DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FPNL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00459

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245610**
2.STATE VENDOR OR MEDICAID NO.
(L2) **440886100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST GERTRUDES HEALTH & REHABILITATION CENTER**
(L4) **1850 SARAZIN STREET**
(L5) **SHAKOPEE, MN** (L6) **55379**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/22/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **105** (L18)
13.Total Certified Beds **105** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Maudelin Saint Jean, HFE NE II 09/21/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/23/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
11/08/1996
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 17, 2021

Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, MN 55379

RE: CCN: 245610
Cycle Start Date: July 22, 2021

Dear Administrator:

On July 22, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility 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 delivered CMS-2567, whereby significant 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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 30, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 30, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 30, 2021.

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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 $11,160; 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 September 30, 2021, 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 September 30, 2021. 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" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 January 22, 2022 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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	**1850 SARAZIN STREET 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) COMPLETION DATE
E 000	Initial Comments On 7/19/21, to 7/22/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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.	E 000		
F 000	INITIAL COMMENTS On 7/19/21, to 7/22/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5610077C (MN70398), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5610075C (MN73180) H5610076C (MN68188) H5610078C (MN66315; MN66130) H5610079C (MN66109) H5610080C (MN64524) H5610081C(MN62672) H5610082C (MN62603	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/27/2021

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

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F 000	Continued From page 1 H5610083C) (MN61854) 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		9/15/21

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F 550	Continued From page 2 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents were dressed in a dignified manner for 1 of 1 residents (R287) who was reviewed for dignity. Findings include: R287's Face Sheet dated 7/22/21, indicated diagnoses of congestive heart failure (CHF), cellulitis, chronic pain, and depression. R287's care plan dated 7/20/21, indicated R287 needed assistance with bathing, grooming, ambulation, transferring, mobility, and toileting. R287's Point of Care History dated 7/12/21, through 7/22/21, indicated R287 required limited to extensive assist of one person in a physical assist to walk in her room, extensive personal	F 550	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, The Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Corrections prior to the resolution of any appeal which may be filed solely because of the requirements under state	

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F 550	Continued From page 3 assistance to move on the unit, a wheelchair or walker for locomotion, and extensive personal assistance to dress, and transfer. R287's Occupational Therapy (OT) Daily Treatment Note dated 7/21/21, indicated certified occupational therapist assistant (COTA)-A worked with R287 to doff and donn a shirt. There was no indication related to pants. R287's progress note dated 7/22/21, at 3:21 p.m. indicated R287 informed social worker (SW)-A she was incontinent in the morning and soaked her bottoms. R287 believed an aide assisted her to remove her bottoms. During an observation on 7/19/21, at 2:25 p.m. nursing assistant (NA)-A walked into R287's room. R287 told NA-A she was having a bowel movement and needed help to the bathroom. During an observation and interview on 7/19/21, at 4:55 p.m. R287 sat in her room in a green gown which tied behind her neck and waist. R287's back was exposed. R287 stated she would prefer to wear "actual clothing" instead of the hospital gown. R287 also stated she felt exposed with the hospital gown on and did not want people to see her back side or in it. R287 stated a unidentified staff member told she had to wear the hospital gown. R287 further stated she would prefer to wear something with pants and top that would cover her body. R287 stated she thought the unidentified aide wanted her to wear the hospital gown as it would be easier to assist. R287 stated she did not want to work with therapy and walk down the hall with her back and bottom exposed. R287 worked with Physical therapy (PT) and OT during this time.	F 550	and federal law that mandate submission of a Plan of Correction within ten (10) days of the receipt of the CMS 2567 form as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance The policy, Resident Rights and Notification of Resident Rights was reviewed and deemed appropriate. R278 preferences on dressing care plan have been reviewed and care planned updated. All other residents potentially affected by this deficient practice were reviewed and care plans were updated as appropriate.	

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F 550	Continued From page 4 During an observation and interview on 7/21/21, at 7:41 a.m. R287 wore a brief and a shirt while she ate breakfast in a chair by a window in her room. R287 had no pants on. R287 stated an unidentified aide assisted her after an incontinent episode the night prior and took her pants off. R287 further stated the unidentified aide did not help her put new pants back on and just left her in her brief. R287 further stated wished the unidentified aide had helped her put new pants back on as she was already embarrassed that she "peed on herself." R287 stated she was even more embarrassed since she had to eat breakfast with no pants and would prefer to wear pants. During an interview at 7/21/21, at 7:45 a.m. COTA-A verified R287 did not have pants on. COTA-A stated there had been another time when R287 had not been wearing pants. COTA-A also stated she was about to work with her and would help get R287 fully dressed. During an interview on 7/22/21, at 1:58 p.m. SW-A stated it would be against one's dignity if a resident wanted to wear pants but was not able to and felt embarrassed and exposed. During an interview on 7/22/21, at 11:15 a.m. the director of nursing (DON) verified a resident should be dressed in a way they want and should not feel embarrassed or exposed. The facility policy Combined Federal and State Bill of Rights dated 2/17, indicated the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or	F 550	It is the policy of St. Gertrude's to provide residents the right to a dignified existence and self-determination. The facility provides each resident with respect and dignity; care for each resident that promotes maintenance and enhances their quality of life, recognizing each resident's individuality. Facility protects the residents rights of its residents. Policies and procedures for resident rights and dignity reviewed and remain current. All staff will attend mandatory educational training starting 8/31/2021 through 9/15/2021. Staff who do not attend will be required to complete the training and pass the post test before returning to work. The Director of Social Services or designee will complete random audits that will be conducted every day for one week, then 5 times a week for 5 weeks, 3 times a week for 3 weeks, then weekly for 4 months and as needed. Audit results will be reviewed by the QAPI committee monthly x4 months for input on the need to increase, decrease or discontinue audits.	

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F 550	Continued From page 5 enhancement of their quality of life. The resident as a right to be treated with respect and dignity.	F 550		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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 expired food items were disposed of to prevent the spread of food borne organisms. This had the potential to affect all 124 residents at the facility who consumed food from the kitchen. Findings include: During an observation and interview on 7/19/21, at 12:18 p.m. the following expired items were found:	F 812	It is the policy of St. Gertrude's to follow CFR(s)L 483.60(I)(1)(2) as it relates to food procurement, store/prepare/serve-sanitary. The policy for the culinary department sanitation and monitoring was reviewed and remains current. The facility procures food from only approved sources that are considered satisfactory by federal, state or local authorities.	9/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING _____ B. WING _____	C 07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERTRUDES HEALTH & REHABILITATION CENTER	1850 SARAZIN STREET 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) COMPLETION DATE
F 812	Continued From page 6 - one partially used ½ gallon Glenview Farms Grade A pasteurized whole milk with vitamin D with an expiration date of 7/11/21; - one 16-ounce (oz) container of sour cream with expiration date of 7/2/21; - In dry storage: three 4 oz containers of Lyons Ready Care honey thickened milk with a use by date of 7/13/21, and twenty-one 4 oz containers of Lyons Ready Care thickened apple juice with use by date of 7/12/21. The food service director (FSD)-C verified the products expiration dates.. During an observation and interview on 7/21/21, at 10:03 a.m. the twenty-one 4 oz containers of Lyons Ready Care thickened apple juice with use by date of 7/12/21, were still on the shelf. FSD-C verified the product expiration date had passed. FSD-C stated no one at the facility was currently prescribed honey thickened products, and he expected his staff to verify the expiration date before any product was used. During an interview on 7/21/21, at 10:07 a.m. with FSD-C he stated it was "unacceptable" to have expired food. The FSD-C stated kitchen policy identified best buy date, and best used date are the same as the expiration date. FSD-C stated any expired products would be discarded the evening before. Example the milk that expired on 7/11/21, should have been discarded on the evening of 7/10/21. Staff check expiration dates when they grab the item, and during weekly inventory. FSD-C provided kitchen food storage policy. During an interview on 7/22/21, at 12:49 p.m. Cook (C)-A stated before using an item she would check the expiration date. If the date	F 812	All expired items found were immediately discarded. Although this deficient practice did not affect a resident or any other residents in this facility, all culinary staff will attend mandatory education on proper food storage rotation and expiration dates of food by 9/1/2021 to ensure any future deficient practices do not occur. The Culinary Director of designee will complete random audits and will be conducted 5 times a week for 5 weeks, 3 times a week for 3 weeks, then weekly x4 months as needed. Audit results will be reviewed by the QAPI committee monthly x4 months for input on the need to increase, decrease or discontinue audits.	

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F 812	Continued From page 7 indicates "best buy date" she would conduct a "quality check" before using. Any product found past the expiration date would be thrown away. Cook-A stated she frequently looked at dairy products expiration date before using. Cook-A stated she does not participate in the weekly inventory. During an interview on 7/22/21, at 2:44 p.m. C-A stated the Glenview Farms Grade A pasteurized whole milk with vitamin D would have been used in certain recipes after the expiration date. The facility menu for 7/11/21, through 7/19/21, was reviewed by C-A for any meal prepared with milk. She identified three meals that used milk. Those meals included Swedish meatballs for lunch on 7/12/21; tator tot casserole for dinner on 7/15/21; and chicken wild rice casserole for dinner on 7/19/21. During an interview on 7/22/21, at 2:48 p.m. the director of nursing (DON) stated resident meals are prepared in the kitchen, not at the attached hospital. The DON stated all 124 residents during 7/11/21, and 7/19/21, would have received the meals served from expired milk. The facility kitchen policy titled Food Safety Manual dated 2013, was reviewed. Policy discussed the term used-by-date. The policy stated any food item labled use-by-date will be treated as the expiraiton date and discard accordingly.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		9/15/21

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F 880	Continued From page 8 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 9 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure glove change and hand hygiene were maintained to prevent the spread of organisms/infection, failed to ensure the use of adequate infection control practices for bedpan storage, observed during personal cares for 1 of 3 residents (141) and failed to ensure adequate infection control practices were maintained with glove change and hand hygiene to prevent the spread of organisms for 1 of 3 residents (R64) observed during incontinent cares, reviewed for personal cares.	F 880	It is the policy of St. Gertrude's to follow CFR: 483.80(a)(1)(2)(4)(e)(f) as it relates to Infection Prevention Control. The policies for Infection Prevention and Control re: equipment/environment and hand hygiene were reviewed and remain current. Information from the Centers for Disease Control were obtained regarding when to DON and DOFF gloves and clarification was added to include indication for hand hygiene to occur when working from soiled to clean. This will	

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F 880	Continued From page 10 Findings Include: R141's Face Sheet dated 7/22/21, indicated R141 diagnoses included urinary tract infection, chronic kidney disease and displaced intertrochanteric fracture of left femur (hip fracture). R141's admission Minimum Data Set (MDS) dated 6/17/21, indicated R141 required extensive assist of two staff for bed mobility, transfers, dressing, toilet use and personal hygiene. R141 was frequently incontinent of bladder. R141's care plan updated 6/29/21, indicated to provide toileting assistance every two hours, provide incontinence care after each incontinent episode, and to use moisture barrier product to perineal area. R141's Physician Orders dated 7/19/21, to 7/26/21, indicated an order for cefdinir 300 milligrams (mg) (an antibiotic used to treat urinary tract infections) twice a day for seven days for urinary tract infection. During interview on 7/19/21, at 4:31 p.m. R141 stated had been to the hospital for urinary tract infection the past month and usually used the bed pan while in bed with staff assist due to bladder frequency. During observation on 7/21/21, at 7:36 a.m. through 7:59 a.m. occupational therapist (OT)-D donned gloves and assisted R141 to the bathroom located in R141's in room, to take a shower. OT-D assisted R141 by stand by assist using a gait belt and escorted R141, who was ambulating with a walker, into the bathroom and onto the shower chair. OT-D assisted R141 with	F 880	ensure that R64 and R141 and all other residents benefit from appropriate use of gloves and hand hygiene. All licensed nurses, occupational/physical therapist and nursing assistants will attend mandatory training starting 8/31 through 9/15/2021. Those who do not attend will be required to complete the training and pass the post test before returning to work. The Director of Nursing or designee will random audits and will be conducted 5 times a week for 5 weeks, 3 times a week for 3 weeks, then weekly x4 months as needed. Audit results will be reviewed by the QAPI committee monthly x4 months for input on the need to increase, decrease or discontinue audits.	

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F 880	Continued From page 11	F 880		

set up by adjusting the water temperature for R141. OT-D then proceeded to take a dirty gown off the floor and place it into a bag and touch the gargabe bin which had trash in it, including soiled incontinent product. OT-D then had to stop as R141 needed some assistance in the shower; OT-D adjusted water temperature. Without changing gloves, OT-D grabbed clean wash cloths and towels out of the closet in bathroom and handed the washcloth to R141. OT-D adjusted a bath towel on floor near the shower stall by folding it and placing it closer to the shower stall. OT-D did not change gloves or sanitize hands but then touched R141's clean blue scrubs, assisted R141 to add soap to washcloth, and proceeded to assist R141 to wash her feet. OT-D then assisted R141 with holding the shower head as R141 washed her own peri areas. OT-D grabbed a bath towel and placed one towel in shower chair as R141 was standing up, handed R141 another bath towel for R141 to dry self. OT-D grabbed wheelchair and placed a dry towel onto the wheelchair, and placed another bath towel near the sink. OT-D grabbed trash bag and tied it up and tied up the dirty laundry trash bag and placed both near the shower door. Still without changing gloves. OT-D picked up a towel that was lying partially on the floor, partially on another towel on the floor, and placed it over R141's shoulders. OT-D then assisted R141 with set up for oral cares by touching R141's toothbrush and tooth paste, and handed to R141 without changing er gloves.

During observation on 7/21/21, at 7:59 a.m. OT-D, informed R141 she would need to grab some items and would be back. OT- D removed gloves and left room.

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F 880	Continued From page 12	F 880		

During observation on 7/21/21, at 8:03 a.m. through 8:25 a.m. OT-D returned to R141's room, used hand sanitizer, donned gloves, grabbed the dirty tied up linen bag, placed dirty towel from floor into a gargabe bag, then touched sink area, touched resident's blue scrubs and assisted R141 to wear top of blue scrubs. OT-D grabbed lotion bottle and applied lotion to R141's feet and legs, wiped hands with dirty towel on floor. OT-D left the room at 8:12 a.m. after changing gloves to get a nurse for a skin check. OT-D returned to the room at 8:13 a.m. and assisted R141 with putting on scrub pants and gripper socks, OT-D then donned gloves, touched the dirty towels, sink area, and assisted to place blue incontinent brief on R141 and then attempted to place barrier cream onto buttock area without changing gloves.

During observation on 7/21/21, at 8:22 a.m. R141's bedpan was directly on the floor near the toilet in R141's bathroom. The bedpan was not in a bag.

During observation on 7/21/21, at 9:01 a.m. R141's bedpan was on the bathroom floor near the toilet. The bedpan was not in a bag.

During interview on 7/21/21, at 8:32 a.m. OT- D stated she was a float OT throughout the building but had worked with R141 about one to two times a week for about six to 10 sessions. OT-D stated should have changed gloves more frequently especially after touching dirty items, dirty surfaces and dirty linens off the floor, emptying the garbage and before applying barrier cream to resident since had touched dirty surfaces and items.

During observation on 7/22/21, at 10:20 a.m.

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F 880	Continued From page 13	F 880		

R141's bedpan was on the bathroom floor near toilet. The bedpan was not in a bag.

During interview on 7/22/21, at 10:26 a.m. licensed practical nurse (LPN)-A verified R141's bedpan was on the floor near the toilet and was not bagged. LPN-A stated bedpans were supposed to be cleaned after each use, placed into a plastic bag and hung on the bathroom railing. LPN-A further stated a new bag should be used after every use before hanging on railing.

R64's Face Sheet dated 7/23/21, indicated diagnoses that included left artificial hip joint, infection following procedure, and urinary tract infection.

R64's admission MDS dated 6/18/21, indicated R64 required extensive assist of two staff for bed mobility, transfers, toileting and personal hygiene.

R64's care plan dated 7/22/21, indicated required assistance with toileting needs.

R64's Physician Order Report dated 6/20/21, to 7/23/21, indicated R64 had an order dated 6/24/21, to 7/1/21, for Ciprofloxacin hydrochloride (hcl), (an antibiotic), 250 mg orally twice a day for urinary tract infection.

During observation on 7/21/21, at 9:44 a.m. nursing assistant (NA)-B had completed helping R64 to the toilet. R64 had a bowel movement and had been changed by NA-B. NA-B had on a face mask, goggles, gown and gloves. NA-B changed gloves after R64 was assited wtih perianal care. NA-B assisted R64 to whee chair to finish morning cares which included cleaning the front

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F 880	Continued From page 14	F 880		

of R64's body and getting dressed. After NA-B assisted R64 to transfer into the wheelchair, occupational therapist (OT)-E entered the room and stated s/he would complete R64's cares. NA-B removed dirty towel from the floor and placed it in trash bag in the trash bin which was in the shower stall. NA-B emptied soiled trash from bin and tied the bag of trash and the dirty linen bags. OT-E asked NA-B to assist her to stand R64 up using the stand up lift. NA-B agreed and placed the dirty bags on the floor near the bathroom door and began to assist OT-E with the stand up lift, touching R64, and sink surfaces. NA-B did not remove her gloves or perform hand hygiene, but proceeded to assist with the using the lift to stand R64 up. While NA-B and OT-E were assisting R64 to stand, R64 began to have a bowel movement and NA-B cleaned R64 perineal area by using wipes with the same gloves. NA-B only changed gloves before administering barrier cream to R64's perineal area.

During interview on 7/21/21, at 11:25 a.m. NA-B verified she should have hand sanitized and changed gloves after touching the soiled trash and soiled linens, when she emptied garbage cans. NA-B also stated she should havechanged gloves after had removed dirty towel from the bathroom floor but before she assisted R64 with the transfer and pericares.

During interview on 7/22/21, at 3:05 p.m. the director of nursing (DON) stated all staff were to follow adequate infection control practices according to the facility infection control training and facility infection control policy.

The facility Infection Prevention and Control

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F 880	Continued From page 15 Policy updated 11/16/2016, indicated the infection prevention and control program existed to assure a safe, sanitary and comfortable environment for residents and personnel. It was designed to help prevent the development and transmission of disease and infection. Microorganisms may enter a resident through various points of entry (direct or indirect) such as incontinent cares without proper hand washing. The facility glove use policy was requested but not received.	F 880		

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	245610	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/21/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/21/2021, 2021. At the time of this survey, ST. GERTRUDES HEALTH CENTER & REHABILITATION CENTER was 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/27/2021

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

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Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

ST. GERTRUDES HEALTH CENTER & REHABILITATION 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

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ST GERTRUDES HEALTH & REHABILITATION CENTER	**1850 SARAZIN STREET** **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) COMPLETION DATE
K 000	Continued From page 2 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 is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 105 beds and had a census of 80 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect	K 223		9/30/21

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K 223	Continued From page 3 smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain self-closing doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.1.1.4.1.3, 19.2.2.2.7, and 7.2.1.8.2. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed that the magnetic-hold assembly of a Kitchen door was damaged and non-functional. The door was being held in an open position by alternate means and would not operate properly in an emergency situation. This deficient condition was confirmed by the Facility Maintenance Director at the time of discovery.	K 223	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, The Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Corrections prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the receipt of the CMS 2567 form as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance The mount for the magnetic lock was non-functional. Re-mounting and brace magnetic lock mechanism to occur.	

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K 223	Continued From page 4	K 223	Repair will be completed by facility maintenance staff. Work order has been entered into facility TELS work order system and repair to be completed by 9/30/ 2021. Ryan Klingenberg, Campus Director of Plant Operations will monitor the TELS work order system for compliance. Ryan Klingenberg, Campus Director of Plant Operations will provide education to the Safety Committee members on this requirement.	
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain exit discharge per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.1.7, 7.7. These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed that the exit door, adjacent to RM 284, had a vertical transition to grade greater	K 271	Expert Concrete Raising, external contractor has been arranged to lift the concrete pads back to the original height, fill gaps with a hard packable material and caulk for aesthetics to prevent water intrusion. Repair to be completed by 9/30/2021. Ryan Klingenberg, Campus Director of Plant Operations will monitor for completion and include exterior walkways on the monthly safety walk through	9/30/21

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K 271	Continued From page 5 than one-half inch and a horizontal transition gap greater than one inch to the concrete. 2. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed in Wing 200, that the Kitchenette area exit door had a vertical transition to grade greater than one-half inch and a horizontal transition gap greater than one-inch to the concrete. These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery.	K 271	completed by the Safety Committee.	
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.6.2.7and NFPA 72 (2010 edition) National Fire Alarm and Signal Code, sections 17.4.2 and 17.14.5. This deficient condition could have an isolated impact on the residents within the facility. Findings include:	K 345	The pull station located at the 132 Nurses station is out dated and non-serviceable. Pull station to be removed as a functioning pull station is mounted on a wall less than 3 ft. from the non-functioning pull station. Out dated pull station will be removed by 10/17/2021. Ryan Klingenberg, Campus Director of Plant Operations will complete education	9/15/21

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K 345	Continued From page 6 On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed that the manual pull-station at 132 Nurses Station was obstructed. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 345	to all staff that pull stations need to be kept free and clear of obstacles in case of fire or emergency by 9/15/2021.	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to implement a fire watch policy associated with the fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review that the Fire Alarm Out-of-Service Plan was incorrect in its time to implement Fire Watch protocol which stated eight hours. This deficient condition was confirmed by the	K 346	St Gertrude□s Emergency Operations Manual phrasing is incorrect in regards to the Fire Alarm out of Service. Emergency Operations Manual will be updated by 9/15/2021 to reflect that if the fire alarm system is out of service the fire watch protocol starts at 4 hours instead of 8 hours. Ryan Klingenberg, Campus Director of Plant Operations will correct phrasing in the Emergency Operations Manual. All Staff will be educated on the phrasing changes by 9/15/2021.	9/15/21

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K 346	Continued From page 7 Facility Maintenance Director at the time of discovery.	K 346		
K 353 SS=F	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 _____ 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 REQUIREMENT 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 9.7.5, 9.7.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, and 5.2.1.1.4. These deficient conditions could have a widespread impact on the residents within the facility. Findings include:	K 353	Missing paperwork in our facility plant operation log books. An area to upload documents has been added to facility TELS work order system. Pertinent documents need to be uploaded before t the regulatory work orders can be completed and closed in TELS work order system. Retrains maintenance staff on proper book keeping. Ryan Klingenberg, Campus Director of Plant Operations has sent all related	9/15/21

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K 353	Continued From page 8 1. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed the sprinkler heads above the kitchen dish-washing area exhibited signs of corrosion and oxidation. 2. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed the sprinkler heads located in RM 140 exhibited signs of corrosion and oxidation. 3. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed the sprinkler heads and piping located in the Therapy Pool Chemical Storage Room exhibited signs of corrosion and oxidation. 4. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed the sprinkler heads located in RM 109 exhibited signs of corrosion and oxidation. 5. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed in RM 116 that cabling had been attached to the sprinkler system piping. These deficient conditions were confirmed by the Maintenance Director at the time of discovery.	K 353	documents via email to Deputy State Fire Marshal Inspector Steven Jurrens on 7/23/2021. Campus Director of Plant Operations will provide education to maintenance staff on TELS work order system change by 9/15/2021 and will monitor the TELS work order system for proper use. Summit, external contractor provides all fire and sprinkler related service work. It has been arranged for Summit to fix the corroded sprinkler heads throughout the facility. Repair to be completed by 10/1/2021. Noted zip tied to a sprinkler line were removed on 7/23/2021. Ryan Klingenberg, Campus Director of Plant Operations or designee will monitor all contractor work areas after work has been completed to assure compliance. Maintenance staff were re-educated on 7/23/2021 as to what to look for while doing visual inspections of the sprinkler heads and that no fixtures can be tied or hanging from fire sprinkler line piping.	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced	K 355		8/23/21

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K 355	Continued From page 9 by: Based on observation and staff interview, the facility failed to inspect, maintain, and provide clear access to fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition) Portable Fire Extinguishers, sections 6.1.3.3.1, 7.2.2 (2), and 7.2.4.5. These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed the fire extinguisher in the Physical Therapy Area was access obstructed. 2. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed the fire extinguisher in RM 503 was access obstructed by item storage. 3. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed the fire extinguisher in the Elevator Room had not been checked/inspected since APRIL 2021. These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery.	K 355	All fire extinguishers need to be kept clear of obstructions and checked monthly. Obstructions were removed on 7/23/2021. Ryan Klingenberg, Campus Director of Plant Operations or designee will do spot checks after work orders has been completed to assure compliance. Maintenance staff has been provided an updated map with room numbers and fire extinguisher locations on 7/23/2021.	
K 374 SS=E	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	K 374		9/30/21

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K 374	Continued From page 10 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of the smoke barrier doors in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 7.2.1.15.2, and 8.5.4.1, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 5.1.2.1. These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed upon testing the Smoke Barrier doors in the area of the Dining Room did not close properly; they bound and stayed ajar. 2. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed upon testing the Smoke Barrier doors in the Physical Therapy area did not close properly; they bound and stayed ajar. These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery.	K 374	Maintenance will adjust doors as needed to assure easy opening, closing and latching functions as required. Any repairs noted to be completed by 9/30/2021 and a facility TELS work order was created to assess function of doors as a quarterly task. Ryan Klingenberg, Campus Director of Plant Operations or designee will monitor TELS work order system to assure compliance.	
K 712 SS=F	Fire Drills	K 712		9/15/21

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K 712	Continued From page 11 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to randomly conduct fire drills in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.7.6. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review that 90 minute time separation was not met for fire drills conducted on 2nd and 3rd shifts for the 1st quarter through the 4th quarter of the calendar year, 2. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review that fire drills were not conducted for 2nd shift during the 2nd quarter and 3rd shift during the 3rd quarter of the calendar year.	K 712	Fire drills will be conducted observing a 90 minute separation on each shift. Documentation will verify compliance. The drill conductor has been re-trained to meet this standard. Ryan Klingenberg, Campus Director of Plant Operations will monitor for compliance when reviewing the fire drill report each month, a system used for presenting to the monthly safety committee.	

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K 712	Continued From page 12 These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery.	K 712		
K 761 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 REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to inspect and test fire rated door assemblies in the facility per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15 and NFPA 80 (2010 edition), Standards for Fire Doors and Other Opening Protectives, sections 5.2.1 This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review, that documented inspection and testing of doors was last completed in February of 2019.	K 761	A facility TELS work order system was added as an annual regulatory task. Related documentation will have to be uploaded to the TELS work order system in order to close out the work order. Annual inspection will be completed by 9/30/2021. Ryan Klingenberg, Campus Director of Plant Operations or designee will monitor the TELS work order system to assure compliance at the end of each month.	9/30/21

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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
K 761	Continued From page 13 This deficient condition was confirmed by the Facility Maintenance Director at the time of discovery.	K 761		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to document the annual electrical receptacle testing in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2, 6.3.4.1 and 6.3.4.2. This deficient condition could have a widespread	K 914	Testing of all electrical receptacles will be completed on an annual basis by Campus Director of Plant Operations or designee in the Maintenance Department. Appropriate tools will be made available to test for polarity and resistance.	9/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245610	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/21/2021**

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K 914	Continued From page 14 impact on the residents within the facility. Findings include: On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review that no records were presented for review to confirm that annual resident room outlet testing had been completed. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 914	Ryan Klingenberg, Campus Director of Plant Operations will assign sections of the facility to be tested each quarter and will place this task into facility TELS work order system and will monitor for compliance at the end of each month.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8	K 920		9/15/21

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K 920	Continued From page 15 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly manage the implementation and usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). This deficient condition could have a patterned impact on the residents within the facility. Findings include: 1. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed that in RM 109, daisy-chained power strips were in use to power equipment and devices. 2. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed that in the Physical Therapy Office, daisy-chained power strips were in use to power equipment and devices. 3. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed that in Wing 400, in the Kitchenette, that an appliance (refrigerator) was connected to a power strip. 4. On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed in the area adjacent to RM 148, that an appliance (refrigerator) was connected to a power strip. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 920	The daisy-chained power strips have been removed. Staff were instructed to remove any non- essential related appliances from work spaces allowing work related items to be plugged directly into the wall or into a single power strip plugged directly into a wall. Maintenance Department will install a new refrigerator cord long enough to reach the outlet by 10/1/2021 for the 400□s Unit refrigerator. Ryan Klingenberg, Campus Director of Plant Operations will provide education to the Safety Committee members on this requirement. All staff will complete education on power strips and plug ins by 9/15/2021.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag	K 923		9/15/21

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K 923	Continued From page 16 CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	K 923		

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K 923	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain medical gas storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.4, 11.6.5 This deficient condition could have a pattered impact on the residents within the facility. Findings include: On 07/21/2021 between 09:30 AM to 02:30 PM, it was revealed that the Med Gas Storage Rooms in the 1000 and 2000 Wings, did not have in-room signage to identify placement locations for empty/full cylinders. This deficient condition was confirmed by the Maintenance Director at the time of discovery.	K 923	Oxygen rooms will have color coded adhesive available to identify full and empty cylinders of oxygen. All staff will complete education for color coding adhesive system in the Oxygen rooms by 9/15/2021. Campus Director of Plant Operations or designee with complete audits weekly for 4 weeks, then twice a month for 1 month, then monthly for 1 month. Audit results will be reviewed by Quality Council and Safety Committee monthly for further actions if needed.	

Electronically delivered
August 17, 2021

Administrator
St Gertrudes Health & Rehabilitation Center
1850 Sarazin Street
Shakopee, MN 55379

Re: State Nursing Home Licensing Orders
Event ID: FPNL11

Dear Administrator:

The above facility was surveyed on July 19, 2021 through July 22, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00459	A. BUILDING: _____ B. WING _____	C 07/22/2021

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2 000	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 7/19/21, to 7/22/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. 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 surveyors 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	2 000		

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2 000	Continued From page 2 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.	2 000		
21080	MN Rule 4658.0650 Subp. 1 Food Supplies; Clean,free from spoilage Subpart 1. Food. All food must be clean, wholesome, free from spoilage, free from adulteration and misbranding, and safe for human consumption. Canned or preserved food which has been processed in a place other than a commercial food-processing establishment is prohibited for use by nursing homes. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired food items were disposed of to prevent the spread of food borne organisms. This had the potential to affect all 124 residents at the facility who consumed food from the kitchen. Findings include: During an observation and interview on 7/19/21, at 12:18 p.m. the following expired items were found: - one partially used ½ gallon Glenview Farms Grade A pasteurized whole milk with vitamin D with an expiration date of 7/11/21; - one 16-ounce (oz) container of sour cream with expiration date of 7/2/21; - In dry storage: three 4 oz containers of Lyons Ready Care honey thickened milk with a use by	21080	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, The Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Corrections prior to the resolution of any appeal which may be filed solely because of the requirements under state	9/15/21

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21080	Continued From page 3 date of 7/13/21, and twenty-one 4 oz containers of Lyons Ready Care thickened apple juice with use by date of 7/12/21. The food service director (FSD)-C verified the products expiration dates.. During an observation and interview on 7/21/21, at 10:03 a.m. the twenty-one 4 oz containers of Lyons Ready Care thickened apple juice with use by date of 7/12/21, were still on the shelf. FSD-C verified the product expiration date had passed. FSD-C stated no one at the facility was currently prescribed honey thickened products, and he expected his staff to verify the expiration date before any product was used. During an interview on 7/21/21, at 10:07 a.m. with FSD-C he stated it was "unacceptable" to have expired food. The FSD-C stated kitchen policy identified best buy date, and best used date are the same as the expiration date. FSD-C stated any expired products would be discarded the evening before. Example the milk that expired on 7/11/21, should have been discarded on the evening of 7/10/21. Staff check expiration dates when they grab the item, and during weekly inventory. FSD-C provided kitchen food storage policy. During an interview on 7/22/21, at 12:49 p.m. Cook (C)-A stated before using an item she would check the expiration date. If the date indicates "best buy date" she would conduct a "quality check" before using. Any product found past the expiration date would be thrown away. Cook-A stated she frequently looked at dairy products expiration date before using. Cook-A stated she does not participate in the weekly inventory.	21080	and federal law that mandate submission of a Plan of Correction within ten (10) days of the receipt of the CMS 2567 form as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance It is the policy of St. Gertrude's to follow CFR(s)L 483.60(I)(1)(2) as it relates to food procurement, store/prepare/serve-sanitary. The policy for the culinary department sanitation and monitoring was reviewed and remains current. The facility procures food from only approved sources that are considered satisfactory by federal, state or local authorities. All expired items found were immediately discarded. Although this deficient practice did not affect a resident or any other	

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21080	Continued From page 4 During an interview on 7/22/21, at 2:44 p.m. C-A stated the Glenview Farms Grade A pasteurized whole milk with vitamin D would have been used in certain recipes after the expiration date. The facility menu for 7/11/21, through 7/19/21, was reviewed by C-A for any meal prepared with milk. She identified three meals that used milk. Those meals included Swedish meatballs for lunch on 7/12/21; tator tot casserole for dinner on 7/15/21; and chicken wild rice casserole for dinner on 7/19/21. During an interview on 7/22/21, at 2:48 p.m. the director of nursing (DON) stated resident meals are prepared in the kitchen, not at the attached hospital. The DON stated all 124 residents during 7/11/21, and 7/19/21, would have received the meals served from expired milk. The facility kitchen policy titled Food Safety Manual dated 2013, was reviewed. Policy discussed the term used-by-date. The policy stated any food item labled use-by-date will be treated as the expiraiton date and discard accordingly. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate storage of food occurs. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to	21080	residents in this facility, all culinary staff will attend mandatory education on proper food storage rotation and expiration dates of food by 9/1/2021 to ensure any future deficient practices do not occur. The Culinary Director of designee will complete random audits and will be conducted 5 times a week for 5 weeks, 3 times a week for 3 weeks, then weekly x4 months as needed. Audit results will be reviewed by the QAPI committee monthly x4 months for input on the need to increase, decrease or discontinue audits.	

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21080	Continued From page 5 determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21080		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure glove change and hand hygiene were maintained to prevent the spread of organisms/infection, failed to ensure the use of adequate infection control practices for bedpan storage, observed during personal cares for 1 of 3 residents (141) and failed to ensure adequate infection control practices were maintained with glove change and hand hygiene to prevent the spread of organisms for 1 of 3 residents (R64) observed during incontinent cares, reviewed for personal cares. Findings Include: R141's Face Sheet dated 7/22/21, indicated R141 diagnoses included urinary tract infection, chronic kidney disease and displaced intertrochanteric fracture of left femur (hip fracture). R141's admission Minimum Data Set (MDS) dated 6/17/21, indicated R141 required extensive assist of two staff for bed mobility, transfers,	21375	It is the policy of St. Gertrude's to follow CFR: 483.80(a)(1)(2)(4)(e)(f) as it relates to Infection Prevention Control. The policies for Infection Prevention and Control re: equipment/environment and hand hygiene were reviewed and remain current. Information from the Centers for Disease Control were obtained regarding when to DON and DOFF gloves and clarification was added to include indication for hand hygiene to occur when working from soiled to clean. This will ensure that R64 and R141 and all other residents benefit from appropriate use of gloves and hand hygiene. All licensed nurses, occupational/physical therapist and nursing assistants will attend mandatory training starting 8/31 through 9/15/2021. Those who do not attend will be required to complete the training and pass the post test before returning to work.	9/15/21

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21375	Continued From page 6 dressing, toilet use and personal hygiene. R141 was frequently incontinent of bladder. R141's care plan updated 6/29/21, indicated to provide toileting assistance every two hours, provide incontinence care after each incontinent episode, and to use moisture barrier product to perineal area. R141's Physician Orders dated 7/19/21, to 7/26/21, indicated an order for cefdinir 300 milligrams (mg) (an antibiotic used to treat urinary tract infections) twice a day for seven days for urinary tract infection. During interview on 7/19/21, at 4:31 p.m. R141 stated had been to the hospital for urinary tract infection the past month and usually used the bed pan while in bed with staff assist due to bladder frequency. During observation on 7/21/21, at 7:36 a.m. through 7:59 a.m. occupational therapist (OT)-D donned gloves and assisted R141 to the bathroom located in R141's in room, to take a shower. OT-D assisted R141 by stand by assist using a gait belt and escorted R141, who was ambulating with a walker, into the bathroom and onto the shower chair. OT-D assisted R141 with set up by adjusting the water temperature for R141. OT-D then proceeded to take a dirty gown off the floor and place it into a bag and touch the gargabe bin which had trash in it, including soiled incontinent product. OT-D then had to stop as R141 needed some assistance in the shower; OT-D adjusted water temperature. Without changing gloves, OT-D grabbed clean wash cloths and towels out of the closet in bathroom and handed the washcloth to R141. OT-D adjusted a bath towel on floor near the shower	21375	The Director of Nursing or designee will random audits and will be conducted 5 times a week for 5 weeks, 3 times a week for 3 weeks, then weekly x4 months as needed. Audit results will be reviewed by the QAPI committee monthly x4 months for input on the need to increase, decrease or discontinue audits.	

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21375	Continued From page 7	21375		

stall by folding it and placing it closer to the shower stall. OT-D did not change gloves or sanitize hands but then touched R141's clean blue scrubs, assisted R141 to add soap to washcloth, and proceeded to assist R141 to wash her feet. OT-D then assisted R141 with holding the shower head as R141 washed her own peri areas. OT-D grabbed a bath towel and placed one towel in shower chair as R141 was standing up, handed R141 another bath towel for R141 to dry self. OT-D grabbed wheelchair and placed a dry towel onto the wheelchair, and placed another bath towel near the sink. OT-D grabbed trash bag and tied it up and tied up the dirty laundry trash bag and placed both near the shower door. Still without changing gloves. OT-D picked up a towel that was lying partially on the floor, partially on another towel on the floor, and placed it over R141's shoulders. OT-D then assisted R141 with set up for oral cares by touching R141's toothbrush and tooth paste, and handed to R141 without changing er gloves.

During observation on 7/21/21, at 7:59 a.m. OT-D, informed R141 she would need to grab some items and would be back. OT- D removed gloves and left room.

During observation on 7/21/21, at 8:03 a.m. through 8:25 a.m. OT-D returned to R141's room, used hand sanitizer, donned gloves, grabbed the dirty tied up linen bag, placed dirty towel from floor into a gargabe bag, then touched sink area, touched resident's blue scrubs and assisted R141 to wear top of blue scrubs. OT-D grabbed lotion bottle and applied lotion to R141's feet and legs, wiped hands with dirty towel on floor. OT-D left the room at 8:12 a.m. after changing gloves to get a nurse for a skin check. OT-D returned to the room at 8:13 a.m. and assisted R141 with

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putting on scrub pants and gripper socks, OT-D then donned gloves, touched the dirty towels, sink area, and assisted to place blue incontinent brief on R141 and then attempted to place barrier cream onto buttock area without changing gloves.

During observation on 7/21/21, at 8:22 a.m. R141's bedpan was directly on the floor near the toilet in R141's bathroom. The bedpan was not in a bag.

During observation on 7/21/21, at 9:01 a.m. R141's bedpan was on the bathroom floor near the toilet. The bedpan was not in a bag.

During interview on 7/21/21, at 8:32 a.m. OT- D stated she was a float OT throughout the building but had worked with R141 about one to two times a week for about six to 10 sessions. OT-D stated should have changed gloves more frequently especially after touching dirty items, dirty surfaces and dirty linens off the floor, emptying the garbage and before applying barrier cream to resident since had touched dirty surfaces and items.

During observation on 7/22/21, at 10:20 a.m. R141's bedpan was on the bathroom floor near toilet. The bedpan was not in a bag.

During interview on 7/22/21, at 10:26 a.m. licensed practical nurse (LPN)-A verified R141's bedpan was on the floor near the toilet and was not bagged. LPN-A stated bedpans were supposed to be cleaned after each use, placed into a plastic bag and hung on the bathroom railing. LPN-A further stated a new bag should be used after every use before hanging on railing.

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21375	Continued From page 9 R64's Face Sheet dated 7/23/21, indicated diagnoses that included left artificial hip joint, infection following procedure, and urinary tract infection. R64's admission MDS dated 6/18/21, indicated R64 required extensive assist of two staff for bed mobility, transfers, toileting and personal hygiene. R64's care plan dated 7/22/21, indicated required assistance with toileting needs. R64's Physician Order Report dated 6/20/21, to 7/23/21, indicated R64 had an order dated 6/24/21, to 7/1/21, for Ciprofloxacin hydrochloride (hcl), (an antibiotic), 250 mg orally twice a day for urinary tract infection. During observation on 7/21/21, at 9:44 a.m. nursing assistant (NA)-B had completed helping R64 to the toilet. R64 had a bowel movement and had been changed by NA-B. NA-B had on a face mask, goggles, gown and gloves. NA-B changed gloves after R64 was assited wtih perianal care. NA-B assisted R64 to whee chair to finish morning cares which included cleaning the front of R64's body and getting dressed. After NA-B assisted R64 to transfer into the wheelchair, occupational therapist (OT)-E entered the room and stated s/he would complete R64's cares. NA-B removed dirty towel from the floor and placed it in trash bag in the trash bin which was in the shower stall. NA-B emptied soiled trash from bin and tied the bag of trash and the dirty linen bags. OT-E asked NA-B to assist her to stand R64 up using the stand up lift. NA-B agreed and placed the dirty bags on the floor near the bathroom door and began to assist OT-E with the stand up lift, touching R64, and sink surfaces. NA-B did not remove her gloves or perform hand	21375		

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hygiene, but proceeded to assist with the using the lift to stand R64 up. While NA-B and OT-E were assisting R64 to stand, R64 began to have a bowel movement and NA-B cleaned R64 perineal area by using wipes with the same gloves. NA-B only changed gloves before administering barrier cream to R64's perineal area.

During interview on 7/21/21, at 11:25 a.m. NA-B verified she should have hand sanitized and changed gloves after touching the soiled trash and soiled linens, when she emptied garbage cans. NA-B also stated she should havechanged gloves after had removed dirty towel from the bathroom floor but before she assisted R64 with the transfer and pericares.

During interview on 7/22/21, at 3:05 p.m. the director of nursing (DON) stated all staff were to follow adequate infection control practices according to the facility infection control training and facility infection control policy.

The facility Infection Prevention and Control Policy updated 11/16/2016, indicated the infection prevention and control program existed to assure a safe, sanitary and comfortable environment for residents and personnel. It was designed to help prevent the development and transmission of disease and infection. Microorganisms may enter a resident through various points of entry (direct or indirect) such as incontinent cares without proper hand washing.

The facility glove use policy was requested but not received.

Suggested Method of Correction

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21375	Continued From page 11 The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including tracking/trending of all illnesses in the facility as well as an antibiotic stewardship program and that a facility assessment and plan are written for water borne pathogens. In addition, the DON or designee could review/revise policies on infection control regarding hand washing and hand hygiene. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction: Twenty-one (21) days.	21375		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents were dressed in a dignified manner for 1 of 1 residents (R287) who was reviewed for dignity. Findings include: R287's Face Sheet dated 7/22/21, indicated diagnoses of congestive heart failure (CHF), cellulitis, chronic pain, and depression.	21805	The policy, Resident Rights and Notification of Resident Rights was reviewed and deemed appropriate. R278 preferences on dressing care plan have been reviewed and care planned updated. All other residents potentially affected by this deficient practice were reviewed and care plans were updated as appropriate.	9/15/21

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21805	Continued From page 12 R287's care plan dated 7/20/21, indicated R287 needed assistance with bathing, grooming, ambulation, transferring, mobility, and toileting. R287's Point of Care History dated 7/12/21, through 7/22/21, indicated R287 required limited to extensive assist of one person in a physical assist to walk in her room, extensive personal assistance to move on the unit, a wheelchair or walker for locomotion, and extensive personal assistance to dress, and transfer. R287's Occupational Therapy (OT) Daily Treatment Note dated 7/21/21, indicated certified occupational therapist assistant (COTA)-A worked with R287 to doff and donn a shirt. There was no indication related to pants. R287's progress note dated 7/22/21, at 3:21 p.m. indicated R287 informed social worker (SW)-A she was incontinent in the morning and soaked her bottoms. R287 believed an aide assisted her to remove her bottoms. During an observation on 7/19/21, at 2:25 p.m. nursing assistant (NA)-A walked into R287's room. R287 told NA-A she was having a bowel movement and needed help to the bathroom. During an observation and interview on 7/19/21, at 4:55 p.m. R287 sat in her room in a green gown which tied behind her neck and waist. R287's back was exposed. R287 stated she would prefer to wear "actual clothing" instead of the hospital gown. R287 also stated she felt exposed with the hospital gown on and did not want people to see her back side or in it. R287 stated a unidentified staff member told she had to wear the hospital gown. R287 further stated she	21805	It is the policy of St. Gertrude's to provide residents the right to a dignified existence and self-determination. The facility provides each resident with respect and dignity; care for each resident that promotes maintenance and enhances their quality of life, recognizing each resident's individuality. Facility protects the residents rights of its residents. Policies and procedures for resident rights and dignity reviewed and remain current. All staff will attend mandatory educational training starting 8/31/2021 through 9/15/2021. Staff who do not attend will be required to complete the training and pass the post test before returning to work. The Director of Social Services or designee will complete random audits that will be conducted every day for one week, then 5 times a week for 5 weeks, 3 times a week for 3 weeks, then weekly for 4 months and as needed. Audit results will be reviewed by the QAPI committee monthly x4 months for input on the need to increase, decrease or discontinue audits.	

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21805	Continued From page 13	21805		

would prefer to wear something with pants and top that would cover her body. R287 stated she thought the unidentified aide wanted her to wear the hospital gown as it would be easier to assist. R287 stated she did not want to work with therapy and walk down the hall with her back and bottom exposed. R287 worked with Physical therapy (PT) and OT during this time.

During an observation and interview on 7/21/21, at 7:41 a.m. R287 wore a brief and a shirt while she ate breakfast in a chair by a window in her room. R287 had no pants on. R287 stated an unidentified aide assisted her after an incontinent episode the night prior and took her pants off. R287 further stated the unidentified aide did not help her put new pants back on and just left her in her brief. R287 further stated wished the unidentified aide had helped her put new pants back on as she was already embarrassed that she "peed on herself." R287 stated she was even more embarrassed since she had to eat breakfast with no pants and would prefer to wear pants.

During an interview at 7/21/21, at 7:45 a.m. COTA-A verified R287 did not have pants on. COTA-A stated there had been another time when R287 had not been wearing pants. COTA-A also stated she was about to work with her and would help get R287 fully dressed.

During an interview on 7/22/21, at 1:58 p.m. SW-A stated it would be against one's dignity if a resident wanted to wear pants but was not able to and felt embarrassed and exposed.

During an interview on 7/22/21, at 11:15 a.m. the director of nursing (DON) verified a resident should be dressed in a way they want and should

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21805	Continued From page 14 not feel embarrassed or exposed. The facility policy Combined Federal and State Bill of Rights dated 2/17, indicated the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life. The resident as a right to be treated with respect and dignity. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		