indicated R127 required substantial assistance with toileting and partial to moderate assistance with bathing. R127's progress notes, dated 1/4/26, indicated R127, "strongly prefers female caregivers. Patient was instructed that the facility does its best to fulfill these requests but that there was no guarantee that we could provide all female caregivers throughout her stay. Patient understood but stated 'I will just do it myself if there is not female to support me.'" R127's care plan and care guide sheets used to direct resident care lacked mention of any care preferences voiced by R127, including the preference for female only caregivers. During an interview on 1/12/26 at 3:48 a.m., R127 stated she had told multiple staff members, multiple times, that she prefers female caregivers, but that male staff keep coming in and she has to remind that that she would prefer a female. During an interview on 1/15/26 at 8:32 a.m., nursing assistant (NA)-J stated R127 did like men caring for her and if there was a man working on the unit they would try to switch assignments. NA-J stated when a resident voiced a preference such as female only care givers staff would pass it along shift to shift via word of mouth. During an interview on 1/15/25 at 8:39 a.m., clinical manager and registered nurse (RN)-H stated she was unaware that R127 had a preference for female only caregivers, stating she would have expected such a preference to be communicated to her to ensure it was care planned. RN-H stated if she was aware R127 had a preference for female only caregivers she would generally talk with staffing and ensure if there were no female nursing assistants working on the unit that the float NA was a female. During an interview on 1/15/26 at 8:45 a.m., licensed social worker (LSW)-A stated R127's preference for female only care givers was communicated to them through the hospital prior to R127 being admitted to the care facility. The Social Services Director (SSD) stated in the same interview that it would be expected that those preferences would be communicated to the nurse manager and care planned as floor staff often float to different units, so it is important to have care plans up to date to ensure preferences are honored and care needs are met. A facility policy titled Comprehensive Assessments and Care Planning, revised 9/27/23, indicated the comprehensive assessment and care plan must include a resident's customary routine and preferences.	F0657		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F0677	This plan of correction constitutes the facility's credible allegation of compliance.	02/18/2026

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F0677 SS = D	Continued from page 14 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 4 residents (R45) reviewed for activities of daily living (ADLs) and were dependent on staff for their ADLs, routinely had their fingernails cleaned and trimmed. Findings include: R45's quarterly Minimum Data Set (MDS) 10/25/25, indicated R45 had intact cognition and was diagnosed with arthritis. R45 was dependent on staff for toileting hygiene, lower body dressing, and putting on and taking off footwear. The MDS indicated R45's most recent admission/entry to the facility was on 7/23/25. R45's Weekly Skin Checks dated 11/7/25 through 1/9/25, included a section with the question "Was nail care completed?" with the options of fingernails trimmed, toenails trimmed, refused, or not necessary. All checks from this period were either checked as not necessary or left blank. R45's care plan dated 1/9/25, indicated she had a self-deficit with ADLs such as grooming, bathing, and oral care. R45's medical record was reviewed and did not indicate R45 had refused toenail care. During an interview and observation on 1/12/26 at 2:43 p.m., R45 was observed sitting in a chair in her room. R45 stated that she felt like her toenails needed to be trimmed and confirmed that they were not causing her pain. R45 stated she didn't think anyone had offered to help her cut her toenails since she was admitted in July of this year. R45's toenails were observed to have grown past the end of her toes, with a varying nail length, and some toenail curling was observed. During an interview on 1/13/26 at 12:45 p.m., registered nurse (RN)-B stated that R45 was not a diabetic, so the aides could assist her with cutting her finger and toenails. When asked when the last time toenail clipping was completed or where it was documented RN-B stated she was not sure.	F0677	Continued from page 14 Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F677 ADL Care Provided for Dependent Residents CITED RESIDENT(S): Resident R45 was asked if nail care could be completed Resident R45 toenails and fingernails were trimmed and cleaned. LIKE RESIDENT(S): Audit was conducted to identify other dependent residents requiring nail care. Nail care was completed if necessary. EDUCATION: The Activities of Daily Living (ADL) policy was reviewed and remains current. Licensed nursing staff and nursing assistants were re-educated that nail care is to be completed weekly, if necessary, typically on the resident's scheduled bath or shower day and documented in the medical record under weekly skin observation. Nursing assistants are responsible for routine nail trimming and cleaning for residents without complicating conditions, while licensed nurses are responsible for nail care for residents with diabetes or other conditions requiring professional oversight. AUDITS: The Director of Nursing or designee will audit five residents' medical records weekly for four weeks, biweekly for one month, and monthly for three months to ensure that nail care is completed if necessary and documented in weekly skin observation. Audit results will be presented to the Quality Council monthly, with additional actions implemented as indicated. Date of Compliance: February 18th, 2026	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0677 SS = D	Continued from page 15 During an interview and observation on 1/13/26 at 12:47 p.m., nursing assistant (NA)-C stated he had assisted R45 with her personal care this morning. NA-C was observed to lift R45's blanket, look at her toes, and state her toenails looked like they could use a trim. R45's toenails were observed to have grown past the end of her toes, with a varying nail length, and some toenail curling was observed. NA-C stated he didn't work on this unit very often, so he was not sure if R45 refused to get her toenails trimmed or the last time toenail trimming was completed. NA-C confirmed he had not offered to cut R45's toenails. During an interview on 1/14/26 at 8:22 a.m., RN-C, the clinical manager for the unit, stated she had reviewed R45's records and did not find evidence that R45 had gotten nail care or refused it recently. RN-C stated staff should either document nail care/nail care refusals in a progress note or on the weekly skin check observation form. RN-C stated she saw that staff had been documenting that it was not applicable to the question of whether R45 had her nails done. RN-C stated that after assessing R45's nails, she felt that they should have been previously cut, so she talked with R45 this week, and R45 had consent to having her toenails trimmed. RN-C stated she was unable to cut all of her toenails, so she was going to ensure a consult was made with podiatry for additional nail care. RN-C stated the nurse was supposed to assess the resident's nails on bath days and ensure that nail care was completed as necessary. The facility's Activities of Daily Living policy dated 7/21 was received but did not include guidance regarding nail care.	F0677		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure communication and collaboration was maintained with a dialysis provider for 1 of 1 resident (R7) reviewed for dialysis.	F0698	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F698 Dialysis CITED RESIDENT(S): Resident R7 will have a dialysis referral form sent to the dialysis provider to ensure effective communication. Facility staff will track the referral form and ensure it is returned, reviewed by	02/18/2026

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F0698 SS = D	Continued from page 16 Findings include: R7's quarterly Minimum Data Set (MDS), dated 11/5/25, indicated R7 was admitted to the care facility on 5/10/24 and was cognitively intact. The MDS further indicated R7 required substantial to maximum assistance with activities of daily living and received dialysis. R7's Orders, dated 11/20/25 directed staff to monitor R7's dialysis fistula and to document R7's vital signs and monitor for shortness of breath, chest pain, nausea and vomiting or seizure activity prior to dialysis. R7's care plan, dated 5/13/24, directed staff to, "obtain Dialysis care plan and coordination of care communication sheet. Check for orders or changes from Dialysis Unit." The care plan further indicated R7 went to dialysis three times a week, on Mondays, Wednesdays, and Fridays. R7's electronic medical record contained only one dialysis communication sheet (Dialysis Run Sheet), dated 10/15/25. R7's paper medical record contain multiple dialysis communication sheets (Dialysis Run Sheets), with the most current being dated 8/25/25. During an interview on 1/14/26 at 8:46 a.m., licensed practical nurse (LPN)-A stated R7 left around 5:00 a.m. for dialysis and arrived back to the care facility around 10:00 a.m. LPN-A stated the facility staff sent along an envelope with the dialysis communication sheet in it but that the facility staff often did not receive the sheet back from dialysis. During an interview on 1/14/26 at 12:25 p.m., the assistant director of nursing (ADON) stated it was expected that staff send the dialysis communication sheet with residents to dialysis, and the nurse was expected to review the sheet for new orders or residents' status when they returned from dialysis. During a follow up interview on 1/15/26 at 9:08 a.m., the ADON confirmed the most current dialysis communication sheet for R7 was from October, stating, "we send the sheet and it doesn't always come back." During an interview on 1/15/26 at 10:50 a.m., the director of nursing confirmed it would be expected that the nurses are following up with the dialysis communication sheets, stating, "we try our best but there is always communication breakdown." A facility policy titled Dialysis Services via Contracted Vendor, revised 5/28/24, indicated, "the licensed nurses have ongoing communication and collaboration with the dialysis facility regarding dialysis care and services."	F0698	Continued from page 16 the unit nurse, and uploaded into the resident's medical record. LIKE RESIDENT(S): All other residents receiving dialysis services will have dialysis referral forms sent to the dialysis provider to support effective communication and continuity of care. EDUCATION: Dialysis Services via Contracted Vendor policy reviewed and remains current. . Licensed nursing staff and nursing assistants were re-educated requirement that dialysis communication/referral forms are returned to the unit nurse for review and then forwarded to Medical Records for uploading into the resident's chart. AUDITS: The Director of Nursing or designee will complete audits of three resident medical records to verify that dialysis referral forms are returned and properly filed. Audits will be conducted weekly for four weeks, biweekly for one month, and then monthly for three months. Audit results will be presented monthly to the Quality Council, with additional actions taken as indicated. Date of Compliance: February 18th, 2026	
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F0812	This plan of correction constitutes the facility's credible allegation of compliance.	02/18/2026

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F0812 SS = F	Continued from page 17 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure frozen food items were stored in a manner to reduce the risk of cross contamination and potential foodborne illness in a walk-in freezer. The facility failed to ensure scoops were not stored in 2 of 3 bulk containers to prevent cross contamination. The facility also failed to ensure hair and beard nets were used in the food preparation area and kitchen utensils sanitizing area. In addition, the facility failed to consistently monitor the dishwasher machine temperature. This had the potential to affect all 98 residents, staff, and visitors who consumed food from the facility kitchen. Findings include: On 1/12/26 at 1:19 p.m., an initial kitchen tour was completed with cook/kitchen supervisor (C)- A, the following was observed: Walk-in freezer - One speed rack had 2 trays of uncovered, unlabeled, uncooked hamburger patties. One of the trays had 5	F0812	Continued from page 17 Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F-812 – Food Procurement, Store/Prepare/Serve-Sanitary Walk-In Freezer CITED RESIDENT(S): All food will be stored in a safe manner in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. Food will be stored in protective covering/container with visible date and label of product. LIKE RESIDENT(S): All food will be stored in a safe manner in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. Food will be stored in protective covering/container with visible date and label of product. EDUCATION: All dietary staff will be re-trained on proper Food Storage, Dating and Labeling. AUDITS: Food Service Director or designee will conduct and document a daily sanitation check list to ensure all foods stored are properly covered/sealed, dated and labeled. Bulk Food Containers CITED RESIDENT(S): All bulk food containers and lids will be kept clean to prevent cross contamination in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. Scoops or any other utensil will not be allowed to be left in the container. LIKE RESIDENT(S): All bulk food containers and lids will be kept clean to prevent cross contamination in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. Scoops or any other utensil will not be allowed to be left in the container. EDUCATION: All dietary staff will be re-trained on proper Food Storage, Dating and Labeling. AUDITS: Food Service Director or designee will conduct and document a daily sanitation check list to ensure all foods stored are stored safely and properly.	

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F0812 SS = F	Continued from page 18 frozen hamburger patties and the other one had 7 - A second speed rack had one tray of 15 uncooked fish filets which were uncovered, and unlabeled. Bulk containers - The lids of a triple bulk container used to store flour, white rice, and brown rice contained debris of flour and rice. Scoops were observed inside the flour and white rice bins. Hair nets - Dietary aid (DA)-A was sanitizing and storing dishes and cookware was not wearing a hair net. High temp dish machine -The log labeled January 2026 had no temperatures recorded on January 1st, 2nd, 3rd and 7th. On January 5th, 2 out of three temps were recorded, and on January 6th, 8th, 9th, 11th and 12th only one of three were recorded. -During the initial tour DA-A was actively using the dish machine. A cycle was observed and the wash cycle temp indicated 150 degrees Fahrenheit (F) while the rinse cycle indicated 180 degrees F. C-A stated the wash temp was low and it should be160 degrees. CA-A did not provide additional instruction to DA-A who continued to use the dish machine. On 1/12/26 at 4:15 p.m. a subsequent kitchen tour was completed. At 4:19 p.m. C-B was setting up the steam table, gathering serving tools, and removing buns from a plastic bag for dinner and placing them on an open tray next to the steam table. C-B had a full beard, about 1 inch long below his chin. C-B stated, “I didn’t know I had to wear a beard net.” During interview on 1/12/26 at 4:23 p.m., food service director (FSD) stated C-A had updated him regarding the concerns found during the initial kitchen tour. Regarding the use of hair and beard nets, FSD stated, “my staff knows better.” FSD added the kitchen staff needs to use hair and beard nets. During this interview C-B entered the FSD’s office and asked where he could find the beard nets. FSD pointed to a shelf in his office, C-B took one and started to put it on as he left FSD’s office. During a subsequent visit to the kitchen on 1/13/26 at 12:01 p.m., FSD stated the dishwasher broke while the	F0812	Continued from page 18 Hairnets/Beard nets CITED RESIDENT(S): Hair Restraints including beard nets will always be worn by dietary staff when in the kitchen during preparation, serving, and plating of food in addition to handling soiled and cleaned dishware and equipment in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. LIKE RESIDENT(S): Hair Restraints including beard nets will always be worn by dietary staff when in the kitchen during preparation, serving, and plating of food in addition to handling soiled and cleaned dishware and equipment. in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. EDUCATION: All dietary staff will be re-trained on Food Code Requirement and Hygiene Expectations. AUDITS: Food Service Director or designee will conduct and document a daily sanitation check list to ensure all dietary staff are adhering to eh Hair/Beard Net requirements. High Temp Dish Machine CITED RESIDENT(S): The facility will operate and maintain the proper operation of the high temp dish machine in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. LIKE RESIDENT(S): The facility will operate and maintain the proper operation of the high temp dish machine in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. EDUCATION: All dietary staff will be re-trained on the Proper Operating Procedures of the High Temp Dish Machine. AUDITS: Food Service Director or designee will visibly check and ensure accurate documentation daily of the dish machine to ensure the high temp dish machine is operating properly.	

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F0812 SS = F	Continued from page 19 staff was washing the breakfast plates that morning. FSD stated they were going to use disposable plates and cups until the wash machine was repaired. Food Storing and kitchen sanitary, and cleaning schedule policies were requested but not received. During observation and interview on 1/14/26 at 11:13 a.m. dietary aid DA-A was washing pots and stainless-steel bins. The dish machine cycle was observed, and the wash cycle indicated 109.6 degrees, and the rinse cycle temp was 194 degrees. DA-A stated he had not paid attention to the temperatures. The dish machine temperature log had no documentation of the morning temp. The Ecolab Service Call Summary dated 1/14/26 at 9:47 p.m., indicated "Scale issues are causing issues that require deliming until Softener is repaired". The document indicated the wash temperature was 162 degrees F and rinse temperature was 183 degrees, both "In Range". Additional comments included "Machine Condition: Issue Found", and "Lime scale buildup due to down water softener. Will need to delime more frequently in the interim." The Ecolab Extra Service Request dated 1/14/26 at 9:44 p.m., indicated the facility requested service for the EC-44 Dish Machine as it was "In constant wash cycle and wasting chemicals; attempted flipping delime switch". Service Comments included "Found a metal lid tucked behind first paddle". During observation and interview on 1/15/26 at 9:31 a.m., breakfast dishes were being washed in the dish machine and the cycle was observed. The wash temperature rose to 108 degrees F, and the rinse temperature rose to 194.3 degrees. DA-B confirmed the wash temperature was low. DA-B prepared to load another tray of dishware for machine washing. During interview on 1/15/26 at 9:50 a.m., FSD responded to the following concerns:Wash machine - FSD stated he was not informed about the wash machine temperatures observed that morning at 9:31 a.m. FSD stated they were having problems with the wash machine. FSD stated an engine component broke 6 weeks ago, but the technician forgot to fill the component with oil and the machine broke again on Tuesday 1/13/26. FSD added, yesterday 1/14/26 “the wash cycle was stuck and would not go to the rinse cycle.” FSD stated every time the wash machine was serviced, the ECOLAB technician emailed a service report. Hair and beard nets - FSD stated he had talked repeatedly to the staff about the use of hair and beard nets. FSD stated “on a regular basis I found	F0812		

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F0812 SS = F	Continued from page 20 staff not wearing hair nets". FSD stated he expected staff to wear hair and beard nets to prevent hair falling in the food, cooking or serving gear. Food storage - FSD stated storing uncovered food in the freezer was "honestly, lazy." All items on the speed racks should be individually covered or cover the whole cart with a proofing bag. FSD stated it was unsanitary because "something can land on it."Bulk containers - FSD stated the scoops should not be left inside the containers because it was a concern for cross contamination. During interview on 1/15/26 at 1:08 p.m., FSD stated the water softener had been down for weeks, and with that not functioning properly, lime and scale had built up in the heating element of the dishwasher. He stated the water softener was back online as of last Friday, but the dishwasher might not be getting soft water yet as it took a while to work through the system. He stated the scaling was building up "pretty badly" and the heating element didn't run consistently because of that. They used lime away and a descaler and reached out to Ecolab tech and there will be a deep scrub on the heating element. FSD stated they had not had a scrub done previously, and it has been an ongoing situation. FSD stated the heating element fluctuated from time to time, and it was a difficult problem because it was inconsistent. When staff notice the temperature is out of range, they should address the temperature and delime it and go back to normal operation. He stated the facility did not have a 3-compartment sink, and they found the issue on Tuesday and then used full disposable dishware. He indicated the service tech was in the facility this afternoon. During interview on 1/15/26 at 1:00 p.m., the administrator stated storing uncovered fish filets and hamburger patties was concerning, not only for cleanliness but because it could affect the patients. Administrator stated she expected the staff to wear hair and beard nets because it was a standard practice, so they did not get hair in the food. Regarding the storage of scoops on dry goods, the administrator stated the scoops should be stored outside of them. Regarding the wash machine, the administrator stated the facility needed to have an appropriate temperature to be in regulation. The Ecolab EC-44 Dishmachine brochure dated 2012, indicated a required wash temperature of 160 degrees F and a rinse temperature of 180 degrees F. The undated facility policy titled Dishwashing Procedures, indicated the facility will implement dishwashing practices that prevent the spread of food-borne illness. The dish machine will be operated	F0812		

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F0812 SS = F	Continued from page 21 in accordance with the manufacturer's instructions.	F0812		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/12/26 to 1/15/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.	20000		02/18/2026

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed with NO licensing orders issued. H56103123C (MN00107776) H56103122C (MN00108406) H56103120C (MN00110401) H56102083C (IQIES 2700198) H56103413C (IQIES 2714096) H56103121C (IQIES 1133928) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		

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20000 20920	Rehab - ADLs CFR(s): MN Rule 4658.0525 Subp. 6 B Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 4 residents (R45) reviewed for activities of daily living (ADLs) and were dependent on staff for their ADLs, routinely had their fingernails cleaned and trimmed. Findings include: R45's quarterly Minimum Data Set (MDS) 10/25/25, indicated R45 had intact cognition and was diagnosed with arthritis. R45 was dependent on staff for toileting hygiene, lower body dressing, and putting on and taking off footwear. The MDS indicated R45's most recent admission/entry to the facility was on 7/23/25. R45's Weekly Skin Checks dated 11/7/25 through 1/9/25, included a section with the question "Was nail care completed?" with the options of fingernails trimmed, toenails trimmed, refused, or not necessary. All checks from this period were either checked as not necessary or left blank. R45’s care plan dated 1/9/25, indicated she had a self-deficit with ADLs such as grooming, bathing, and oral care. R45's medical record was reviewed and did not indicate R45 had refused toenail care. During an interview and observation on 1/12/26 at 2:43 p.m., R45 was observed sitting in a chair in her room. R45 stated that she felt like her toenails needed to be trimmed and confirmed that they were not causing her pain. R45 stated she didn't think anyone had offered to help her cut her toenails since she was admitted in July of this year. R45's toenails were observed to have grown past the end of her toes, with a varying nail length, and some toenail curling was observed.	20000 20920	Corrected.	02/18/2026

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20920	Continued from page 3 During an interview on 1/13/26 at 12:45 p.m., registered nurse (RN)-B stated that R45 was not a diabetic, so the aides could assist her with cutting her finger and toenails. When asked when the last time toenail clipping was completed or where it was documented RN-B stated she was not sure. During an interview and observation on 1/13/26 at 12:47 p.m., nursing assistant (NA)-C stated he had assisted R45 with her personal care this morning. NA-C was observed to lift R45's blanket, look at her toes, and state her toenails looked like they could use a trim. R45's toenails were observed to have grown past the end of her toes, with a varying nail length, and some toenail curling was observed. NA-C stated he didn't work on this unit very often, so he was not sure if R45 refused to get her toenails trimmed or the last time toenail trimming was completed. NA-C confirmed he had not offered to cut R45's toenails. During an interview on 1/14/26 at 8:22 a.m., RN-C, the clinical manager for the unit, stated she had reviewed R45's records and did not find evidence that R45 had gotten nail care or refused it recently. RN-C stated staff should either document nail care/nail care refusals in a progress note or on the weekly skin check observation form. RN-C stated she saw that staff had been documenting that it was not applicable to the question of whether R45 had her nails done. RN-C stated that after assessing R45's nails, she felt that they should have been previously cut, so she talked with R45 this week, and R45 had consent to having her toenails trimmed. RN-C stated she was unable to cut all of her toenails, so she was going to ensure a consult was made with podiatry for additional nail care. RN-C stated the nurse was supposed to assess the resident's nails on bath days and ensure that nail care was completed as necessary. The facility's Activities of Daily Living policy dated 7/21 was received but did not include guidance regarding nail care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable care plans and policies to ensure hygiene and personal care needs are provided to dependent residents; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 days	20920		
21100	Food Supplies; Storage of Perishable food CFR(s): MN Rule 4658.0650 Subp. 5	21100	Corrected.	02/18/2026

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21100	Continued from page 4 Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure frozen food items were stored in a manner to reduce the risk of cross contamination and potential foodborne illness in a walk-in freezer. The facility failed to ensure scoops were not stored in 2 of 3 bulk containers to prevent cross contamination. This had to potential to affect all 98 residents, staff, and visitors who consumed food from the facility kitchen. Findings include: On 1/12/26 at 1:19 p.m., an initial kitchen tour was completed with cook/kitchen supervisor (C)- A, the following was observed: Walk-in freezer - One speed rack had 2 trays of uncovered, unlabeled, uncooked hamburger patties. One of the trays had 5 frozen hamburger patties and the other one had 7 - A second speed rack had one tray of 15 uncooked fish filets which were uncovered, and unlabeled. Bulk containers - The lids of a triple bulk container used to store flour, white rice, and brown rice contained debris of flour and rice. Scoops were observed inside the flour and white rice bins. During interview on 1/15/26 at 9:50 a.m., FSD responded to the following concerns:Food storage - FSD stated storing uncovered food in the freezer was “honestly, lazy.” All items on the speed racks should be individually covered or cover the whole cart with a proofing bag. FSD stated it was unsanitary because “something can land on it.”Bulk containers - FSD stated the scoops should not be left inside the containers because it was a concern for cross contamination.During interview on 1/15/26 at 1:00 p.m., the administrator stated storing uncovered fish filets and hamburger patties was concerning, not only for cleanliness but because it could affect the patients. Regarding the	21100		

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21100	Continued from page 5 storage of scoops on dry goods, the administrator stated the scoops should be stored outside of them. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to administer baseline tuberculosis (TB) screening for 5 of 6 (RN-C, RN-F, LPN-A, NA-H, NA-I) staff members reviewed for testing. This had the potential to affect all residents, staff and visitors of the facility.	21426	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Identified Employee(s): The facility immediately reviewed employee health files upon notification of the deficiency. It was identified that the TB Screening Tool was not present in the employee health record due to an oversight during annual compliance review. The affected employee(s) completed the TB Screening Tool, and results were reviewed and documented per facility policy and Minnesota Department of Health requirements. No evidence of action tuberculosis was identified. Other Employee(s): The facility conducted a full audit of employee health files to ensure the presence of a completed TB Screening Tool in accordance with MDH and CDC guidelines. Any missing documentation identified during the audit was corrected immediately. Audit: All current employees will have a completed TB Screening Tool on file. A standardized TB Screening Tool has been added to new hire onboarding packets. Human Resources or Designee is responsible for	02/18/2026

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21426	Continued from page 6 Findings include: The Centers for Disease Control (CDC) guidelines for preventing the transmission of mycobacterium tuberculosis (TB) in Health Care Settings, 2019, directed that all residents and staff (Pre-placement) must receive a baseline TB screening. The baseline TB screening should consist of assessment for TB risk factors and history; assessment for current symptoms of active TB; and testing for the presence of infection with mycobacterium tuberculosis. Employee file for registered nurse (RN)-C indicated RN-C started at facility on 2/21/22. A document was provided indicating a QuantiFERON -TB gold (blood test for TB exposure) test result was completed on 12/13/21. This was followed by a chest x-ray which was completed on 2/21/22 indicating no evidence of active tuberculosis. The employee file lacked evidence of a baseline TB screening being completed. Employee file for RN-F indicated RN-F started at facility on 9/16/25. A document was provided indicating a QuantiFERON -TB gold test was completed on 9/9/25. The employee file lacked evidence of a baseline TB screening being completed. Employee file for licensed practical nurse (LPN)-A indicated LPN-A started with the company on 7/15/24 and transferred to the facility on 10/9/25. A document was provided indicating an x-ray was completed for TB on 12/1/23 which indicated no evidence of active TB. The employee file lacked evidence of a baseline TB screening being completed. Employee file for nursing assistant (NA)-H indicated NA-H started at facility on 7/23/25. A document was provided indicating a QuantiFERON -TB gold test was completed on 7/17/25. The employee file lacked evidence of a baseline TB screening being completed. Employee file for NA-I indicated NA-I started at facility on 12/12/25. A document was provided indicating a chest x-ray had been completed on 12/8/25 and was negative for active tuberculosis. The employee file lacked evidence of a baseline TB screening being completed. During an interview on 1/15/26 at 8:56 a.m., assistant director of nursing (ADON) verified she was the infection preventionist for the facility. ADON stated staff are tested for TB prior to starting at the facility and the do the QuantiFERON-TB gold test. ADON stated this was done so “we don’t have TB in the	21426	Continued from page 6 verifying completion and documentation during onboarding. Human Resources or Designee will conduct ongoing audits to ensure compliance. Monthly audits of employee health files for three months, and quarterly audits thereafter for one (1) year. Date of Compliance: February 18th, 2026.	

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21426	Continued from page 7 building." ADON stated TB was very contagious and the facility was not able to care for residents with TB. ADON stated human resources tracks staff TB testing. ADON was not sure if a baseline TB screen was completed with staff. During an interview on 1/15/26 at 11:08 a.m., director of nursing (DON) stated upon hire staff complete a baseline TB screening along with a QuantiFERON-TB gold test. DON verified the staff results above and verified RN-C, RN-F, LPN-A, NA-H and NA-I did not have baseline TB screenings completed. DON indicated it was important all screenings and testing are completed as staff could have TB and that would affect residents and other staff. During an interview on 1/15/26 at 11:21a.m., administrator reviewed employee files provided. Administrator requested to follow up. During a follow up interview on 1/15/26 at 12:36 p.m., administrator verified the facility did not have the baseline TB screening for the staff requested. A facility policy titled Tuberculosis Program for Associates, revised 6/22/23, indicated "every new associate will begin by filling out the personal risk assessment and symptom review. This will be reviewed by the IP to determine if further testing is required, or if the associate indicates they have a high-risk condition." "For communities in MN, MO and ND and WI, or those that have positive risk assessment, a tuberculin skin test (TST) or blood test (QuantiFERON or T-spot), depending on community preference, will be performed on newly hired associates." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review tuberculosis policies and procedures to ensure compliance. The director of nursing (DON) or designee could review the screening process for staff to be sure the documentation of the TB screening are completed per guidelines. The DON or designee could audit for screening and TB testing for residents and staff. The results of these audits could be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21535	Unnecessary Drug Usage; General CFR(s): MN Rule4658.1315 Subp.1 ABCD	21535	Corrected.	02/18/2026

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21535	Continued from page 8 Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide and document an appropriate diagnosis for a prescribed psychotropic medication for 1 of 5 (R100) residents and failed to provide appropriate side effect monitoring (i.e., orthostatic blood pressure) with antipsychotic medication consumption for 1 of 3 (R49) residents reviewed for unnecessary medication use. Findings include: R100's quarterly Minimum Data Set (MDS), dated 10/30/25, indicated R100 was admitted to the care facility on 6/14/22 and was cognitively intact. The MDS further indicated R100 had no documented hallucinations or delusions during the look-back period. R100's Diagnoses List, indicated R100 had diagnoses including vascular dementia, history of stroke and adjustment order with anxiety. R100's Physician Order Report, dated 12/1/25 - 12/31/25, indicated an order, dated 9/11/25, for Abilify 5 milligrams (mg) once a day for bothersome and frightening hallucinations. R100's Consultant Pharmacist Recommendation to Physician, printed 12/29/25, indicated, "this resident [R100] is receiving antipsychotic agent Aripiprazole [Abilify] (currently listed on the MAR for hallucinations), but lacks an allowable diagnosis to support its use." R100's	21535		

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21535	Continued from page 9 progress note, dated 1/13/26, indicated the nurse practitioner reviewed the pharmacist recommendation from December and due to R100 not having an appropriate diagnosis for antipsychotic medication the Abilify was discontinued. During an interview on 1/14/26 at 12:25 p.m., the assistant director of nursing (ADON) stated it would be expected that the nurse managers review psychotropic medications for an appropriate diagnosis when ordered, stating the pharmacist will also review medications and inform the facility staff if there is not an appropriate diagnosis attached to the medication order, confirming R100's Abilify, ordered 9/11/25, did not have an appropriate diagnosis. A facility policy titled Psychotropic Medication Use, reviewed 9/7/23 indicated "psychotropic medications are ordered by the medical provider to treat a specific condition as diagnosed and documented in the medical record." R49's admission Minimum Data Set (MDS) assessment, dated 10/20/25, indicated R49 had intact cognition with no hallucinations or delusions and no behavioral symptoms including physical or verbal behavioral symptoms directed at others, or behavioral symptoms not directed toward others. Further it indicted R49 received an antipsychotic medication. R49's January 2026 Medication and Treatment Administration Record (MAR)/TAR), printed 1/15/26, included the following orders: -aripiprazole (antipsychotic medication used to treat mental/mood disorder) 10 milligram (mg) tablet – give 10 mg by mouth at bedtime for moderate episode of recurrent major depressive disorder with a start date of 10/14/25. Medication was documented as administered every day in January. -orthostatic blood pressure related to antipsychotic use once a month on the 14th with a start date of 10/14/25. The MAR/TAR indicated a signature of completion. The document lacked documentation of the blood pressures. -per therapy recommendations: discontinue assist of 2 with sara steady assist of 1 with sara steady for all transfers. Knee brace as needed for comfort with a start date of 1/5/26. -per therapy recommendations: discontinue ceiling lift assist of 2 with sara steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26.	21535		

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21535	Continued from page 10 R49's December 2025 MAR/TAR included the following orders: -aripiprazole (antipsychotic medication used to treat mental/mood disorder) 10 milligram (mg) tablet – give 10 mg by mouth at bedtime for moderate episode of recurrent major depressive disorder with a start date of 10/14/25. Medication was documented as administered every day in December. -orthostatic blood pressure related to antipsychotic use once a month on the 14th with a start date of 10/14/25. The MAR/TAR indicated a signature of completion. The document lacked documentation of the blood pressures. -per therapy recommendations: discontinue ceiling lift assist of 2 with sara steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26. -per therapy recommendations: discontinue ceiling lift. Assist of 2 staff with sara steady for all transfer.KI on right lower extremity at all times except skin checks. Please support right lower extremity to maintain right knee during extension during transfers. No ambulation at this time with a start date of 12/16/25 and discontinue date of 12/18/25. -per therapy recommendations: discontinue ceiling lift. Assist of 2 with sara steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26. R49's care plan, printed 1/15/26, identified the following: -Under Activities of Daily Living (ADL)s Functional category, the care plan identified R49 had a self-deficit with ambulation, transferring, mobility, oral cares, grooming and bathing and indicated "Resident has a tendency to self-transfer, self-ambulate, and not use her call button for assistance." -Under the Mood state category, the care plan identified R49 had a diagnosis of major depressive disorder and to "obtain monthly orthostatic blood pressure per pharmacy recommendations."	21535		

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21535	Continued from page 11 R49's blood pressure and pulse logs for 12/1/25 to 1/15/26 were reviewed. The document lacked evidence of orthostatic blood pressure being completed and documented. R49's progress notes for 12/1/25 to 1/15/26 were reviewed. The document lacked evidence of orthostatic static pressures being completed and documented. During an interview on 1/15/26, R49 was observed sitting in her wheelchair. R49 stated things were going well, denied any concerns and engaged in the conversation. During an interview on 1/15/26 at 10:20 a.m., licensed practical nurse (LPN)-B stated if a resident needed to have orthostatic blood pressures taken then an order was put in the electronic medical record (EMR). LPN-B stated the orders would show up under the treatments and documented on the MAR/TAR, and the vital signs would flow over to the vital signs section of the EMR. LPN-B stated some residents who were on antipsychotic medications had orders for orthostatic blood pressures to be taken but not all residents. LPN-B was not sure how it was decided who needed to have orthostatic blood pressures taken when a resident was on antipsychotic medications and stated the health unit coordinator or nurse manager put the orders in. LPN-B verified R49 had an order to have orthostatic blood pressures taken monthly and verified it was signed off for 12/14/25 and 1/14/26 as completed. LPN-B verified there were not blood pressures on the MAR/TAR and no blood pressures entered in the vital signs section of the EMR on 12/14/25 or 1/14/26. LPN-B stated, "it looks like they weren't done." LPN-B stated R49 was able to stand with assist of 1 and EZ stand (device that assists person to stand). LPN-B stated there was a risk of orthostatic hypotension when a person took antipsychotic medication(s). During an interview on 1/15/26 at 11:04 a.m., director of nursing (DON) stated the expectation would be any resident on an antipsychotic medication should be getting orthostatic blood pressures done monthly. DON stated it's important to monitor orthostatic blood pressures as antipsychotic medications can affect blood pressures which can increase falls. DON could not find any orthostatic blood pressures documented for R49 the last few months. A facility policy titled Psychotropic Medication Use,	21535		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	**1850 SARAZIN STREET , SHAKOPEE, Minnesota, 55379**

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21535	Continued from page 12 reviewed 9/7/23, indicated “When psychotropic medications are ordered, the IDT identifies target behaviors, medication side effects to be monitored and implements a resident centered care plan with both non-pharmacologic and pharmacological interventions.” SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review records of residents prescribed medications for appropriate monitoring and diagnosis. Education of appropriate staff could be provided. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure a resident was appropriately assessed and had an appropriate order in place to self-administer nebulizer medication for 1 of 1 resident (R80) reviewed for self-administration of medications. Findings include: R80's significant change Minimum Data Set (MDS), dated 11/16/25, indicated R80 was cognitively intact and required partial to moderate assistance with most activities of daily living. R80's active orders, printed 1/15/26, contained an order for albuterol sulfate for nebulization once a day in the morning and three times a day as needed for difficulty breathing, shortness of breath, wheezing and/or bronchospasm prevention. R80's care plan, dated 10/30/25, indicated, "I [R80] will independently administer respiratory treatments as ordered and I will receive assistance setting up, disassembling, and cleaning respiratory equipment from a licensed nurse." with interventions to include, "acquire physician's order for self-administration of respiratory treatments" and, "perform a self-administration medication assessment per facility protocol."	21565	Corrected.	02/18/2026

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21565	Continued from page 13 R80's electronic medical record lacked an order and an assessment for self-administration of her respiratory treatments (i.e. albuterol sulfate via nebulization).During an interview on 1/14/26 at 10:30 a.m., licensed practical nurse (LPN)-A stated R80 administered her nebulizer independently. She indicated licensed staff would put the medication in the nebulizer and leave R80 with the medication who would turn off the nebulizer machine on her own when the medication was gone, stating he checked back with her in 10-15 minutes after starting the nebulizer. During observation on 1/14/26 at 11:45 a.m., LPN-A entered R80's room, handed her the hand-held nebulizer mouthpiece, already filled with the albuterol medication, turned on the nebulizer machine, and left R80 to self-administer the medication independently. During an interview on 1/15/26 at 9:08 a.m., the assistant director of nursing (ADON) confirmed there was not an order or assessment in place for R80 to self-administer her nebulizer medication and that it would be expected to have those in place prior to self-administration of any medications. A facility policy titled Self-Administration of Medications, revised 4/10/25, indicated each resident will be assessed for the ability to physically and mentally self-administer any medication and, if deemed appropriate, a physician order would be obtained to self-administer the assessed medications. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review residents who are on nebulized medication to ensure the proper assessments and orders are in place. Education of appropriate staff could be provided. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21705	Plant Housekeeping, Operation, & Maintenance CFR(s): MN Rule 4658.1415 Subp. 6 Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees	21705	Corrected.	02/18/2026

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21705	Continued from page 14 Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident rooms were maintained at a comfortable temperature between 71 and 81 degrees Fahrenheit for 1 of 1 residents (R57) reviewed who indicated their rooms were cold. Findings Include: R57's admission Minimum Data Set (MDS) assessment, dated 12/22/25, indicated a diagnosis of cerebral infarction (stroke) with intact cognition. During an interview on 1/12/26 at 5:19 p.m., R57 stated his room was cold. R57 was observed wearing a winter coat while sitting in a recliner chair in his room between the bed and the window which he reported was where he spent the majority of his time. R57 stated he had reported his concerns to staff and had been told "this room is always like this." R57 stated, "I am froze." The thermostat on the wall indicated 72.9 degrees Fahrenheit (F). At 5:50 p.m., surveyor obtained temperatures in the room: 66.2 degrees F by the tv, 68.3 degrees F around the chair R57 was sitting in, and 67.7 degrees F between the chair and the wall. During an interview on 1/12/26 at 5:58 p.m., nursing assistant (NA)-C stated R57 had complained of his room being cold about a week or so ago. NA-C stated he thought a form had been filled out for maintenance to look at R57's room temperature. NA-C verified that R57 was wearing a winter coat due to being cold when he brought him to the bathroom this evening. During a follow up interview on 1/13/25 at 9:55 a.m., R57 stated he did not use his personal refrigerator as it was cold enough in the room to keep items on the counter to keep them cold. On 1/14/26 at 10:46 a.m., surveyor obtained temperatures in R57's room. It was 66.5 degrees F around R57's chair.	21705		

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21705	Continued from page 15 During an interview on 1/14/26 at 12:20 p.m., director of maintenance (DOM) stated that he had received a complaint of R57's room being cold last week and had the vendor come out and look at his room. DOM stated after the vendor was out, the room was above 71 degrees F. The next day, DOM check the room temperature via computer as temperatures can be checked from the thermostats via computer without having to disrupt the residents. He stated the computer indicated the room was above 71 degrees F. DOM and surveyor obtained temperatures in R57's room: the area around R57 was 69.7 degrees F, and the middle of the room was 70.2 degrees. R57's thermostat indicated 72.3. DOM stated R57's room temperatures are not within the required 71-81 degrees F and would call the vendor out again. During an interview on 1/15/26 at 11:15 a.m., administrator stated temperatures are to be between 71-81 degrees F. Administrator stated the vendor came out yesterday for R57's room and switched the wires. Administrator stated the room was currently temping at 74 degrees F where the resident sits. A facility policy on room temperatures was requested and not received. SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could develop and implement policies and procedures to ensure resident rooms are maintained at a comfortable temperature and educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21705		
21810	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 6 Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to accommodate resident needs by ensuring the call light was accessible for 1 of 1 resident (R26) reviewed	21810	Corrected.	02/18/2026

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21810	Continued from page 16 for call lights. Findings include: R26's quarterly Minimum Data Set (MDS) dated 1/12/26, identified R26 with impaired cognition, no rejection of cares or wandering, impairment in lower extremity range of motion, required a walker or wheelchair for mobility, and needed partial to moderate assistance with dressing, transfers, and hygiene. Diagnoses include heart failure, kidney disease, arthritis, depression and anxiety. During observation and interview with R26 on 1/12/26 at 5:01 p.m., R26 was lying in bed with call light out of reach on nightstand next to head of bed. R26 stated she could not see it and wanted assistance to get up out of bed to go to dinner. "Normally I use the call light if I need help. If it is out of reach then I make noise to get attention to get [staff] to answer my pleas." During observation and interview with nursing assistant (NA)-B on 1/12/26 at 5:04 p.m., NA-B verified R26's call light was out of reach, "It should be in reach to ask for help". During interview with NA-D on 1/15/26 at 6:52 a.m., NA-D stated it was important to place the call light "next to patients at all times. If out of reach the residents can fall. For safety." During interview with registered nurse (RN)-G on 1/15/26 at 7:04 a.m., RN-B stated, "[staff] always make sure [call light] is in reach and [residents] know how to use it." During interview with director of nursing (DON) on 1/15/26 at 9:57 a.m., DON stated expectation of staff to place the call light call within reach at all times so residents can call for help if needed. Facility policy titled Call Lights-Call System Activation and Response dated 5/28/2024 identified:Each resident is provided with a means to call staff directly for assistance. The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to	21810		

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21810	Continued from page 17 ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BLDG THREE NEW ... B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/13/2026. At the time of this survey, ST GERTRUDES HEALTH AND REHABILIATION CENTER found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		05/28/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BLDG THREE NEW ... B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. ST GERTRUDES HEALTH AND REHABILIATION CENTER was constructed at 4 different times. The original 1-story building with no basement was constructed in 1996 and was determined to be of Type V (111) construction. In 1999, an addition was constructed to the East Wing that was determined to be of Type V (111) construction. In 2007 a 1-story addition with no basement was constructed and was determined to be of Type V (111) construction. In 2011 a 2-story building with a full basement was constructed and was determined to be of Type II (222). Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility has a capacity of 105 beds and had a census of 100 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		
K0344 SS = F	Fire Alarm - Control Functions CFR(s): NFPA 101	K0344	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not	02/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **03 - BLDG THREE NEW ...** B. WING	**01/13/2026**

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K0344 SS = F	Continued from page 2 Fire Alarm - Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain alternative power supply documentation per NFPA 101 (2012 edition), Life Safety Code, section 19.3.4.4 and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.9. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/13/2026 between 11:00 AM and 3:00 PM, it was revealed by a review of available documentation that documentation presented for review was incomplete. Alternative power supply (battery back-up) change / install date(s) were incomplete for resident sleeping room(s) having smoke detection, interconnect to Nurse-call. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0344	Continued from page 2 constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. K-344 – Fire Alarm – Control Functions: Documentation to be completed for alternative power supply (battery back-up) including the change / install date (s) in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.4.4. and NFPA 72 (210 edition), National Fire Alarm and Signaling Code, section 14.4.9. Plant Operations Director or designee will monitor monthly compliance of documentation to ensure thoroughness of timely completion and compliance. Date of Compliance: February 18th, 2026.	
K0353 SS = D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K0353	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. K-353 – Sprinkler System – Maintenance and Testing: Summit visited on 02/05/2026 to resolve the sprinkler head in Family Rm (RM 115) exhibiting signs of paint splatter. Plant Ops Director or designee will monitor yearly ensuring compliance of any new paint around sprinkler heads. Date of Compliance: February 18th, 2026.	02/18/2026

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K0353 SS = D	Continued from page 3 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2, 5.2.1.1.2(6). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/13/2026 at 12:45 PM, it was revealed by observation that in the Family Rm (RM 115) sprinkler head(s) exhibiting signs of paint splatter. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353		
K0374 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility	K0374	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. K-374 – Subdivision of Building Spaces – Smoke Barrier Doors: Smoke Barrier Doors will be reviewed to test, maintain, and inspect per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4, ensuring no allowance of passage of smoke. Smoke Barrier Doors test, maintenance and inspection is in TELs for monitoring to ensure compliance. Plant Ops Director or designee will monitor yearly compliance of this inspection. Due to the nature of product availability, the facility is unable to make corrections within the 60 day requirement as indicated in completion date and facility is requesting a waiver for extension.	03/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BLDG THREE NEW ... B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	1850 SARAZIN STREET , SHAKOPEE, Minnesota, 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0374 SS = F	Continued from page 4 failed to test, maintain, and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include:On 01/13/2026 at 1:00 PM, it was revealed by observation that the smoke barrier door assembly by RM 141, did not close and seal the opening, which would allow the passage of smoke. On 01/13/2026 at 1:15 PM, it was revealed by observation that the 400 Wing, smoke barrier door assembly did not close and seal the opening, which would allow the passage of smoke. On 01/13/2026 at 2:00 PM, it was revealed by observation that the Basement smoke barrier door assembly, did not close and seal the opening, which would allow the passage of smoke. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0374		
K0761 SS = F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.3, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. These	K0761	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. K-761 – Maintenance, Inspection & Testing – Doors: Facility will inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.3, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. Doors to function properly upon test which includes doors to not be damaged, close appropriate, and seal the opening upon test. Maintenance, Inspection & Testing of doors is in TELs for monitoring to ensure compliance. Plant Ops Director or designee will monitor yearly compliance of this inspection. Due to the nature of product availability, the facility is unable to make corrections within the 60 day requirement as indicated in completion date and facility is requesting a waiver for extension.	03/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BLDG THREE NEW ... B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	1850 SARAZIN STREET , SHAKOPEE, Minnesota, 55379

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K0761 SS = F	Continued from page 5 deficient findings could have a widespread impact on the residents within the facility. Findings include:On 01/13/2026 at 1:30 PM, it was revealed by observation that the 200 Wing egress door (North corridor) was damaged and did not function properly upon test. On 01/13/2026 at 1:40 PM, it was revealed by observation that the fire door assembly, separating the SNF from HOSP, had a damaged closure mechanism and the door would not close and seal the opening upon test. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K0761		
K0918 SS = F Bldg. 03	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by:	K0918	K-918 – Electrical Systems – Essential Electric System Maintenance and Testing: Facility will ensure that documentation is present for review to confirm that annual fuel quality testing is occurring. This is in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.8. Annual fuel quality testing is in TELs for monitoring to ensure compliance. Plant Ops Director or designee will monitor yearly compliance of this inspection. Due to the nature of the fuel testing completed on January 27th, 2026, the date of compliance is March 3rd, 2026.	03/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BLDG THREE NEW ... B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	1850 SARAZIN STREET , SHAKOPEE, Minnesota, 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0918 SS = F Bldg. 03	Continued from page 6 Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/13/2026 between 11:00 AM and 3:00 PM, it was revealed by a review of available documentation, that no documentation was presented for review to confirm that annual fuel quality testing is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0918		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 27, 2026

Administrator
St Gertrudes Health & Rehabilitation Center
1850 SARAZIN STREET
SHAKOPEE, MN 55379

RE: CCN: 245610
Cycle Start Date: December 18, 2025

Dear Administrator:

On January 6, 2026, we informed you that we may impose enforcement remedies.

On January 15, 2026, the Minnesota Departments of Health and Public Safety completed a revisit/survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 18, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 18, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 18, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed

care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 18, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Gertrudes Health & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 18, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E"tag), i.e., the plan of correction should be directed to:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 18, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare &

Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 27, 2026

Administrator
St Gertrudes Health & Rehabilitation Center
1850 SARAZIN STREET
SHAKOPEE, MN 55379

Re: State Nursing Home Licensing Orders
Event ID: 1DDFD3-H1

Dear Administrator:

The above facility survey was completed on January 15, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	1850 SARAZIN STREET , SHAKOPEE, Minnesota, 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 1/12/26- 1/15/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		02/18/2026
F0000	INITIAL COMMENTS On 1/12/26 to 1/15/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H56103123C (MN00107776) H56103122C (MN00108406) H56103120C (MN00110401) H56102083C (IQIES 2700198) H56103413C (IQIES 2714096) H56103121C (IQIES 1133928) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F0000		02/18/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	1850 SARAZIN STREET , SHAKOPEE, Minnesota, 55379

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F0000	Continued from page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure a resident was appropriately assessed and had an appropriate order in place to self-administer nebulizer medication for 1 of 1 resident (R80) reviewed for self-administration of medications. Findings include: R80's significant change Minimum Data Set (MDS), dated 11/16/25, indicated R80 was cognitively intact and required partial to moderate assistance with most activities of daily living. R80's active orders, printed 1/15/26, contained an order for albuterol sulfate for nebulization once a day in the morning and three times a day as needed for difficulty breathing, shortness of breath, wheezing and/or bronchospasm prevention. R80's care plan, dated 10/30/25, indicated, "I [R80] will independently administer respiratory treatments as ordered and I will receive assistance setting up, disassembling, and cleaning respiratory equipment from a licensed nurse." with interventions to include, "acquire physician's order for self-administration of respiratory treatments" and, "perform a self-administration medication assessment per facility protocol." R80's electronic medical record lacked an order and an assessment for self-administration of her respiratory treatments (i.e. albuterol sulfate via nebulization).During an interview on 1/14/26 at 10:30 a.m., licensed practical nurse (LPN)-A stated R80 administered her nebulizer independently. She indicated licensed staff would put the medication in the nebulizer and leave R80 with the medication who would turn off the nebulizer machine on her own when the medication was gone, stating he checked back with her	F0554	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F554 Resident Self-Admin Meds- Clinically Approp CITED RESIDENT(S): Resident R80 was evaluated for the appropriateness of self-administering a nebulizer following nursing set-up. Resident demonstrated the ability to safely self-administer the nebulizer after nurse set-up; order obtained from provider and care plan updated. LIKE RESIDENT(S): A facility-wide audit was conducted to identify other residents who self-administer nebulizers after nursing set-up. All residents identified have a completed self-administration evaluated, a provider order and care plan updated accordingly. EDUCATION: The Self-Administration of Medications policy was reviewed and remains current. Licensed nurses were re-educated that any resident with an order for a nebulizer will have a self-administration evaluation completed. If the resident is determined to be appropriate to self-administer medications, a provider order will be obtained, and the resident’s care plan will be updated accordingly. AUDITS: The Director of Nursing or designee will complete audits of five residents’ medical records to ensure that residents who self-administer nebulizers after nurse set-up have an appropriate assessment and provider order in place. Audits will be conducted weekly for four weeks, biweekly for one month, and then monthly for three months. Audit results will be presented monthly to the Quality Council, with additional actions taken as indicated. Date of Compliance: February 18th, 2026	02/18/2026

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St Gertrudes Health & Rehabilitation Center	1850 SARAZIN STREET , SHAKOPEE, Minnesota, 55379

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F0554 SS = D	Continued from page 2 in 10-15 minutes after starting the nebulizer. During observation on 1/14/26 at 11:45 a.m., LPN-A entered R80's room, handed her the hand-held nebulizer mouthpiece, already filled with the albuterol medication, turned on the nebulizer machine, and left R80 to self-administer the medication independently. During an interview on 1/15/26 at 9:08 a.m., the assistant director of nursing (ADON) confirmed there was not an order or assessment in place for R80 to self-administer her nebulizer medication and that it would be expected to have those in place prior to self-administration of any medications. A facility policy titled Self-Administration of Medications, revised 4/10/25, indicated each resident will be assessed for the ability to physically and mentally self-administer any medication and, if deemed appropriate, a physician order would be obtained to self-administer the assessed medications.	F0554		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to accommodate resident needs by ensuring the call light was accessible for 1 of 1 resident (R26) reviewed for call lights. Findings include: R26's quarterly Minimum Data Set (MDS) dated 1/12/26, identified R26 with impaired cognition, no rejection of cares or wandering, impairment in lower extremity range of motion, required a walker or wheelchair for mobility, and needed partial to moderate assistance with dressing, transfers, and hygiene. Diagnoses include heart failure, kidney disease, arthritis, depression and anxiety. During observation and interview with R26 on 1/12/26 at 5:01 p.m., R26 was lying in bed with call light out of reach on nightstand next to head of bed. R26 stated she could not see it and wanted assistance to get up out of bed to go to dinner. "Normally I use the call light if	F0558	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F558 Reasonable Accommodations Needs/Preferences CITED RESIDENT(S): Resident R26 was provided a pendant call light. LIKE RESIDENT(S): All other residents in long-term care were audited to ensure call lights were within reach. EDUCATION: Call Lights-Call System Activation and Response policy reviewed and remains current. Licensed nursing staff and nursing assistant were re-educated to ensure call lights are within reach while residents are in their room; specifically, when in their bed or other sleeping accommodation within the resident room. AUDITS: The Director of Nursing or designee will complete audits of five residents to confirm call lights are placed within in their room. Audits will be conducted weekly for four weeks, biweekly for one month, and then monthly for three months. Audit results will be presented monthly to the Quality Council, with	02/18/2026

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F0558 SS = D	Continued from page 3 I need help. If it is out of reach then I make noise to get attention to get [staff] to answer my pleas." During observation and interview with nursing assistant (NA)-B on 1/12/26 at 5:04 p.m., NA-B verified R26's call light was out of reach, "It should be in reach to ask for help". During interview with NA-D on 1/15/26 at 6:52 a.m., NA-D stated it was important to place the call light "next to patients at all times. If out of reach the residents can fall. For safety." During interview with registered nurse (RN)-G on 1/15/26 at 7:04 a.m., RN-B stated, "[staff] always make sure [call light] is in reach and [residents] know how to use it." During interview with director of nursing (DON) on 1/15/26 at 9:57 a.m., DON stated expectation of staff to place the call light call within reach at all times so residents can call for help if needed. Facility policy titled Call Lights-Call System Activation and Response dated 5/28/2024 identified:Each resident is provided with a means to call staff directly for assistance. The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room.	F0558	Continued from page 3 additional actions taken as indicated. Date of Compliance: February 18th, 2026	
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F0584	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F-584 – Safe/Clean/Comfortable/Homelike Environment CITED RESIDENT(S): Resident R57 room temperature was corrected and adjusted to within the acceptable range of 71 – 81 degrees. LIKE RESIDENT(S): No other concerns identified. Licensed nursing staff and nursing assistants were re-educated regarding resident room temperature standards of 71-81 degrees and recognizing signs of discomfort related to room temperature including what to do if room temperature is outside of acceptable	02/18/2026

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F0584 SS = D	Continued from page 4 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident rooms were maintained at a comfortable temperature between 71 and 81 degrees Fahrenheit for 1 of 1 residents (R57) reviewed who indicated their rooms were cold. Findings Include: R57's admission Minimum Data Set (MDS) assessment, dated 12/22/25, indicated a diagnosis of cerebral infarction (stroke) with intact cognition. During an interview on 1/12/26 at 5:19 p.m., R57 stated his room was cold. R57 was observed wearing a winter coat while sitting in a recliner chair in his room between the bed and the window which he reported was where he spent the majority of his time. R57 stated he had reported his concerns to staff and had been told "this room is always like this." R57 stated, "I am froze." The thermostat on the wall indicated 72.9 degrees Fahrenheit (F). At 5:50 p.m., surveyor obtained temperatures in the room: 66.2 degrees F by the tv, 68.3 degrees F around the chair R57 was sitting in, and	F0584	Continued from page 4 range. EDUCATION: Licensed nursing staff and nursing assistants were re-educated regarding resident room temperature standards of 71-81 degrees and recognizing signs of discomfort related to room temperature including what to do if room temperature is outside of acceptable range. AUDITS: The Plant Ops Director or designee will complete weekly audits of all thermostats and HVAC performance, and document findings and ensure corrective actions in place as deemed necessary. Audits will be conducted weekly for four weeks, biweekly for one month, and monthly for three months. Audit results will be presented monthly to the Quality Council, with additional actions taken as indicated. Date of Compliance: February 18th, 2026.	

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F0584 SS = D	Continued from page 5 67.7 degrees F between the chair and the wall. During an interview on 1/12/26 at 5:58 p.m., nursing assistant (NA)-C stated R57 had complained of his room being cold about a week or so ago. NA-C stated he thought a form had been filled out for maintenance to look at R57's room temperature. NA-C verified that R57 was wearing a winter coat due to being cold when he brought him to the bathroom this evening. During a follow up interview on 1/13/25 at 9:55 a.m., R57 stated he did not use his personal refrigerator as it was cold enough in the room to keep items on the counter to keep them cold. On 1/14/26 at 10:46 a.m., surveyor obtained temperatures in R57's room. It was 66.5 degrees F around R57's chair. During an interview on 1/14/26 at 12:20 p.m., director of maintenance (DOM) stated that he had received a complaint of R57's room being cold last week and had the vendor come out and look at his room. DOM stated after the vendor was out, the room was above 71 degrees F. The next day, DOM check the room temperature via computer as temperatures can be checked from the thermostats via computer without having to disrupt the residents. He stated the computer indicated the room was above 71 degrees F. DOM and surveyor obtained temperatures in R57's room: the area around R57 was 69.7 degrees F, and the middle of the room was 70.2 degrees. R57's thermostat indicated 72.3. DOM stated R57's room temperatures are not within the required 71-81 degrees F and would call the vendor out again. During an interview on 1/15/26 at 11:15 a.m., administrator stated temperatures are to be between 71-81 degrees F. Administrator stated the vendor came out yesterday for R57's room and switched the wires. Administrator stated the room was currently temping at 74 degrees F where the resident sits. A facility policy on room temperatures was requested and not received.	F0584		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F0605	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in	02/18/2026

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F0605 SS = D	Continued from page 6 §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An	F0605	Continued from page 6 accordance with federal and state law requirements. F0605 Right to be Free from Chemical Restraints CITED RESIDENT(S): Resident R100, Abilify was discontinued on 1/13/2026. Resident R49, orthostatic blood pressure monitoring was completed on 2/3/2026 and will be completed per protocol thereafter. LIKE RESIDENT(S): Residents currently prescribed antipsychotic medications will have their medical records reviewed to ensure an appropriate diagnosis is documented and that orthostatic blood pressure monitoring has been completed within the past 30 days. EDUCATION: The Psychotropic Medication Use policy was reviewed and remains current. Licensed nurses, Health Unit Coordinators, and Providers were re-educated on the requirement for appropriate diagnosis and documentation for antipsychotic medication use. Licensed nurses and Health Unit Coordinators were also re-educated to ensure orthostatic blood pressure monitoring is included in monthly orders for new admissions and completed as ordered. AUDITS: The Director of Nursing or designee will complete audits of five residents' medical records to verify appropriate antipsychotic diagnosis documentation and completion of orthostatic blood pressure monitoring. Audits will be conducted weekly for four weeks, biweekly for one month, and then monthly for three months. Audit results will be presented monthly to the Quality Council, with additional actions taken as indicated. Date of Compliance: February 18th, 2026	

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F0605 SS = D	Continued from page 7 unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner	F0605		

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F0605 SS = D	Continued from page 8 evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide and document an appropriate diagnosis for a prescribed psychotropic medication for 1 of 5 (R100) residents and failed to provide appropriate side effect monitoring (i.e., orthostatic blood pressure) with antipsychotic medication consumption for 1 of 3 (R49) residents reviewed for unnecessary medication use. Findings include: R100's quarterly Minimum Data Set (MDS), dated 10/30/25, indicated R100 was admitted to the care facility on 6/14/22 and was cognitively intact. The MDS further indicated R100 had no documented hallucinations or delusions during the look-back period. R100's Diagnoses List, indicated R100 had diagnoses including vascular dementia, history of stroke and adjustment order with anxiety. R100's Physician Order Report, dated 12/1/25 - 12/31/25, indicated an order, dated 9/11/25, for Abilify 5 milligrams (mg) once a day for bothersome and frightening hallucinations. R100's Consultant Pharmacist Recommendation to Physician, printed 12/29/25, indicated, "this resident [R100] is receiving antipsychotic agent Aripiprazole [Abilify] (currently listed on the MAR for hallucinations), but lacks an allowable diagnosis to support its use." R100's progress note, dated 1/13/26, indicated the nurse practitioner reviewed the pharmacist recommendation from December and due to R100 not having an appropriate diagnosis for antipsychotic medication the Abilify was discontinued. During an interview on 1/14/26 at 12:25 p.m., the assistant director of nursing (ADON) stated it would be expected that the nurse managers review psychotropic medications for an appropriate diagnosis when ordered,	F0605		

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F0605 SS = D	Continued from page 9 stating the pharmacist will also review medications and inform the facility staff if there is not an appropriate diagnosis attached to the medication order, confirming R100's Abilify, ordered 9/11/25, did not have an appropriate diagnosis. A facility policy titled Psychotropic Medication Use, reviewed 9/7/23 indicated "psychotropic medications are ordered by the medical provider to treat a specific condition as diagnosed and documented in the medical record." R49's admission Minimum Data Set (MDS) assessment, dated 10/20/25, indicated R49 had intact cognition with no hallucinations or delusions and no behavioral symptoms including physical or verbal behavioral symptoms directed at others, or behavioral symptoms not directed toward others. Further it indicted R49 received an antipsychotic medication. R49's January 2026 Medication and Treatment Administration Record (MAR)/TAR), printed 1/15/26, included the following orders: -aripiprazole (antipsychotic medication used to treat mental/mood disorder) 10 milligram (mg) tablet – give 10 mg by mouth at bedtime for moderate episode of recurrent major depressive disorder with a start date of 10/14/25. Medication was documented as administered every day in January. -orthostatic blood pressure related to antipsychotic use once a month on the 14th with a start date of 10/14/25. The MAR/TAR indicated a signature of completion. The document lacked documentation of the blood pressures. -per therapy recommendations: discontinue assist of 2 with sara steady assist of 1 with sara steady for all transfers. Knee brace as needed for comfort with a start date of 1/5/26. -per therapy recommendations: discontinue ceiling lift assist of 2 with sara steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26. R49's December 2025 MAR/TAR included the following orders:	F0605		

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F0605 SS = D	Continued from page 10 -aripiprazole (antipsychotic medication used to treat mental/mood disorder) 10 milligram (mg) tablet – give 10 mg by mouth at bedtime for moderate episode of recurrent major depressive disorder with a start date of 10/14/25. Medication was documented as administered every day in December. -orthostatic blood pressure related to antipsychotic use once a month on the 14th with a start date of 10/14/25. The MAR/TAR indicated a signature of completion. The document lacked documentation of the blood pressures. -per therapy recommendations: discontinue ceiling lift assist of 2 with sara steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26. -per therapy recommendations: discontinue ceiling lift. Assist of 2 staff with sara steady for all transfer.KI on right lower extremity at all times except skin checks. Please support right lower extremity to maintain right knee during extension during transfers. No ambulation at this time with a start date of 12/16/25 and discontinue date of 12/18/25. -per therapy recommendations: discontinue ceiling lift. Assist of 2 with sara steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26. R49's care plan, printed 1/15/26, identified the following: -Under Activities of Daily Living (ADL)s Functional category, the care plan identified R49 had a self-deficit with ambulation, transferring, mobility, oral cares, grooming and bathing and indicated "Resident has a tendency to self-transfer, self-ambulate, and not use her call button for assistance." -Under the Mood state category, the care plan identified R49 had a diagnosis of major depressive disorder and to "obtain monthly orthostatic blood pressure per pharmacy recommendations." R49's blood pressure and pulse logs for 12/1/25 to 1/15/26 were reviewed. The document lacked evidence of	F0605		

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St Gertrudes Health & Rehabilitation Center	1850 SARAZIN STREET , SHAKOPEE, Minnesota, 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0605 SS = D	Continued from page 11 orthostatic blood pressure being completed and documented. R49's progress notes for 12/1/25 to 1/15/26 were reviewed. The document lacked evidence of orthostatic static pressures being completed and documented. During an interview on 1/15/26, R49 was observed sitting in her wheelchair. R49 stated things were going well, denied any concerns and engaged in the conversation. During an interview on 1/15/26 at 10:20 a.m., licensed practical nurse (LPN)-B stated if a resident needed to have orthostatic blood pressures taken then an order was put in the electronic medical record (EMR). LPN-B stated the orders would show up under the treatments and documented on the MAR/TAR, and the vital signs would flow over to the vital signs section of the EMR. LPN-B stated some residents who were on antipsychotic medications had orders for orthostatic blood pressures to be taken but not all residents. LPN-B was not sure how it was decided who needed to have orthostatic blood pressures taken when a resident was on antipsychotic medications and stated the health unit coordinator or nurse manager put the orders in. LPN-B verified R49 had an order to have orthostatic blood pressures taken monthly and verified it was signed off for 12/14/25 and 1/14/26 as completed. LPN-B verified there were not blood pressures on the MAR/TAR and no blood pressures entered in the vital signs section of the EMR on 12/14/25 or 1/14/26. LPN-B stated, "it looks like they weren't done." LPN-B stated R49 was able to stand with assist of 1 and EZ stand (device that assists person to stand). LPN-B stated there was a risk of orthostatic hypotension when a person took antipsychotic medication(s). During an interview on 1/15/26 at 11:04 a.m., director of nursing (DON) stated the expectation would be any resident on an antipsychotic medication should be getting orthostatic blood pressures done monthly. DON stated it's important to monitor orthostatic blood pressures as antipsychotic medications can affect blood pressures which can increase falls. DON could not find any orthostatic blood pressures documented for R49 the last few months. A facility policy titled Psychotropic Medication Use, reviewed 9/7/23, indicated "When psychotropic medications are ordered, the IDT identifies target behaviors, medication side effects to be monitored and	F0605		

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F0605 SS = D	Continued from page 12 implements a resident centered care plan with both non-pharmacologic and pharmacological interventions.”	F0605		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure a resident's preferences were care planned to ensure preferences were honored for 1 of 1 resident (R127) reviewed who preferred to have female only caregivers. Findings include: R127's admission Minimum Data Set (MDS), dated 1/10/26, indicated R127 was admitted to the care facility on 1/4/26 and was cognitively intact. The MDS further	F0657	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F657 Care Plan Timing and Revision CITED RESIDENT(S): Resident R127’s care plan was updated on 1/15/2026 to reflect a preference for female caregivers. Resident was discharged from the facility on 1/23/2026. LIKE RESIDENT(S): All newly admitted residents will have their personal preferences reviewed and discussed during the 48-hour care conference. Any new identified preferences will be communicated to nursing leadership and incorporated into the individualized care plan as appropriate. EDUCATION: Comprehensive Assessment and Care Planning policy was reviewed and remains current. Licensed nursing staff and nursing assistants were re-educated that any resident preference must be communicated to nursing leadership. Nursing will inquire about resident preferences during the 48-hour care conference for all new admissions. AUDITS: The Director of Nursing or designee will audit five residents’ medical records weekly for four weeks, biweekly for one month, and monthly for three months to ensure resident preferences are identified, communicated, and incorporated into care plans. Audit results will be presented to the Quality Council monthly, with additional actions implemented as indicated. Date of Compliance: February 18th, 2026	02/18/2026

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F0657 SS = D	Continued from page 13 indicated R127 required substantial assistance with toileting and partial to moderate assistance with bathing. R127's progress notes, dated 1/4/26, indicated R127, "strongly prefers female caregivers. Patient was instructed that the facility does its best to fulfill these requests but that there was no guarantee that we could provide all female caregivers throughout her stay. Patient understood but stated 'I will just do it myself if there is not female to support me.'" R127's care plan and care guide sheets used to direct resident care lacked mention of any care preferences voiced by R127, including the preference for female only caregivers. During an interview on 1/12/26 at 3:48 a.m., R127 stated she had told multiple staff members, multiple times, that she prefers female caregivers, but that male staff keep coming in and she has to remind that that she would prefer a female. During an interview on 1/15/26 at 8:32 a.m., nursing assistant (NA)-J stated R127 did like men caring for her and if there was a man working on the unit they would try to switch assignments. NA-J stated when a resident voiced a preference such as female only care givers staff would pass it along shift to shift via word of mouth. During an interview on 1/15/25 at 8:39 a.m., clinical manager and registered nurse (RN)-H stated she was unaware that R127 had a preference for female only caregivers, stating she would have expected such a preference to be communicated to her to ensure it was care planned. RN-H stated if she was aware R127 had a preference for female only caregivers she would generally talk with staffing and ensure if there were no female nursing assistants working on the unit that the float NA was a female. During an interview on 1/15/26 at 8:45 a.m., licensed social worker (LSW)-A stated R127's preference for female only care givers was communicated to them through the hospital prior to R127 being admitted to the care facility. The Social Services Director (SSD) stated in the same interview that it would be expected that those preferences would be communicated to the nurse manager and care planned as floor staff often float to different units, so it is important to have care plans up to date to ensure preferences are honored and care needs are met. A facility policy titled Comprehensive Assessments and Care Planning, revised 9/27/23, indicated the comprehensive assessment and care plan must include a resident's customary routine and preferences.	F0657		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F0677	This plan of correction constitutes the facility's credible allegation of compliance.	02/18/2026

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F0677 SS = D	Continued from page 14 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 4 residents (R45) reviewed for activities of daily living (ADLs) and were dependent on staff for their ADLs, routinely had their fingernails cleaned and trimmed. Findings include: R45's quarterly Minimum Data Set (MDS) 10/25/25, indicated R45 had intact cognition and was diagnosed with arthritis. R45 was dependent on staff for toileting hygiene, lower body dressing, and putting on and taking off footwear. The MDS indicated R45's most recent admission/entry to the facility was on 7/23/25. R45's Weekly Skin Checks dated 11/7/25 through 1/9/25, included a section with the question "Was nail care completed?" with the options of fingernails trimmed, toenails trimmed, refused, or not necessary. All checks from this period were either checked as not necessary or left blank. R45's care plan dated 1/9/25, indicated she had a self-deficit with ADLs such as grooming, bathing, and oral care. R45's medical record was reviewed and did not indicate R45 had refused toenail care. During an interview and observation on 1/12/26 at 2:43 p.m., R45 was observed sitting in a chair in her room. R45 stated that she felt like her toenails needed to be trimmed and confirmed that they were not causing her pain. R45 stated she didn't think anyone had offered to help her cut her toenails since she was admitted in July of this year. R45's toenails were observed to have grown past the end of her toes, with a varying nail length, and some toenail curling was observed. During an interview on 1/13/26 at 12:45 p.m., registered nurse (RN)-B stated that R45 was not a diabetic, so the aides could assist her with cutting her finger and toenails. When asked when the last time toenail clipping was completed or where it was documented RN-B stated she was not sure.	F0677	Continued from page 14 Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F677 ADL Care Provided for Dependent Residents CITED RESIDENT(S): Resident R45 was asked if nail care could be completed Resident R45 toenails and fingernails were trimmed and cleaned. LIKE RESIDENT(S): Audit was conducted to identify other dependent residents requiring nail care. Nail care was completed if necessary. EDUCATION: The Activities of Daily Living (ADL) policy was reviewed and remains current. Licensed nursing staff and nursing assistants were re-educated that nail care is to be completed weekly, if necessary, typically on the resident's scheduled bath or shower day and documented in the medical record under weekly skin observation. Nursing assistants are responsible for routine nail trimming and cleaning for residents without complicating conditions, while licensed nurses are responsible for nail care for residents with diabetes or other conditions requiring professional oversight. AUDITS: The Director of Nursing or designee will audit five residents' medical records weekly for four weeks, biweekly for one month, and monthly for three months to ensure that nail care is completed if necessary and documented in weekly skin observation. Audit results will be presented to the Quality Council monthly, with additional actions implemented as indicated. Date of Compliance: February 18th, 2026	

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F0677 SS = D	Continued from page 15 During an interview and observation on 1/13/26 at 12:47 p.m., nursing assistant (NA)-C stated he had assisted R45 with her personal care this morning. NA-C was observed to lift R45's blanket, look at her toes, and state her toenails looked like they could use a trim. R45's toenails were observed to have grown past the end of her toes, with a varying nail length, and some toenail curling was observed. NA-C stated he didn't work on this unit very often, so he was not sure if R45 refused to get her toenails trimmed or the last time toenail trimming was completed. NA-C confirmed he had not offered to cut R45's toenails. During an interview on 1/14/26 at 8:22 a.m., RN-C, the clinical manager for the unit, stated she had reviewed R45's records and did not find evidence that R45 had gotten nail care or refused it recently. RN-C stated staff should either document nail care/nail care refusals in a progress note or on the weekly skin check observation form. RN-C stated she saw that staff had been documenting that it was not applicable to the question of whether R45 had her nails done. RN-C stated that after assessing R45's nails, she felt that they should have been previously cut, so she talked with R45 this week, and R45 had consent to having her toenails trimmed. RN-C stated she was unable to cut all of her toenails, so she was going to ensure a consult was made with podiatry for additional nail care. RN-C stated the nurse was supposed to assess the resident's nails on bath days and ensure that nail care was completed as necessary. The facility's Activities of Daily Living policy dated 7/21 was received but did not include guidance regarding nail care.	F0677		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure communication and collaboration was maintained with a dialysis provider for 1 of 1 resident (R7) reviewed for dialysis.	F0698	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F698 Dialysis CITED RESIDENT(S): Resident R7 will have a dialysis referral form sent to the dialysis provider to ensure effective communication. Facility staff will track the referral form and ensure it is returned, reviewed by	02/18/2026

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F0698 SS = D	Continued from page 16 Findings include: R7's quarterly Minimum Data Set (MDS), dated 11/5/25, indicated R7 was admitted to the care facility on 5/10/24 and was cognitively intact. The MDS further indicated R7 required substantial to maximum assistance with activities of daily living and received dialysis. R7's Orders, dated 11/20/25 directed staff to monitor R7's dialysis fistula and to document R7's vital signs and monitor for shortness of breath, chest pain, nausea and vomiting or seizure activity prior to dialysis. R7's care plan, dated 5/13/24, directed staff to, "obtain Dialysis care plan and coordination of care communication sheet. Check for orders or changes from Dialysis Unit." The care plan further indicated R7 went to dialysis three times a week, on Mondays, Wednesdays, and Fridays. R7's electronic medical record contained only one dialysis communication sheet (Dialysis Run Sheet), dated 10/15/25. R7's paper medical record contain multiple dialysis communication sheets (Dialysis Run Sheets), with the most current being dated 8/25/25. During an interview on 1/14/26 at 8:46 a.m., licensed practical nurse (LPN)-A stated R7 left around 5:00 a.m. for dialysis and arrived back to the care facility around 10:00 a.m. LPN-A stated the facility staff sent along an envelope with the dialysis communication sheet in it but that the facility staff often did not receive the sheet back from dialysis. During an interview on 1/14/26 at 12:25 p.m., the assistant director of nursing (ADON) stated it was expected that staff send the dialysis communication sheet with residents to dialysis, and the nurse was expected to review the sheet for new orders or residents' status when they returned from dialysis. During a follow up interview on 1/15/26 at 9:08 a.m., the ADON confirmed the most current dialysis communication sheet for R7 was from October, stating, "we send the sheet and it doesn't always come back." During an interview on 1/15/26 at 10:50 a.m., the director of nursing confirmed it would be expected that the nurses are following up with the dialysis communication sheets, stating, "we try our best but there is always communication breakdown." A facility policy titled Dialysis Services via Contracted Vendor, revised 5/28/24, indicated, "the licensed nurses have ongoing communication and collaboration with the dialysis facility regarding dialysis care and services."	F0698	Continued from page 16 the unit nurse, and uploaded into the resident's medical record. LIKE RESIDENT(S): All other residents receiving dialysis services will have dialysis referral forms sent to the dialysis provider to support effective communication and continuity of care. EDUCATION: Dialysis Services via Contracted Vendor policy reviewed and remains current. . Licensed nursing staff and nursing assistants were re-educated requirement that dialysis communication/referral forms are returned to the unit nurse for review and then forwarded to Medical Records for uploading into the resident's chart. AUDITS: The Director of Nursing or designee will complete audits of three resident medical records to verify that dialysis referral forms are returned and properly filed. Audits will be conducted weekly for four weeks, biweekly for one month, and then monthly for three months. Audit results will be presented monthly to the Quality Council, with additional actions taken as indicated. Date of Compliance: February 18th, 2026	
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F0812	This plan of correction constitutes the facility's credible allegation of compliance.	02/18/2026

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F0812 SS = F	Continued from page 17 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure frozen food items were stored in a manner to reduce the risk of cross contamination and potential foodborne illness in a walk-in freezer. The facility failed to ensure scoops were not stored in 2 of 3 bulk containers to prevent cross contamination. The facility also failed to ensure hair and beard nets were used in the food preparation area and kitchen utensils sanitizing area. In addition, the facility failed to consistently monitor the dishwasher machine temperature. This had the potential to affect all 98 residents, staff, and visitors who consumed food from the facility kitchen. Findings include: On 1/12/26 at 1:19 p.m., an initial kitchen tour was completed with cook/kitchen supervisor (C)- A, the following was observed: Walk-in freezer - One speed rack had 2 trays of uncovered, unlabeled, uncooked hamburger patties. One of the trays had 5	F0812	Continued from page 17 Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F-812 – Food Procurement, Store/Prepare/Serve-Sanitary Walk-In Freezer CITED RESIDENT(S): All food will be stored in a safe manner in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. Food will be stored in protective covering/container with visible date and label of product. LIKE RESIDENT(S): All food will be stored in a safe manner in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. Food will be stored in protective covering/container with visible date and label of product. EDUCATION: All dietary staff will be re-trained on proper Food Storage, Dating and Labeling. AUDITS: Food Service Director or designee will conduct and document a daily sanitation check list to ensure all foods stored are properly covered/sealed, dated and labeled. Bulk Food Containers CITED RESIDENT(S): All bulk food containers and lids will be kept clean to prevent cross contamination in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. Scoops or any other utensil will not be allowed to be left in the container. LIKE RESIDENT(S): All bulk food containers and lids will be kept clean to prevent cross contamination in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. Scoops or any other utensil will not be allowed to be left in the container. EDUCATION: All dietary staff will be re-trained on proper Food Storage, Dating and Labeling. AUDITS: Food Service Director or designee will conduct and document a daily sanitation check list to ensure all foods stored are stored safely and properly.	

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F0812 SS = F	Continued from page 18 frozen hamburger patties and the other one had 7 - A second speed rack had one tray of 15 uncooked fish filets which were uncovered, and unlabeled. Bulk containers - The lids of a triple bulk container used to store flour, white rice, and brown rice contained debris of flour and rice. Scoops were observed inside the flour and white rice bins. Hair nets - Dietary aid (DA)-A was sanitizing and storing dishes and cookware was not wearing a hair net. High temp dish machine -The log labeled January 2026 had no temperatures recorded on January 1st, 2nd, 3rd and 7th. On January 5th, 2 out of three temps were recorded, and on January 6th, 8th, 9th, 11th and 12th only one of three were recorded. -During the initial tour DA-A was actively using the dish machine. A cycle was observed and the wash cycle temp indicated 150 degrees Fahrenheit (F) while the rinse cycle indicated 180 degrees F. C-A stated the wash temp was low and it should be160 degrees. CA-A did not provide additional instruction to DA-A who continued to use the dish machine. On 1/12/26 at 4:15 p.m. a subsequent kitchen tour was completed. At 4:19 p.m. C-B was setting up the steam table, gathering serving tools, and removing buns from a plastic bag for dinner and placing them on an open tray next to the steam table. C-B had a full beard, about 1 inch long below his chin. C-B stated, “I didn’t know I had to wear a beard net.” During interview on 1/12/26 at 4:23 p.m., food service director (FSD) stated C-A had updated him regarding the concerns found during the initial kitchen tour. Regarding the use of hair and beard nets, FSD stated, “my staff knows better.” FSD added the kitchen staff needs to use hair and beard nets. During this interview C-B entered the FSD’s office and asked where he could find the beard nets. FSD pointed to a shelf in his office, C-B took one and started to put it on as he left FSD’s office. During a subsequent visit to the kitchen on 1/13/26 at 12:01 p.m., FSD stated the dishwasher broke while the	F0812	Continued from page 18 Hairnets/Beard nets CITED RESIDENT(S): Hair Restraints including beard nets will always be worn by dietary staff when in the kitchen during preparation, serving, and plating of food in addition to handling soiled and cleaned dishware and equipment in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. LIKE RESIDENT(S): Hair Restraints including beard nets will always be worn by dietary staff when in the kitchen during preparation, serving, and plating of food in addition to handling soiled and cleaned dishware and equipment. in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. EDUCATION: All dietary staff will be re-trained on Food Code Requirement and Hygiene Expectations. AUDITS: Food Service Director or designee will conduct and document a daily sanitation check list to ensure all dietary staff are adhering to eh Hair/Beard Net requirements. High Temp Dish Machine CITED RESIDENT(S): The facility will operate and maintain the proper operation of the high temp dish machine in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. LIKE RESIDENT(S): The facility will operate and maintain the proper operation of the high temp dish machine in accordance with CFR(s): 483.60(i)(1)(2), Food safety requirements. EDUCATION: All dietary staff will be re-trained on the Proper Operating Procedures of the High Temp Dish Machine. AUDITS: Food Service Director or designee will visibly check and ensure accurate documentation daily of the dish machine to ensure the high temp dish machine is operating properly.	

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F0812 SS = F	Continued from page 19 staff was washing the breakfast plates that morning. FSD stated they were going to use disposable plates and cups until the wash machine was repaired. Food Storing and kitchen sanitary, and cleaning schedule policies were requested but not received. During observation and interview on 1/14/26 at 11:13 a.m. dietary aid DA-A was washing pots and stainless-steel bins. The dish machine cycle was observed, and the wash cycle indicated 109.6 degrees, and the rinse cycle temp was 194 degrees. DA-A stated he had not paid attention to the temperatures. The dish machine temperature log had no documentation of the morning temp. The Ecolab Service Call Summary dated 1/14/26 at 9:47 p.m., indicated "Scale issues are causing issues that require deliming until Softener is repaired". The document indicated the wash temperature was 162 degrees F and rinse temperature was 183 degrees, both "In Range". Additional comments included "Machine Condition: Issue Found", and "Lime scale buildup due to down water softener. Will need to delime more frequently in the interim." The Ecolab Extra Service Request dated 1/14/26 at 9:44 p.m., indicated the facility requested service for the EC-44 Dish Machine as it was "In constant wash cycle and wasting chemicals; attempted flipping delime switch". Service Comments included "Found a metal lid tucked behind first paddle". During observation and interview on 1/15/26 at 9:31 a.m., breakfast dishes were being washed in the dish machine and the cycle was observed. The wash temperature rose to 108 degrees F, and the rinse temperature rose to 194.3 degrees. DA-B confirmed the wash temperature was low. DA-B prepared to load another tray of dishware for machine washing. During interview on 1/15/26 at 9:50 a.m., FSD responded to the following concerns:Wash machine - FSD stated he was not informed about the wash machine temperatures observed that morning at 9:31 a.m. FSD stated they were having problems with the wash machine. FSD stated an engine component broke 6 weeks ago, but the technician forgot to fill the component with oil and the machine broke again on Tuesday 1/13/26. FSD added, yesterday 1/14/26 “the wash cycle was stuck and would not go to the rinse cycle.” FSD stated every time the wash machine was serviced, the ECOLAB technician emailed a service report. Hair and beard nets - FSD stated he had talked repeatedly to the staff about the use of hair and beard nets. FSD stated “on a regular basis I found	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

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F0812 SS = F	Continued from page 20 staff not wearing hair nets". FSD stated he expected staff to wear hair and beard nets to prevent hair falling in the food, cooking or serving gear. Food storage - FSD stated storing uncovered food in the freezer was "honestly, lazy." All items on the speed racks should be individually covered or cover the whole cart with a proofing bag. FSD stated it was unsanitary because "something can land on it."Bulk containers - FSD stated the scoops should not be left inside the containers because it was a concern for cross contamination. During interview on 1/15/26 at 1:08 p.m., FSD stated the water softener had been down for weeks, and with that not functioning properly, lime and scale had built up in the heating element of the dishwasher. He stated the water softener was back online as of last Friday, but the dishwasher might not be getting soft water yet as it took a while to work through the system. He stated the scaling was building up "pretty badly" and the heating element didn't run consistently because of that. They used lime away and a descaler and reached out to Ecolab tech and there will be a deep scrub on the heating element. FSD stated they had not had a scrub done previously, and it has been an ongoing situation. FSD stated the heating element fluctuated from time to time, and it was a difficult problem because it was inconsistent. When staff notice the temperature is out of range, they should address the temperature and delime it and go back to normal operation. He stated the facility did not have a 3-compartment sink, and they found the issue on Tuesday and then used full disposable dishware. He indicated the service tech was in the facility this afternoon. During interview on 1/15/26 at 1:00 p.m., the administrator stated storing uncovered fish filets and hamburger patties was concerning, not only for cleanliness but because it could affect the patients. Administrator stated she expected the staff to wear hair and beard nets because it was a standard practice, so they did not get hair in the food. Regarding the storage of scoops on dry goods, the administrator stated the scoops should be stored outside of them. Regarding the wash machine, the administrator stated the facility needed to have an appropriate temperature to be in regulation. The Ecolab EC-44 Dishmachine brochure dated 2012, indicated a required wash temperature of 160 degrees F and a rinse temperature of 180 degrees F. The undated facility policy titled Dishwashing Procedures, indicated the facility will implement dishwashing practices that prevent the spread of food-borne illness. The dish machine will be operated	F0812		

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F0812 SS = F	Continued from page 21 in accordance with the manufacturer's instructions.	F0812		

Minnesota State Department of Health

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/12/26 to 1/15/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.	20000		02/18/2026

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed with NO licensing orders issued. H56103123C (MN00107776) H56103122C (MN00108406) H56103120C (MN00110401) H56102083C (IQIES 2700198) H56103413C (IQIES 2714096) H56103121C (IQIES 1133928) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		

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20000 20920	Rehab - ADLs CFR(s): MN Rule 4658.0525 Subp. 6 B Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 4 residents (R45) reviewed for activities of daily living (ADLs) and were dependent on staff for their ADLs, routinely had their fingernails cleaned and trimmed. Findings include: R45's quarterly Minimum Data Set (MDS) 10/25/25, indicated R45 had intact cognition and was diagnosed with arthritis. R45 was dependent on staff for toileting hygiene, lower body dressing, and putting on and taking off footwear. The MDS indicated R45's most recent admission/entry to the facility was on 7/23/25. R45's Weekly Skin Checks dated 11/7/25 through 1/9/25, included a section with the question "Was nail care completed?" with the options of fingernails trimmed, toenails trimmed, refused, or not necessary. All checks from this period were either checked as not necessary or left blank. R45’s care plan dated 1/9/25, indicated she had a self-deficit with ADLs such as grooming, bathing, and oral care. R45's medical record was reviewed and did not indicate R45 had refused toenail care. During an interview and observation on 1/12/26 at 2:43 p.m., R45 was observed sitting in a chair in her room. R45 stated that she felt like her toenails needed to be trimmed and confirmed that they were not causing her pain. R45 stated she didn't think anyone had offered to help her cut her toenails since she was admitted in July of this year. R45's toenails were observed to have grown past the end of her toes, with a varying nail length, and some toenail curling was observed.	20000 20920	Corrected.	02/18/2026

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20920	Continued from page 3 During an interview on 1/13/26 at 12:45 p.m., registered nurse (RN)-B stated that R45 was not a diabetic, so the aides could assist her with cutting her finger and toenails. When asked when the last time toenail clipping was completed or where it was documented RN-B stated she was not sure. During an interview and observation on 1/13/26 at 12:47 p.m., nursing assistant (NA)-C stated he had assisted R45 with her personal care this morning. NA-C was observed to lift R45's blanket, look at her toes, and state her toenails looked like they could use a trim. R45's toenails were observed to have grown past the end of her toes, with a varying nail length, and some toenail curling was observed. NA-C stated he didn't work on this unit very often, so he was not sure if R45 refused to get her toenails trimmed or the last time toenail trimming was completed. NA-C confirmed he had not offered to cut R45's toenails. During an interview on 1/14/26 at 8:22 a.m., RN-C, the clinical manager for the unit, stated she had reviewed R45's records and did not find evidence that R45 had gotten nail care or refused it recently. RN-C stated staff should either document nail care/nail care refusals in a progress note or on the weekly skin check observation form. RN-C stated she saw that staff had been documenting that it was not applicable to the question of whether R45 had her nails done. RN-C stated that after assessing R45's nails, she felt that they should have been previously cut, so she talked with R45 this week, and R45 had consent to having her toenails trimmed. RN-C stated she was unable to cut all of her toenails, so she was going to ensure a consult was made with podiatry for additional nail care. RN-C stated the nurse was supposed to assess the resident's nails on bath days and ensure that nail care was completed as necessary. The facility's Activities of Daily Living policy dated 7/21 was received but did not include guidance regarding nail care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable care plans and policies to ensure hygiene and personal care needs are provided to dependent residents; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 days	20920		
21100	Food Supplies; Storage of Perishable food CFR(s): MN Rule 4658.0650 Subp. 5	21100	Corrected.	02/18/2026

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21100	Continued from page 4 Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure frozen food items were stored in a manner to reduce the risk of cross contamination and potential foodborne illness in a walk-in freezer. The facility failed to ensure scoops were not stored in 2 of 3 bulk containers to prevent cross contamination. This had to potential to affect all 98 residents, staff, and visitors who consumed food from the facility kitchen. Findings include: On 1/12/26 at 1:19 p.m., an initial kitchen tour was completed with cook/kitchen supervisor (C)- A, the following was observed: Walk-in freezer - One speed rack had 2 trays of uncovered, unlabeled, uncooked hamburger patties. One of the trays had 5 frozen hamburger patties and the other one had 7 - A second speed rack had one tray of 15 uncooked fish filets which were uncovered, and unlabeled. Bulk containers - The lids of a triple bulk container used to store flour, white rice, and brown rice contained debris of flour and rice. Scoops were observed inside the flour and white rice bins. During interview on 1/15/26 at 9:50 a.m., FSD responded to the following concerns:Food storage - FSD stated storing uncovered food in the freezer was “honestly, lazy.” All items on the speed racks should be individually covered or cover the whole cart with a proofing bag. FSD stated it was unsanitary because “something can land on it.”Bulk containers - FSD stated the scoops should not be left inside the containers because it was a concern for cross contamination.During interview on 1/15/26 at 1:00 p.m., the administrator stated storing uncovered fish filets and hamburger patties was concerning, not only for cleanliness but because it could affect the patients. Regarding the	21100		

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21100	Continued from page 5 storage of scoops on dry goods, the administrator stated the scoops should be stored outside of them. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to administer baseline tuberculosis (TB) screening for 5 of 6 (RN-C, RN-F, LPN-A, NA-H, NA-I) staff members reviewed for testing. This had the potential to affect all residents, staff and visitors of the facility.	21426	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Identified Employee(s): The facility immediately reviewed employee health files upon notification of the deficiency. It was identified that the TB Screening Tool was not present in the employee health record due to an oversight during annual compliance review. The affected employee(s) completed the TB Screening Tool, and results were reviewed and documented per facility policy and Minnesota Department of Health requirements. No evidence of action tuberculosis was identified. Other Employee(s): The facility conducted a full audit of employee health files to ensure the presence of a completed TB Screening Tool in accordance with MDH and CDC guidelines. Any missing documentation identified during the audit was corrected immediately. Audit: All current employees will have a completed TB Screening Tool on file. A standardized TB Screening Tool has been added to new hire onboarding packets. Human Resources or Designee is responsible for	02/18/2026

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21426	Continued from page 6 Findings include: The Centers for Disease Control (CDC) guidelines for preventing the transmission of mycobacterium tuberculosis (TB) in Health Care Settings, 2019, directed that all residents and staff (Pre-placement) must receive a baseline TB screening. The baseline TB screening should consist of assessment for TB risk factors and history; assessment for current symptoms of active TB; and testing for the presence of infection with mycobacterium tuberculosis. Employee file for registered nurse (RN)-C indicated RN-C started at facility on 2/21/22. A document was provided indicating a QuantiFERON -TB gold (blood test for TB exposure) test result was completed on 12/13/21. This was followed by a chest x-ray which was completed on 2/21/22 indicating no evidence of active tuberculosis. The employee file lacked evidence of a baseline TB screening being completed. Employee file for RN-F indicated RN-F started at facility on 9/16/25. A document was provided indicating a QuantiFERON -TB gold test was completed on 9/9/25. The employee file lacked evidence of a baseline TB screening being completed. Employee file for licensed practical nurse (LPN)-A indicated LPN-A started with the company on 7/15/24 and transferred to the facility on 10/9/25. A document was provided indicating an x-ray was completed for TB on 12/1/23 which indicated no evidence of active TB. The employee file lacked evidence of a baseline TB screening being completed. Employee file for nursing assistant (NA)-H indicated NA-H started at facility on 7/23/25. A document was provided indicating a QuantiFERON -TB gold test was completed on 7/17/25. The employee file lacked evidence of a baseline TB screening being completed. Employee file for NA-I indicated NA-I started at facility on 12/12/25. A document was provided indicating a chest x-ray had been completed on 12/8/25 and was negative for active tuberculosis. The employee file lacked evidence of a baseline TB screening being completed. During an interview on 1/15/26 at 8:56 a.m., assistant director of nursing (ADON) verified she was the infection preventionist for the facility. ADON stated staff are tested for TB prior to starting at the facility and the do the QuantiFERON-TB gold test. ADON stated this was done so “we don’t have TB in the	21426	Continued from page 6 verifying completion and documentation during onboarding. Human Resources or Designee will conduct ongoing audits to ensure compliance. Monthly audits of employee health files for three months, and quarterly audits thereafter for one (1) year. Date of Compliance: February 18th, 2026.	

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21426	Continued from page 7 building." ADON stated TB was very contagious and the facility was not able to care for residents with TB. ADON stated human resources tracks staff TB testing. ADON was not sure if a baseline TB screen was completed with staff. During an interview on 1/15/26 at 11:08 a.m., director of nursing (DON) stated upon hire staff complete a baseline TB screening along with a QuantiFERON-TB gold test. DON verified the staff results above and verified RN-C, RN-F, LPN-A, NA-H and NA-I did not have baseline TB screenings completed. DON indicated it was important all screenings and testing are completed as staff could have TB and that would affect residents and other staff. During an interview on 1/15/26 at 11:21a.m., administrator reviewed employee files provided. Administrator requested to follow up. During a follow up interview on 1/15/26 at 12:36 p.m., administrator verified the facility did not have the baseline TB screening for the staff requested. A facility policy titled Tuberculosis Program for Associates, revised 6/22/23, indicated "every new associate will begin by filling out the personal risk assessment and symptom review. This will be reviewed by the IP to determine if further testing is required, or if the associate indicates they have a high-risk condition." "For communities in MN, MO and ND and WI, or those that have positive risk assessment, a tuberculin skin test (TST) or blood test (QuantiFERON or T-spot), depending on community preference, will be performed on newly hired associates." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review tuberculosis policies and procedures to ensure compliance. The director of nursing (DON) or designee could review the screening process for staff to be sure the documentation of the TB screening are completed per guidelines. The DON or designee could audit for screening and TB testing for residents and staff. The results of these audits could be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21535	Unnecessary Drug Usage; General CFR(s): MN Rule4658.1315 Subp.1 ABCD	21535	Corrected.	02/18/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
21535	Continued from page 8 Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide and document an appropriate diagnosis for a prescribed psychotropic medication for 1 of 5 (R100) residents and failed to provide appropriate side effect monitoring (i.e., orthostatic blood pressure) with antipsychotic medication consumption for 1 of 3 (R49) residents reviewed for unnecessary medication use. Findings include: R100's quarterly Minimum Data Set (MDS), dated 10/30/25, indicated R100 was admitted to the care facility on 6/14/22 and was cognitively intact. The MDS further indicated R100 had no documented hallucinations or delusions during the look-back period. R100's Diagnoses List, indicated R100 had diagnoses including vascular dementia, history of stroke and adjustment order with anxiety. R100's Physician Order Report, dated 12/1/25 - 12/31/25, indicated an order, dated 9/11/25, for Abilify 5 milligrams (mg) once a day for bothersome and frightening hallucinations. R100's Consultant Pharmacist Recommendation to Physician, printed 12/29/25, indicated, "this resident [R100] is receiving antipsychotic agent Aripiprazole [Abilify] (currently listed on the MAR for hallucinations), but lacks an allowable diagnosis to support its use." R100's	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	**1850 SARAZIN STREET , SHAKOPEE, Minnesota, 55379**

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21535	Continued from page 9 progress note, dated 1/13/26, indicated the nurse practitioner reviewed the pharmacist recommendation from December and due to R100 not having an appropriate diagnosis for antipsychotic medication the Abilify was discontinued. During an interview on 1/14/26 at 12:25 p.m., the assistant director of nursing (ADON) stated it would be expected that the nurse managers review psychotropic medications for an appropriate diagnosis when ordered, stating the pharmacist will also review medications and inform the facility staff if there is not an appropriate diagnosis attached to the medication order, confirming R100's Abilify, ordered 9/11/25, did not have an appropriate diagnosis. A facility policy titled Psychotropic Medication Use, reviewed 9/7/23 indicated "psychotropic medications are ordered by the medical provider to treat a specific condition as diagnosed and documented in the medical record." R49's admission Minimum Data Set (MDS) assessment, dated 10/20/25, indicated R49 had intact cognition with no hallucinations or delusions and no behavioral symptoms including physical or verbal behavioral symptoms directed at others, or behavioral symptoms not directed toward others. Further it indicted R49 received an antipsychotic medication. R49's January 2026 Medication and Treatment Administration Record (MAR)/TAR), printed 1/15/26, included the following orders: -aripiprazole (antipsychotic medication used to treat mental/mood disorder) 10 milligram (mg) tablet – give 10 mg by mouth at bedtime for moderate episode of recurrent major depressive disorder with a start date of 10/14/25. Medication was documented as administered every day in January. -orthostatic blood pressure related to antipsychotic use once a month on the 14th with a start date of 10/14/25. The MAR/TAR indicated a signature of completion. The document lacked documentation of the blood pressures. -per therapy recommendations: discontinue assist of 2 with sara steady assist of 1 with sara steady for all transfers. Knee brace as needed for comfort with a start date of 1/5/26. -per therapy recommendations: discontinue ceiling lift assist of 2 with sara steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26.	21535		

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21535	Continued from page 10 R49's December 2025 MAR/TAR included the following orders: -aripiprazole (antipsychotic medication used to treat mental/mood disorder) 10 milligram (mg) tablet – give 10 mg by mouth at bedtime for moderate episode of recurrent major depressive disorder with a start date of 10/14/25. Medication was documented as administered every day in December. -orthostatic blood pressure related to antipsychotic use once a month on the 14th with a start date of 10/14/25. The MAR/TAR indicated a signature of completion. The document lacked documentation of the blood pressures. -per therapy recommendations: discontinue ceiling lift assist of 2 with sara steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26. -per therapy recommendations: discontinue ceiling lift. Assist of 2 staff with sara steady for all transfer.KI on right lower extremity at all times except skin checks. Please support right lower extremity to maintain right knee during extension during transfers. No ambulation at this time with a start date of 12/16/25 and discontinue date of 12/18/25. -per therapy recommendations: discontinue ceiling lift. Assist of 2 with sara steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26. R49's care plan, printed 1/15/26, identified the following: -Under Activities of Daily Living (ADL)s Functional category, the care plan identified R49 had a self-deficit with ambulation, transferring, mobility, oral cares, grooming and bathing and indicated "Resident has a tendency to self-transfer, self-ambulate, and not use her call button for assistance." -Under the Mood state category, the care plan identified R49 had a diagnosis of major depressive disorder and to "obtain monthly orthostatic blood pressure per pharmacy recommendations."	21535		

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21535	Continued from page 11 R49's blood pressure and pulse logs for 12/1/25 to 1/15/26 were reviewed. The document lacked evidence of orthostatic blood pressure being completed and documented. R49's progress notes for 12/1/25 to 1/15/26 were reviewed. The document lacked evidence of orthostatic static pressures being completed and documented. During an interview on 1/15/26, R49 was observed sitting in her wheelchair. R49 stated things were going well, denied any concerns and engaged in the conversation. During an interview on 1/15/26 at 10:20 a.m., licensed practical nurse (LPN)-B stated if a resident needed to have orthostatic blood pressures taken then an order was put in the electronic medical record (EMR). LPN-B stated the orders would show up under the treatments and documented on the MAR/TAR, and the vital signs would flow over to the vital signs section of the EMR. LPN-B stated some residents who were on antipsychotic medications had orders for orthostatic blood pressures to be taken but not all residents. LPN-B was not sure how it was decided who needed to have orthostatic blood pressures taken when a resident was on antipsychotic medications and stated the health unit coordinator or nurse manager put the orders in. LPN-B verified R49 had an order to have orthostatic blood pressures taken monthly and verified it was signed off for 12/14/25 and 1/14/26 as completed. LPN-B verified there were not blood pressures on the MAR/TAR and no blood pressures entered in the vital signs section of the EMR on 12/14/25 or 1/14/26. LPN-B stated, "it looks like they weren't done." LPN-B stated R49 was able to stand with assist of 1 and EZ stand (device that assists person to stand). LPN-B stated there was a risk of orthostatic hypotension when a person took antipsychotic medication(s). During an interview on 1/15/26 at 11:04 a.m., director of nursing (DON) stated the expectation would be any resident on an antipsychotic medication should be getting orthostatic blood pressures done monthly. DON stated it's important to monitor orthostatic blood pressures as antipsychotic medications can affect blood pressures which can increase falls. DON could not find any orthostatic blood pressures documented for R49 the last few months. A facility policy titled Psychotropic Medication Use,	21535		

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21535	Continued from page 12 reviewed 9/7/23, indicated “When psychotropic medications are ordered, the IDT identifies target behaviors, medication side effects to be monitored and implements a resident centered care plan with both non-pharmacologic and pharmacological interventions.” SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review records of residents prescribed medications for appropriate monitoring and diagnosis. Education of appropriate staff could be provided. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21565	Administration of Medications Self Admin CFR(s): MN Rule 4658.1325 Subp. 4 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to ensure a resident was appropriately assessed and had an appropriate order in place to self-administer nebulizer medication for 1 of 1 resident (R80) reviewed for self-administration of medications. Findings include: R80's significant change Minimum Data Set (MDS), dated 11/16/25, indicated R80 was cognitively intact and required partial to moderate assistance with most activities of daily living. R80's active orders, printed 1/15/26, contained an order for albuterol sulfate for nebulization once a day in the morning and three times a day as needed for difficulty breathing, shortness of breath, wheezing and/or bronchospasm prevention. R80's care plan, dated 10/30/25, indicated, "I [R80] will independently administer respiratory treatments as ordered and I will receive assistance setting up, disassembling, and cleaning respiratory equipment from a licensed nurse." with interventions to include, "acquire physician's order for self-administration of respiratory treatments" and, "perform a self-administration medication assessment per facility protocol."	21565	Corrected.	02/18/2026

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21565	Continued from page 13 R80's electronic medical record lacked an order and an assessment for self-administration of her respiratory treatments (i.e. albuterol sulfate via nebulization).During an interview on 1/14/26 at 10:30 a.m., licensed practical nurse (LPN)-A stated R80 administered her nebulizer independently. She indicated licensed staff would put the medication in the nebulizer and leave R80 with the medication who would turn off the nebulizer machine on her own when the medication was gone, stating he checked back with her in 10-15 minutes after starting the nebulizer. During observation on 1/14/26 at 11:45 a.m., LPN-A entered R80's room, handed her the hand-held nebulizer mouthpiece, already filled with the albuterol medication, turned on the nebulizer machine, and left R80 to self-administer the medication independently. During an interview on 1/15/26 at 9:08 a.m., the assistant director of nursing (ADON) confirmed there was not an order or assessment in place for R80 to self-administer her nebulizer medication and that it would be expected to have those in place prior to self-administration of any medications. A facility policy titled Self-Administration of Medications, revised 4/10/25, indicated each resident will be assessed for the ability to physically and mentally self-administer any medication and, if deemed appropriate, a physician order would be obtained to self-administer the assessed medications. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review residents who are on nebulized medication to ensure the proper assessments and orders are in place. Education of appropriate staff could be provided. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21705	Plant Housekeeping, Operation, & Maintenance CFR(s): MN Rule 4658.1415 Subp. 6 Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees	21705	Corrected.	02/18/2026

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21705	Continued from page 14 Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident rooms were maintained at a comfortable temperature between 71 and 81 degrees Fahrenheit for 1 of 1 residents (R57) reviewed who indicated their rooms were cold. Findings Include: R57's admission Minimum Data Set (MDS) assessment, dated 12/22/25, indicated a diagnosis of cerebral infarction (stroke) with intact cognition. During an interview on 1/12/26 at 5:19 p.m., R57 stated his room was cold. R57 was observed wearing a winter coat while sitting in a recliner chair in his room between the bed and the window which he reported was where he spent the majority of his time. R57 stated he had reported his concerns to staff and had been told "this room is always like this." R57 stated, "I am froze." The thermostat on the wall indicated 72.9 degrees Fahrenheit (F). At 5:50 p.m., surveyor obtained temperatures in the room: 66.2 degrees F by the tv, 68.3 degrees F around the chair R57 was sitting in, and 67.7 degrees F between the chair and the wall. During an interview on 1/12/26 at 5:58 p.m., nursing assistant (NA)-C stated R57 had complained of his room being cold about a week or so ago. NA-C stated he thought a form had been filled out for maintenance to look at R57's room temperature. NA-C verified that R57 was wearing a winter coat due to being cold when he brought him to the bathroom this evening. During a follow up interview on 1/13/25 at 9:55 a.m., R57 stated he did not use his personal refrigerator as it was cold enough in the room to keep items on the counter to keep them cold. On 1/14/26 at 10:46 a.m., surveyor obtained temperatures in R57's room. It was 66.5 degrees F around R57's chair.	21705		

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21705	Continued from page 15 During an interview on 1/14/26 at 12:20 p.m., director of maintenance (DOM) stated that he had received a complaint of R57's room being cold last week and had the vendor come out and look at his room. DOM stated after the vendor was out, the room was above 71 degrees F. The next day, DOM check the room temperature via computer as temperatures can be checked from the thermostats via computer without having to disrupt the residents. He stated the computer indicated the room was above 71 degrees F. DOM and surveyor obtained temperatures in R57's room: the area around R57 was 69.7 degrees F, and the middle of the room was 70.2 degrees. R57's thermostat indicated 72.3. DOM stated R57's room temperatures are not within the required 71-81 degrees F and would call the vendor out again. During an interview on 1/15/26 at 11:15 a.m., administrator stated temperatures are to be between 71-81 degrees F. Administrator stated the vendor came out yesterday for R57's room and switched the wires. Administrator stated the room was currently temping at 74 degrees F where the resident sits. A facility policy on room temperatures was requested and not received. SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could develop and implement policies and procedures to ensure resident rooms are maintained at a comfortable temperature and educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21705		
21810	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 6 Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to accommodate resident needs by ensuring the call light was accessible for 1 of 1 resident (R26) reviewed	21810	Corrected.	02/18/2026

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21810	Continued from page 16 for call lights. Findings include: R26's quarterly Minimum Data Set (MDS) dated 1/12/26, identified R26 with impaired cognition, no rejection of cares or wandering, impairment in lower extremity range of motion, required a walker or wheelchair for mobility, and needed partial to moderate assistance with dressing, transfers, and hygiene. Diagnoses include heart failure, kidney disease, arthritis, depression and anxiety. During observation and interview with R26 on 1/12/26 at 5:01 p.m., R26 was lying in bed with call light out of reach on nightstand next to head of bed. R26 stated she could not see it and wanted assistance to get up out of bed to go to dinner. "Normally I use the call light if I need help. If it is out of reach then I make noise to get attention to get [staff] to answer my pleas." During observation and interview with nursing assistant (NA)-B on 1/12/26 at 5:04 p.m., NA-B verified R26's call light was out of reach, "It should be in reach to ask for help". During interview with NA-D on 1/15/26 at 6:52 a.m., NA-D stated it was important to place the call light "next to patients at all times. If out of reach the residents can fall. For safety." During interview with registered nurse (RN)-G on 1/15/26 at 7:04 a.m., RN-B stated, "[staff] always make sure [call light] is in reach and [residents] know how to use it." During interview with director of nursing (DON) on 1/15/26 at 9:57 a.m., DON stated expectation of staff to place the call light call within reach at all times so residents can call for help if needed. Facility policy titled Call Lights-Call System Activation and Response dated 5/28/2024 identified:Each resident is provided with a means to call staff directly for assistance. The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to	21810		

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21810	Continued from page 17 ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BLDG THREE NEW ... B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/13/2026. At the time of this survey, ST GERTRUDES HEALTH AND REHABILIATION CENTER found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		05/28/2026

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 reverse for further 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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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. ST GERTRUDES HEALTH AND REHABILIATION CENTER was constructed at 4 different times. The original 1-story building with no basement was constructed in 1996 and was determined to be of Type V (111) construction. In 1999, an addition was constructed to the East Wing that was determined to be of Type V (111) construction. In 2007 a 1-story addition with no basement was constructed and was determined to be of Type V (111) construction. In 2011 a 2-story building with a full basement was constructed and was determined to be of Type II (222). Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility has a capacity of 105 beds and had a census of 100 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		
K0344 SS = F	Fire Alarm - Control Functions CFR(s): NFPA 101	K0344	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not	02/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **03 - BLDG THREE NEW ...** B. WING	**01/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	**1850 SARAZIN STREET , SHAKOPEE, Minnesota, 55379**

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K0344 SS = F	Continued from page 2 Fire Alarm - Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain alternative power supply documentation per NFPA 101 (2012 edition), Life Safety Code, section 19.3.4.4 and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.9. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/13/2026 between 11:00 AM and 3:00 PM, it was revealed by a review of available documentation that documentation presented for review was incomplete. Alternative power supply (battery back-up) change / install date(s) were incomplete for resident sleeping room(s) having smoke detection, interconnect to Nurse-call. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0344	Continued from page 2 constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. K-344 – Fire Alarm – Control Functions: Documentation to be completed for alternative power supply (battery back-up) including the change / install date (s) in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.4.4. and NFPA 72 (210 edition), National Fire Alarm and Signaling Code, section 14.4.9. Plant Operations Director or designee will monitor monthly compliance of documentation to ensure thoroughness of timely completion and compliance. Date of Compliance: February 18th, 2026.	
K0353 SS = D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K0353	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. K-353 – Sprinkler System – Maintenance and Testing: Summit visited on 02/05/2026 to resolve the sprinkler head in Family Rm (RM 115) exhibiting signs of paint splatter. Plant Ops Director or designee will monitor yearly ensuring compliance of any new paint around sprinkler heads. Date of Compliance: February 18th, 2026.	02/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BLDG THREE NEW ... B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	1850 SARAZIN STREET , SHAKOPEE, Minnesota, 55379

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K0353 SS = D	Continued from page 3 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2, 5.2.1.1.2(6). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/13/2026 at 12:45 PM, it was revealed by observation that in the Family Rm (RM 115) sprinkler head(s) exhibiting signs of paint splatter. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353		
K0374 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility	K0374	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. K-374 – Subdivision of Building Spaces – Smoke Barrier Doors: Smoke Barrier Doors will be reviewed to test, maintain, and inspect per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4, ensuring no allowance of passage of smoke. Smoke Barrier Doors test, maintenance and inspection is in TELs for monitoring to ensure compliance. Plant Ops Director or designee will monitor yearly compliance of this inspection. Due to the nature of product availability, the facility is unable to make corrections within the 60 day requirement as indicated in completion date and facility is requesting a waiver for extension.	03/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BLDG THREE NEW ... B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

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K0374 SS = F	Continued from page 4 failed to test, maintain, and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include:On 01/13/2026 at 1:00 PM, it was revealed by observation that the smoke barrier door assembly by RM 141, did not close and seal the opening, which would allow the passage of smoke. On 01/13/2026 at 1:15 PM, it was revealed by observation that the 400 Wing, smoke barrier door assembly did not close and seal the opening, which would allow the passage of smoke. On 01/13/2026 at 2:00 PM, it was revealed by observation that the Basement smoke barrier door assembly, did not close and seal the opening, which would allow the passage of smoke. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0374		
K0761 SS = F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.3, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. These	K0761	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. K-761 – Maintenance, Inspection & Testing – Doors: Facility will inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.3, 7.2.1.15 and NFPA 80 (2010 edition), sections 5.2.1. Doors to function properly upon test which includes doors to not be damaged, close appropriate, and seal the opening upon test. Maintenance, Inspection & Testing of doors is in TELs for monitoring to ensure compliance. Plant Ops Director or designee will monitor yearly compliance of this inspection. Due to the nature of product availability, the facility is unable to make corrections within the 60 day requirement as indicated in completion date and facility is requesting a waiver for extension.	03/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BLDG THREE NEW ... B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

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K0761 SS = F	Continued from page 5 deficient findings could have a widespread impact on the residents within the facility. Findings include:On 01/13/2026 at 1:30 PM, it was revealed by observation that the 200 Wing egress door (North corridor) was damaged and did not function properly upon test. On 01/13/2026 at 1:40 PM, it was revealed by observation that the fire door assembly, separating the SNF from HOSP, had a damaged closure mechanism and the door would not close and seal the opening upon test. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K0761		
K0918 SS = F Bldg. 03	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by:	K0918	K-918 – Electrical Systems – Essential Electric System Maintenance and Testing: Facility will ensure that documentation is present for review to confirm that annual fuel quality testing is occurring. This is in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.8. Annual fuel quality testing is in TELs for monitoring to ensure compliance. Plant Ops Director or designee will monitor yearly compliance of this inspection. Due to the nature of the fuel testing completed on January 27th, 2026, the date of compliance is March 3rd, 2026.	03/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BLDG THREE NEW ... B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

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K0918 SS = F Bldg. 03	Continued from page 6 Based on observation, review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/13/2026 between 11:00 AM and 3:00 PM, it was revealed by a review of available documentation, that no documentation was presented for review to confirm that annual fuel quality testing is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0918		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 7, 2026

Administrator
St Gertrudes Health & Rehabilitation Center
1850 SARAZIN STREET
SHAKOPEE, MN 55379

RE: CCN: 245610
Cycle Start Date: December 18, 2025

Dear Administrator:

On January 27, 2026, we notified you a remedy was imposed. On March 30, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 3, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 18, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 27, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 18, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 3, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Correction of the Life Safety Code deficiencies cited under K374 and K761 at the time of the March 30, 2026 survey, has not yet been verified. Your plan of correction for these deficiencies, including your request for a temporary waiver with a date of completion of June 30, 2026, has been approved. Failure to come into substantial compliance with these deficiencies by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 7, 2026

Administrator
St Gertrudes Health & Rehabilitation Center
1850 SARAZIN STREET
SHAKOPEE, MN 55379

Re: Reinspection Results
Event ID: 1DDFD3-H2

Dear Administrator:

On February 24, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 15, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us