Electronically Delivered

July 6, 2026

Licensee
The Gardens at St Gertrudes
1850 Sarazin Street
Shakopee, MN 55379

RE: Project Number(s) SL30475016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 5, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating

factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30475	A. BUILDING: _____ B. WING _____	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT ST GERTRUDES	1850 SARAZIN ST SHAKOPEE, MN 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) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30475016-0 On June 1, 2026, through June 3, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 37 residents; 33 receiving services under the Assisted Living Facility license. Immediate Order 1290 was issued on June 2, 2026, however, due to additional information received on June 3, the Immediate Order was rescinded.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485		

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0 485	Continued From page 1 (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 1, 2026, at 10:18 a.m., licensed assisted living director	0 485		

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0 485	Continued From page 2 (LALD)-A stated they were familiar with current minimum assisted living requirements. On June 1, 2026, at 12:14 p.m., regional director of housing/ registered nurse (RDHS/RN)-F provided the licensee's Assisted Living Residency Agreement (contract) dated May 2024, and [licensee] Minnesota Assisted Living Meal Opt Out Acknowledgement. Included on page two of the contract, under section II. Fees and Payment, letter 'C' indicated "The Monthly Rate includes meals and other amenities as described in the attached price sheet. While meals are included in the Monthly Rate, you are not required to include or pay for meals as part of this Agreement. If you do not wish to include meals as part of this Agreement, Community will arrange with you to deduct or credit you for the cost of meals that are included in the Monthly Rate." Included on the meal opt out form, was an opportunity for the residents to decline three meals daily in exchange for a $270 credit monthly. Resident assisted living contracts lacked an option for residents to opt out of payment for one, two, or three meals residents would not want. On June 1, 2026, at 3:40 p.m., LALD-A stated all residents received the same contract and the contract included the cost of meals in the resident's monthly rent. LALD-A further stated a resident had the opportunity to decline all meals and receive a $270 monthly rent credit. LALD-A stated LALD-A was unaware the licensee's contract was missing required content and that the licensee was required to provide residents with an opportunity to opt out of one, two, or three meals. The Minnesota Department of Health Assisted	0 485		

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0 485	Continued From page 3 Living Resources and Frequently Asked Questions (FAQs) website, last updated October 13, 2025, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated	0 775		

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0 775	Continued From page 4 June 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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01650	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were revised to include the required content for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 1, 2026, at 12:39 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. R4 was admitted to the facility on March 31, 2016. R4 diagnoses included diabetes, atrial fibrillation (rapid and irregular heart rhythm), chronic kidney disease (kidney damage resulting in loss of ability to filter blood properly), heart failure, anxiety, and hypertension (elevated blood pressure). R4's Service Plan With Schedule (service plan) dated March 26, 2026, indicated R4 received blood glucose checks. R4's Physician Order Report dated June 2, 2026, indicated R4 received blood glucose monitoring	01650		

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01650	Continued From page 6 two times daily, before breakfast and before supper. On June 2, 2026, at 7:11 a.m., the surveyor observed unlicensed personnel (ULP)- D complete blood glucose testing on R4. R4's service plan lacked the frequency of blood glucose monitoring as ordered. On June 3, 2026, at 12:44 p.m., clinical nurse supervisor (CNS)-B stated CNS-B was not aware R4's blood glucose monitoring frequency was required to be included on the service plan when it was included in the order and on R4's electronic medication administration record (eMAR). The licensee's Medication & Treatment Orders-Receiving, Implementing, Renewal and Re-ordering policy dated 2021, indicated the RN (registered nurse) ensured all treatment order changes were updated on the resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	01880		

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01880	Continued From page 7 Based on observation, interview, and record review, the licensee failed to ensure one of one medication refrigerators storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. In addition, licensee failed to ensure over the counter (OTC) and prescription medications were stored in a securely locked and substantially constructed compartment permitting only authorized personnel to have access for one of one resident. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 1, 2026, at 10:23 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. MEDICATION REFRIGERATOR On June 2, 2026, at 1:10 p.m., the surveyor observed the licensee's medication refrigerator with unlicensed personnel (ULP)-G. ULP-G stated the current temperature was 28 degrees Fahrenheit (F). The current medications stored in the medication refrigerator were: - R10's three unopened Lantus (long-acting insulin) pens; - R11's unopened bottle of Latanoprost (lowers	01880		

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01880	Continued From page 8 abnormally high pressure inside of the eye); and - R12's two unopened Mounjaro (manages blood sugar levels for people with type two diabetes) injections. The licensee's Temperature Log for Refrigerator-Fahrenheit dated May 1, 2026, through May 31, 2026, and June 1, 2026, through June 2, 2026, indicated the medication refrigerator temperature was expected to be documented daily and if the temperature was above 46 degrees F or below 36 degrees F, instruction was to contact the local or state health department immediately. The Temperature Log for Refrigerator- Fahrenheit chart included the following entries: - May 7, 2026, the temperature was 35 degrees F; - May 8, 2026, the temperature was 35 degrees F; - May 10, 2026, the temperature was 35 degrees F; - May 11, 2026, the temperature was 34 degrees F; - May 13, 2026, the temperature was 31 degrees F; - May 16, 2026, the temperature was 34 degrees F; - May 17, 2026, the temperature was 32 degrees F; - May 19, 2026, the temperature was 34 degrees F; - May 22, 2026, the temperature was 35 degrees F; - May 25, 2026, the temperature was 34 degrees F; - May 28, 2026, the temperature was 35 degrees F; - May 29, 2026, the temperature was 34 degrees F; - May 30, 2026, the temperature was 31 degrees	01880		

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01880	Continued From page 9 F; - June 1, 2026, the temperature was 35 degrees F; and - June 2, 2026, the temperature was 33 degrees F. The manufacturer's instructions for Lantus dated June 2022, indicated to store unopened Lantus in the refrigerator at 36 degrees F to 46 degrees F. Do not allow Lantus to freeze. The manufacturer's instructions for latanoprost 0.005% ophthalmic solution dated September 2020, indicated to store unopened bottles of latanoprost in the refrigerator at 36 degrees F to 46 degrees F. The manufacturer's instructions for Mounjaro dated May 2022, indicated to store Mounjaro in the refrigerator at 36 degrees F to 46 degrees F. Do not allow Mounjaro to freeze. On June 2, 2026, at 1:11 p.m., ULP-G stated when a medication refrigerator temperature reading is above 46 degrees F or below 36 degrees F, staff were trained to notify the nurse immediately however there was no documentation requirement for that action. ULP-G further stated ULP-G notified CNS-B of the low reading on June 2, 2026. On June 2, 2026, at 1:42 p.m., CNS-B stated staff were trained to record the medication refrigerator temperature daily and to notify CNS-B if the temperature was out of range. CNS-B further stated CNS-B had not been notified of the temperatures in May and June which were out of range and CNS-B didn't have a process for auditing the temperature log currently.	01880		

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01880	Continued From page 10 SECURE STORAGE R4 admitted to the licensee on March 31, 2016. R4 diagnoses included diabetes, atrial fibrillation (rapid and irregular heart rhythm), chronic kidney disease (kidney damage resulting in loss of ability to filter blood properly), heart failure, anxiety, and hypertension (elevated blood pressure). R4's Service Plan With Schedule (service plan) dated March 26, 2026, indicated R4 received medication management services. R4's Medication Management Assessment dated April 3, 2026, indicated under the section titled 'Assessment of Need for Medication Management Services' the following: - medications at risk for diversion- has no medications at risk for diversion/meds are locked up and nurse does medication check weekly; and - services needed based on assessment- administration of medications, storing and securing of medications, monitoring of medications for effectiveness and side effects, coordinating refills, handling and implementing changes to prescriptions, and communications with prescriber and pharmacy. On June 2, 2026, at 7:11 a.m., the surveyor observed ULP-D administer scheduled medication and treatments. During the medication and treatment observation, the surveyor observed the following items in plain sight on R4's side and dining tables: - Cortisone 10 (anti-itch cream), partial tube, expires August 2026; - Benadryl extra strength cream (anti-itch cream), partial tube, expires July 2026; - Benadryl extra strength cream, partial tube, expired September 2023;	01880		

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01880	Continued From page 11 - Neosporin plus Pain relief (prevents infection in minor wounds and relieve associated pain), partial tube; - Benadryl extra strength gel, partial tube, expires September 2026; - Icy Hot (temporary relieve muscle and joint aches and pains) original roll-on, partial container, expires November 2028; -anti-itch lotion- camphor 0.5%/menthol 0.5% lotion, partial bottle, expires November 2026; - Pataday extra strength (eye allergy itch relief) drops, partial bottle; - Aspercreme max (maximum) strength with lidocaine 4% (targeted pain relief) patches, partial box; and - Robitussin maximum strength (suppresses cough and loosen mucus), partial bottle, expires October 2028. R4's Physician Order Report dated June 2, 2026, included an order for Neosporin plus pain relief cream to be applied on the top and bottom of R4's toes and feet in the morning and at bedtime and lidocaine 4% patch be applied every morning and removed in the evening. All other medications listed above were not included. R4's prescribed and over the counter (OTC) medications were not stored appropriately according to R4's medication management assessment. On June 2, 2026, at 7:48 a.m., ULP-D stated R4's Neosporin plus pain relief cream was kept in R4's room by staff for convenience. ULP-D further stated R4's family occasionally brought in additional medications for R4 to use and ULP-D was uncertain whether nursing was notified of the OTC medications.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30475	A. BUILDING: _____ B. WING _____	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT ST GERTRUDES	1850 SARAZIN ST SHAKOPEE, MN 55379

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01880	Continued From page 12 On June 2, 2026, at 2:52 p.m., CNS-B stated the licensee provided all medication management services for R4 and no medications should be stored in the R4's room. CNS-B further stated R4 was assessed and determined to not be appropriate for self-administration of medication and CNS-B was unaware R4 had the above-mentioned OTC medications in R4's room. CNS-B stated staff were trained to store all prescribed medications in the medication cart and to notify nursing if family provided any additional medications/supplements. The licensee's Storage of Medications policy dated February 1, 2025, indicated the registered nurse (RN) completed the medication management plan which may indicate the need for secured storage of medication. The policy further indicated when the RN determined secured storage of medication is needed, the RN identified where medications were stored, how they were secured or locked under proper temperature control, and who had access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications in one of two medication carts. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on June 1, 2026, at 10:23 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On June 2, 2026, at 12:29 p.m., the surveyor observed the second-floor secured medication cart with registered nurse (RN)-H and observed the following: - R7's ondansetron 4 milligrams (mg), quantity seven tablets, expired May 8, 2026; - R7's bisacodyl 5 mg, 26 tablets, expired April 21, 2026; and - R10's Preservision Areds 2, open bottle with unknown number of capsules, expired April 2026. On June 2, 2026, at 12:38 p.m., RN-H stated RN-H audited the medication carts weekly. RN-H further stated RN-H hadn't looked through R7's medications recently due to R7 being admitted to	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30475	A. BUILDING: _____ B. WING _____	06/05/2026

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01890	Continued From page 14 a local transitional care unit (TCU) and R10's expired medication was missed in error. On June 3, 2026, at 12:38 p.m., CNS-B stated nursing staff completed weekly audits of all medication supplies and the expired medications were missed in error. The licensee's Medication Disposal and Med (sic) Safe policy revised March 3, 2022, indicated the licensee disposed of expired medications managed by the licensee according to the accepted practices of the Minnesota Board of Pharmacy and documented the disposal in the resident's medical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St. Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

THE GARDENS AT ST GERTRUDES
1850 SARAZIN STREET
Shakopee, MN 55379
Scott County
Parcel:

Phone:

License Info

License: HIFD 30475

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1062261118
Inspection Type: Full - Single
Date: 6/1/2026 Time: 2:37:55 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Site visit confirms Cura is still handling food service on behalf of St. Gertrude's. They will continue to be inspected regularly by MDL FPLS. They have no outstanding orders in need of correction at this time.

Report for Allison Skillingstad (HRD).

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1062261118 from 6/1/2026

Bill Harrison
Operator- Cura

Nicholas Streeter, RS
Public Health Sanitarian 2
nicholas.streeter@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30475016	**Date:** 6/2/2026
Facility Name: Gardens at St. Gertrudes	
Facility Address: 1850 Sarazin St., Shakopee, MN 55379	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments:

   The fire rating placards on fire doors around the facility were painted over and difficult to read. Fire rated doors should have the appropriate rating placards displayed and unobstructed.

   The smoke detector head installed near the second-floor nurses' station was pulling loose from the ceiling and was not securely attached. All fire detection equipment including the head should be affixed securely and maintained in proper working condition.

   The strobe device on the smoke alarm installed in resident room 154 was not functioning properly when tested. All components of supplied smoke alarms should be functional and maintained in working condition.

3. Storage shall be maintained 2 feet (610 mm) or more below the ceiling in nonsprinklered areas of buildings or a minimum of 18 inches (457 mm) below sprinkler head deflectors in sprinklered areas of buildings. [Minn. Stat. 144G.45 subd. 2; MSFC 315.3.1]

Comments: Proper clearance around the sprinkler head in storage room 218 was maintained and items were placed directly underneath the sprinkler head which may have obstructed the flow of water. Proper clearance around sprinkler heads should be maintained and stored items should be placed sufficiently far below sprinkler equipment.

4. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. Where panic or fire exit hardware is installed, it shall comply with the following: The maximum unlatching force shall not exceed 15 pounds (67 N). [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3, MSFC 1010.1.10.1]

   Comments: Exit doors around the facility were difficult to open and required excessive force to operate. The panic hardware on exit doors was not operating properly and was catching on the frame in a way that obstructed ready egress from the facility. Panic hardware should be maintained in proper working condition and egress routes should allow unobstructed exiting without requiring excessive force.

5. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

   Comments: An unapproved multiplug adapter was in use in resident room 154 to power multiple electronics. Unapproved multiplug adapters should be removed or replaced.

6. The emergency power system for means of egress illumination shall provide power for not less than 30 minutes and consist of storage batteries, unit equipment, or an on-site generator. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.5.3]

   Comments: The exit sign provided in the courtyard of the facility failed to illuminate when tested. The exit sign appeared to be weathered and was not functional. Exit signage should be maintained in operable condition and should be capable of supplying required emergency power.