Electronically delivered
December 20, 2021

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

RE: CCN: 245610
Cycle Start Date: December 1, 2021

Dear Administrator:

On December 1, 2021, a survey was completed at your facility by the Minnesota Departments 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 1, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 1, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

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.

Feel free to contact me if you have questions.

Sincerely,

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 12/01/2021

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 000	INITIAL COMMENTS On 12/1/21, an abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH) to conduct multiple complaint investigations. St. Gertrudes Health & Rehabilitation Center was found to not be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5610091C (MN78827); with non-compliance cited at F600. H5610097C (MN55370); however, no deficiencies issued due to actions taken prior to survey. H5610100C (MN51757); however, no deficiencies issued due to actions taken prior to survey. The following complaints were found to be unsubstantiated: H5610092C (MN77354) H5610093C (MN77256, MN77255) H5610094C (MN61242) H5610095C (MN59424) H5610096C (MN56224) H5610098C (MN54714) H5610099C (MN54003) H5610101C (MN50796) The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 12/28/2021

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 Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from verbal abuse for 1 of 3 residents (R11) reviewed for abuse. Findings include: R11's admission Minimum Data Set (MDS) dated	F 600	This plan of correction is submitted as required under the federal and state regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the	12/28/21

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F 600	Continued From page 2 11/18/21, indicated R11 was cognitively intact and had adequate hearing. R11 was frequently incontinent of bowel and bladder, and required extensive assistance with bed mobility and transfers. R11's diagnoses included stroke, spinal fracture, and weakness. R11's care plan dated 11/13/21, identified R11 could verbally ask for assistance and required assistance of one staff to remain free from skin breakdown. A Nursing Home Incident Report (NHIR) dated 11/24/21, at 11:29 p.m. indicated a staff member used a demeaning and angry tone towards R11 when asking why she did not call for assistance. R11 then verbalized she attempted to use the call light and also verbally attempted to get the attention of staff; however, she was unable to get the call light to work and her voice was weak. The NHIR further identified the staff member continued to use an angry and demeaning tone throughout the interaction and R11 felt the staff member was angry with her for having an accident in bed. The interaction made R11 feel, "bad and unsafe." A written statement by nursing assistant (NA)-A dated 11/25/21, indicated he responded to a call light in R11's room on 11/24/21, as registered nurse (RN)-A exited R11's room. R11 was noted to be in the fetal position, in bed, with her head near the foot of the bed and had an incontinent episode with soiled bedding. Licensed practical nurse (LPN)-A was overheard being verbally abusive, towards R11, and stated, "Why would you do this" in a very upset and demeaning tone. Further, LPN-A asked R11, three or four times, "Why didn't you use your call button?" R11 then	F 600	plan of care does not constitute agreement by the facility that the surveyor's findings and/or conclusion are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. Please accept this plan of correction as our credible allegation of compliance. (Affected Resident) An electronic report was filed on 11/24/2021 with MDS regarding R11's allegations. Interview conducted with resident. (Completed 11/25/2021). Resident had no further concerns. Resident was given a copy of the resident rights booklet and the abuse prevention plan was reviewed with the resident with resident verbalizing understanding on 11/27/2021. (Like Resident) 1. Conducted risk group interviews of like residents with no other residents expressing concerns related to their care or safety (Completed 11/25/2021). All residents and/or resident representatives have been provided a resident rights booklet upon admission to which their Resident Rights were reviewed with them and are continually re-reviewed during Care Conferences. (Preventing the Reoccurrence of Deficient Practice) 1. Facility's abuse prevention policy reviewed; remains current with update occurring 8/2020 (Completed	

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F 600	Continued From page 3 responded, "I tried to." LPN-A then asked R11 why she did not yell for help and R11 replied, "I tried and tried, so I gave up." NA-A documented LPN-A's response was very unprofessional and cruel. LPN-A then began to transfer R11 and NA-A was asked to change the bedding on R11's bed. NA-A gathered the soiled linens and overheard LPN-A belittle R11, when cleaning R11 in the bathroom. NA-A was unable to remember the exact words LPN-A had used. A progress note dated 11/25/21, at 9:06 a.m. indicated R11 verbalized "yesterday [11/24/21] was a bad day and someone "mistreated" her. During an interview on 12/1/21, at 10:31 a.m. R11 stated she did not recall the incident involving LPN-A on 11/24/21, but she knew something was going on because an official came in and apologized to her. During an interview on 12/1/21, at 12:20 p.m. NA-A stated he responded to a call light in R11's room on 11/24/21, as RN-A was leaving R11's room. NA-A stated R11 had an episode of bowel incontinence and R11's bedding was soiled. NA-A overheard LPN-A, who was in R11's room, "verbally abusing" and "belittling" R11. Specifically, LPN-A verbalized, "Why would you do that?" LPN-A was was flustered and raised her voice in a very unprofessional manner. Further, LPN-A questioned R11 why she did not press her call light. R11 responded she tried to use her call light and LPN-A then questioned why R11 did not scream for help. R11 responded she had yelled, however, gave up. NA-A stated he then left R11's room to dispose of soiled bedding. NA-A stated he then returned to R11's room and LPN-A demonstrated how to squeeze the call light to R11	F 600	12/28/2021). Abuse Prevention Plans and Resident Rights for all residents are reviewed with all staff on an annual, Significant Change and PRN. 2. Education provided to personnel responsible for conducting investigations (Charge Nurses, Clinical Managers, Social Workers, Director of Nursing and Administrator) relative to the completion of thorough investigations (Completed 12/28/2021). 1. Education was provided to all staff from three different sources. ¿ Minnesota Department of Human Services Vulnerable Adults Mandated Training Course ¿ The Vulnerable Adults Act ¿ Definition of maltreatment ¿ Who are the mandated reporters ¿ The Common Entry Point (CEP) ¿ EduCare Vulnerable Adult Training Course ¿ Identify who is a vulnerable adult and who must report. ¿ List what is reportable. ¿ Describe where reports are submitted. ¿ Learn when reports should be submitted. ¿ Understand why vulnerable adult laws are so important ¿ Benedictine Shakopee In-Service ¿ Definitions of vulnerable adult and maltreatment ¿ Reporting suspected maltreatment ¿ Mandated reporters ¿ Scenarios (Monitoring Performance)	

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F 600	Continued From page 4 multiple times. LPN-A was very loud and condescending. During an interview on 12/1/1, at 12:28 p.m. LPN-A stated she responded to a call light in R11's room which was turned on by RN-A. R11 was found with her head towards the footboard of her bed and LPN-A asked what happened. RN-A responded she found R11 in that position. LPN-A stated she realized R11 tried to get to the bathroom, however, was already incontinent of bowel. LPN-A confirmed she asked R11 why she did not turn her call light on and R11 replied she turned the call light on and staff did not see it. LPN-A speculated the call light may had malfunctioned. LPN-A then stated she questioned R11 why she did not call out verbally and R11 responded she had yelled. LPN-A stated she then left R11's room to get clean bedding and upon return told RN-A she would take R11 to the bathroom to clean her up. LPN-A stated NA-A then entered R11's room and she requested NA-A to change the linen, but "He didn't like that I said that." NA-A then left and RN-A was still in R11's room. LPN-A stated she requested RN-A to get wipes and RN-A left and subsequently returned to R11's room. During an interview on 12/1/21, at 1:26 p.m. the director of nursing (DON) stated she received a phone call from RN-B on 11/24/21, and was informed NA-A overheard R11 being verbally abused by LPN-A. The DON directed RN-B to interview R11, ensure R11 was safe, and remove LPN-A from the facility. The DON stated R11 corroborated the report of abuse when interviewed. Further, the DON interviewed R11 herself and due to R11's statements and NA-A's statement, the allegation of abuse was	F 600	1. Administrator and/or DON will audit all reported incidents for thoroughness of investigation for a period of (3) months, and then periodically for an additional (3) months (commencing immediately). Administrator and/or DON will conduct education retention audits monthly to ensure all staff have retained the training provided by randomly selecting a list of employees. 2. Risk group interviews will continue to be conducted on 2 residents per week x 4 and 1 resident per week x 8 weeks. Follow up will be reviewed in Quality Council for continuance of interviews as deemed appropriate by the Quality Council and audit results. 3. Administrator, DON, or designee to present audit results to QA committee. 4. Affected Resident will be periodically assessed for safety by Social Services as post Trauma Review and provided emotional support interventions. Megan Diamond Administrator	

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F 600	Continued From page 5 substantiated. During an interview on 12/1/21, at 2:25 p.m. RN-A stated she went to R11's room to give medications and saw R11's head towards the foot of the bed. RN-A stated she asked R11 why she was laying that way and R11 verbalized she wanted to go to the toilet. RN-A stated she reminded R11 to use the call light because it was not safe to self-transfer. RN-A stated stool was noted on R11's pants and she turned R11's call light on. RN-A stated LPN-A and NA-A responded to R11's room and RN-A told them R11 was soiled and wanted to get out of bed. She also asked LPN-A to clean R11 and change the bedding. RN-A then left R11's room and did not hear any further interactions. During an interview on 12/1/21, at 2:48 p.m. RN-B stated NA-A's direct supervisor approached her at approximately 8:00 p.m. on 11/24/21, and informed her NA-A witnessed LPN-A use abusive language towards R11. RN-B stated she interviewed NA-A and he explained he answered R11's call light, who had a bowel movement when in bed, and LPN-A and RN-A were in R11's room. RN-B stated NA-A told her RN-A left the room and LPN-A spoke to R11 in a demeaning and angry tone in which R11 was asked why she did not call for help by LPN-A. RN-B was told R11 responded the call light did not work and she tried to call out, but nobody heard her, and eventually gave up. RN-B stated she then interviewed R11 who told her LPN-A was angry with her and R11 did not feel safe with LPN-A unless NA-A was present. A late entry progress note dated 12/1/21, at 2:59 p.m. indicated RN-B was informed NA-A	F 600		

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F 600	Continued From page 6 witnessed LPN-A verbally abuse a resident. Management was notified and interviews were conducted with NA-A, LPN-A, and R11. R11 did state "NAR [LPN-A] was at first angry with the patient and the patient was fearful." LPN-A was asked to leave the facility and not return until a full investigation could be completed. During an interview on 12/1/21, at 3:37 p.m. the administrator stated she was informed of the alleged abuse by RN-B, via phone, on the evening of 11/24/21. She stated LPN-A was removed from the facility and written statements were obtained from LPN-A and NA-A. The administrator stated the allegation of abuse against R11 was substantiated based on witness and resident statements. Facility policy titled Abuse Prevention Plan dated 8/14/21, identified abuse included the willful use of repeated or malicious oral, written, or gestured language towards a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.	F 600		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2021

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

Re: Event ID: EJBM11

Dear Administrator:

The above facility survey was completed on December 1, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

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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 11/29/21 to 11/30/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). The Estates at Chateau was found in compliance with the Minnesota state licensure rules for nursing homes.	2 000		

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ST GERTRUDES HEALTH & REHABILITATION	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) COMPLETE DATE
2 000	Continued From page 1 The following complaints were found to be substantiated: H5610091C (MN78827); with no licensing orders cited. H5610097C (MN55370); with no licensing orders cited. H5610100C (MN51757); with no licensing orders cited. The following complaints were found to be unsubstantiated: H5610092C (MN77354) H5610093C (MN77256, MN77255) H5610094C (MN61242) H5610095C (MN59424) H5610096C (MN56224) H5610098C (MN54714) H5610099C (MN54003) H5610101C (MN50796) MDH is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		