Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 18, 2025

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

RE: CCN: 245610
Cycle Start Date: August 1, 2025

Dear Administrator:

On September 10, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 18, 2025

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

Re: Reinspection Results
Event ID: 1D2BC4-H2

Dear Administrator:

On September 10, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 1, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 6, 2025

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

RE: CCN:245610

Cycle Start Date: August 1, 2025

Dear Administrator:

On August 1, 2025, a survey was completed at your facility by the Minnesota Department of Health 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Regional Operations Supervisor, Rapid Response
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 November 1, 2025 (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 February 1, 2026 (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)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 6, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 1D2BC4-H1

Dear Administrator:

The above facility was surveyed on August 1, 2025 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:

LeAnn Huseth, RN, Regional Operations Supervisor, Rapid Response
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

Please feel free to call me with any questions.

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/01/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/1/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H56101209C	20000		08/26/2025

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/01/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Continued from page 1 (2574651); with order(s) issued at 0265. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	20000		
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:	20265	Corrected	08/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/01/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20265	Continued from page 2 A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the resident representative was notified in a timely manner of a deterioration in wound status for 1 of 3 residents (R1) reviewed for non-pressure skin impairments. Findings include: R1's admission Minimum Data Set (MDS), dated 6/29/25, identified R1 admitted to the care center on 6/23/25 from the acute care hospital. The MDS outlined R1 as having significant cognitive impairment, needing substantial assistance with most activities of daily living (ADLs), and having several medical conditions including a history of stroke, high blood pressure, thyroid disorder, and hemiparesis (i.e., muscle weakness or partial paralysis on one side of the body). The MDS identified R1 as having one un-healed stage II pressure injury present on admission, along with a subsequent section reading, "M1040. Other Ulcers, Wounds and Skin Problems," which indicated R1 as having moisture-associated skin damage (i.e., MASD; a type of skin damage that occurs when skin is exposed to prolonged moisture, leading to inflammation and erosion).	20265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/01/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20265	Continued from page 3 On 8/1/25 at 9:53 a.m., R1's family member (FM)-A was interviewed via telephone. FM-A explained R1 had admitted to the care center in June 2025 from the hospital after having a stroke and needing therapy services. FM-A stated R1 had a "small sore" on her coccyx when she admitted to the care center which the nurse identified on their initial skin check adding they had assumed the care center would address and prevent it from worsening. FM-A expressed several concerns about R1's care while at the facility and added aloud, "The attention to her really lacked." FM-A explained R1 then contracted COVID-19 and suddenly, on 7/21/25, they were notified the wound had significantly changed and R1 needed to be hospitalized for it. FM-A stated nobody had ever mentioned or updated them on the wound since R1 admitted adding aloud, "We were not updated at all on that wound." FM-A stated they were shocked to learn about how bad the wound had become when they learned of it from the hospital adding, "It just floored me." FM-A added, "We had no idea that is was that bad." R1's Weekly Skin Check, dated 6/23/25, identified a section to record current skin alterations upon R1's admission. This indicated R1 had a fluid-filled blister present along with another checkmark placed next to the option reading, "Moisture Associated Skin Damage." The evaluation included a place to record the location of these which was answered with a radio-button next to the option, "Other." The corresponding section to record dictation on, "Other," had text which read, "See note." R23's corresponding progress note, dated 6/23/25, identified R1 admitted to the care center on that same date. The note listed a section labeled, "Skin:," which outlined R1 as having a blister on her right heel which the hospital reported as a stage II pressure injury along with an additional skin impairment recorded as, " ... 0.1 cm [centimeters] X [by] 0.1 cm X 0.1 cm and 0.2 cm X 0.3cm [sic] X 0.1 cm wounds noted on sacral region [which] hospital reported as moisture-associated [MASD]." R1's Wound Management Detail Report, printed 8/1/25, identified all the facility' wound tracking within the medical record and dated back to her admission on 6/23/25. The report outlined R1's coccyx/sacral wound as, "Other - moisture associated," and recorded it as being present upon admission with dictation on 6/23/25 reading, "two small wounds ... [measurements; see progress note] ... both blanchable." However, the next recorded entry was dated 7/10/25 and outlined the wound as now being 10 cm X 5.5 cm with a healing status recorded, "Declining," adding further, "See the progress notes." R1's corresponding progress note,	20265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/01/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20265	Continued from page 4 dated 7/10/25, identified R1 was evaluated by the registered nurse manager (RN)-B with dictation reading, " ... was assessed today following a reported change in condition related to a wound that was present upon admission ... a boil-like lesion was observed near the anus in the coccyx/perianal region. Additionally, a coccyx wound was noted, measuring 10 cm (L) x 5.5 cm (W). The wound appears purple/red in color, with irregular edges, central necrosis, and blanchable red tissue surrounded by areas of white discoloration ... odor was noted during the inspection ... A dressing was applied to protect the compromised skin." However, R1's medical record was reviewed and lacked evidence R1's family member (FM) or responsible party had been notified of the change in condition and declining wound status despite R1 having severe cognitive impairment and the wound increasing in size with signs of necrosis, having an odor, and showing significant discoloration. When interviewed on 8/1/25 at 10:32 a.m., RN-A stated they recalled working with R1 and described her as being "totally dependent" for most ADLs. RN-A explained they had noticed the wound worsening towards the end of her stay at the care center and believed the nurse manager (RN-B) was aware and addressing it. However, RN-A stated they did not recall ever updating R1's family member about the wound adding, "[Not] specifically." RN-A stated any conversations with family, including updates on wound conditions, should be recorded in the medical record. On 8/1/25 at 1:03 p.m., RN-B and the director of nursing (DON) were interviewed, and both verified they had a chance to review R1's medical record. RN-B explained the floor nurse had asked them to observe R1's coccyx wound on 7/10/25, which was the first time they had seen it. RN-B stated the area was purple and red in color and appeared more like a deep-tissue injury at that time so the DON was notified about it. DON verified the documented characteristics from admission to 7/10/25 and expressed, "I would consider that a change." DON stated there was some conflicting charting from the hospital on the potential origin of the wound but reiterated there was care being done for it throughout her stay such as repositioning, nutritional supplements, and a dressing being applied. RN-B stated FM-A was R1's acting responsible party, and explained FM-A had been present in the room on 7/14/25 while R1's wound care was completed; however, RN-B verified they did not specifically mention or review the coccyx wound with them but rather discussed the heel ulcer which was healing. RN-B and DON both	20265		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/01/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20265	Continued from page 5 acknowledged the lack of documentation within the medical record to demonstrate R1's FM-A had been updated timely about the coccyx wound condition on 7/10/25 and RN-B expressed aloud, "I feel like any change of condition should be notified to the family." A facility-provided Change In Condition policy, dated 10/2023, identified when a significant change is the resident's physical or mental status is identified, the provider and resident representative would be consulted. The policy listed a step-by-step procedure which included, "6. Notify the resident/resident representative." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on family notification(s); then educate direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	20265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 8/1/25, an abbreviated survey was completed by surveyors from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H56101209C (2574651); with non-compliance cited at F580, F684. 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.	F0000		08/26/2025
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F0580	F580 Notify of Changes CITED RESIDENT(S): R1 is no longer residing at facility and discharged on 7/22/2025. LIKE RESIDENT(S): All residents in house and/or their representative will be notified of any deterioration in wound status. EDUCATION: All licensed nurses will be re-educated on notification to resident and/or resident representative if resident experiences a deterioration in wound status. The notification will be documented in the medical record. AUDITS: Director of Nursing or designee will audit facility activity report two times a week for 4 weeks then twice a month for 1 month, then monthly for 1 month regarding notification to resident and/or resident representative if a wound deteriorates. Audit results will be reviewed by Quality Council monthly for further actions if needed. Date of Compliance: August 26th, 2025	08/26/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 1 treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the resident representative was notified in a timely manner of a deterioration in wound status for 1 of 3 residents (R1) reviewed for non-pressure skin impairments. Findings include: R1's admission Minimum Data Set (MDS), dated 6/29/25, identified R1 admitted to the care center on 6/23/25 from the acute care hospital. The MDS outlined R1 as having significant cognitive impairment, needing substantial assistance with most activities of daily	F0580	Continued from page 1 This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 2 living (ADLs), and having several medical conditions including a history of stroke, high blood pressure, thyroid disorder, and hemiparesis (i.e., muscle weakness or partial paralysis on one side of the body). The MDS identified R1 as having one un-healed stage II pressure injury present on admission, along with a subsequent section reading, "M1040. Other Ulcers, Wounds and Skin Problems," which indicated R1 as having moisture-associated skin damage (i.e., MASD; a type of skin damage that occurs when skin is exposed to prolonged moisture, leading to inflammation and erosion). On 8/1/25 at 9:53 a.m., R1's family member (FM)-A was interviewed via telephone. FM-A explained R1 had admitted to the care center in June 2025 from the hospital after having a stroke and needing therapy services. FM-A stated R1 had a "small sore" on her coccyx when she admitted to the care center which the nurse identified on their initial skin check adding they had assumed the care center would address and prevent it from worsening. FM-A expressed several concerns about R1's care while at the facility and added aloud, "The attention to her really lacked." FM-A explained R1 then contracted COVID-19 and suddenly, on 7/21/25, they were notified the wound had significantly changed and R1 needed to be hospitalized for it. FM-A stated nobody had ever mentioned or updated them on the wound since R1 admitted adding aloud, "We were not updated at all on that wound." FM-A stated they were shocked to learn about how bad the wound had become when they learned of it from the hospital adding, "It just floored me." FM-A added, "We had no idea that is was that bad." R1's Weekly Skin Check, dated 6/23/25, identified a section to record current skin alterations upon R1's admission. This indicated R1 had a fluid-filled blister present along with another checkmark placed next to the option reading, "Moisture Associated Skin Damage." The evaluation included a place to record the location of these which was answered with a radio-button next to the option, "Other." The corresponding section to record dictation on, "Other," had text which read, "See note." R23's corresponding progress note, dated 6/23/25, identified R1 admitted to the care center on that same date. The note listed a section labeled, "Skin:," which outlined R1 as having a blister on her right heel which the hospital reported as a stage II pressure injury along with an additional skin impairment recorded as, " ... 0.1 cm [centimeters] X [by] 0.1 cm X 0.1 cm and 0.2 cm X 0.3cm [sic] X 0.1 cm wounds noted on sacral region [which] hospital reported as moisture-associated [MASD]."	F0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 3 R1's Wound Management Detail Report, printed 8/1/25, identified all the facility' wound tracking within the medical record and dated back to her admission on 6/23/25. The report outlined R1's coccyx/sacral wound as, "Other - moisture associated," and recorded it as being present upon admission with dictation on 6/23/25 reading, "two small wounds ... [measurements; see progress note] ... both blanchable." However, the next recorded entry was dated 7/10/25 and outlined the wound as now being 10 cm X 5.5 cm with a healing status recorded, "Declining," adding further, "See the progress notes." R1's corresponding progress note, dated 7/10/25, identified R1 was evaluated by the registered nurse manager (RN)-B with dictation reading, " ... was assessed today following a reported change in condition related to a wound that was present upon admission ... a boil-like lesion was observed near the anus in the coccyx/perianal region. Additionally, a coccyx wound was noted, measuring 10 cm (L) x 5.5 cm (W). The wound appears purple/red in color, with irregular edges, central necrosis, and blanchable red tissue surrounded by areas of white discoloration ... odor was noted during the inspection ... A dressing was applied to protect the compromised skin." However, R1's medical record was reviewed and lacked evidence R1's family member (FM) or responsible party had been notified of the change in condition and declining wound status despite R1 having severe cognitive impairment and the wound increasing in size with signs of necrosis, having an odor, and showing significant discoloration. When interviewed on 8/1/25 at 10:32 a.m., RN-A stated they recalled working with R1 and described her as being "totally dependent" for most ADLs. RN-A explained they had noticed the wound worsening towards the end of her stay at the care center and believed the nurse manager (RN-B) was aware and addressing it. However, RN-A stated they did not recall ever updating R1's family member about the wound adding, "[Not] specifically." RN-A stated any conversations with family, including updates on wound conditions, should be recorded in the medical record. On 8/1/25 at 1:03 p.m., RN-B and the director of nursing (DON) were interviewed, and both verified they had a chance to review R1's medical record. RN-B explained the floor nurse had asked them to observe R1's coccyx wound on 7/10/25, which was the first time they had seen it. RN-B stated the area was purple and red in color and appeared more like a deep-tissue injury at that time so the DON was notified about it.	F0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 4 DON verified the documented characteristics from admission to 7/10/25 and expressed, "I would consider that a change." DON stated there was some conflicting charting from the hospital on the potential origin of the wound but reiterated there was care being done for it throughout her stay such as repositioning, nutritional supplements, and a dressing being applied. RN-B stated FM-A was R1's acting responsible party, and explained FM-A had been present in the room on 7/14/25 while R1's wound care was completed; however, RN-B verified they did not specifically mention or review the coccyx wound with them but rather discussed the heel ulcer which was healing. RN-B and DON both acknowledged the lack of documentation within the medical record to demonstrate R1's FM-A had been updated timely about the coccyx wound condition on 7/10/25 and RN-B expressed aloud, "I feel like any change of condition should be notified to the family." A facility-provided Change In Condition policy, dated 10/2023, identified when a significant change is the resident's physical or mental status is identified, the provider and resident representative would be consulted. The policy listed a step-by-step procedure which included, "6. Notify the resident/resident representative."	F0580		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to comprehensively assess the bowel and bladder status to determine what, if any, proactive interventions were needed to help promote healing of developed moisture-associated skin damage (MASD; a type of skin damage that occurs when skin is exposed to prolonged moisture, leading to inflammation and erosion) for 1 of 3 residents (R1) reviewed for non-pressure skin impairments. Findings include:	F0684	F684 Quality of Care CITED RESIDENT(S): R1 is no longer residing at facility and discharged on 7/22/2025. LIKE RESIDENT(S): All residents with any skin impairment noted to gluteal or perineal area will have a 72 hour bowel and bladder diary and bowel and bladder assessment completed on admission or re-admission to facility. Following results, resident’s care plan will be updated appropriately. EDUCATION: All licensed nurses and certified nursing assistants will be re-educated on the completion of bowel and bladder assessments on new or re-admissions to facility by the utilization of the 72 hour bowel and bladder diary and bowel and bladder assessments. Clinical nurse manager or designee will then update care plan appropriately following assessment completion. AUDITS: Director of Nursing or designee will audit 5 resident’s medical record and care plan weekly for 4 weeks, then twice a month for 1 month, then monthly for 1 month regarding bowel and bladder management. Audit results will be reviewed by Quality Council monthly for further actions if needed.	08/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0684 SS = D	Continued from page 5 R1's admission Minimum Data Set (MDS), dated 6/29/25, identified R1 admitted to the care center on 6/23/25 from the acute care hospital. The MDS outlined R1 as having significant cognitive impairment, needing substantial assistance with most activities of daily living (ADLs), and having several medical conditions including a history of stroke, high blood pressure, thyroid disorder, and hemiparesis (i.e., muscle weakness or partial paralysis on one side of the body). The MDS identified R1 as using no appliances for bowel and bladder (i.e., ostomy, catheter) and being frequently incontinent of both bowel and bladder. Further, the MDS identified R1 as having moisture-associated skin damage (i.e., MASD; a type of skin damage that occurs when skin is exposed to prolonged moisture, leading to inflammation and erosion). On 8/1/25 at 9:53 a.m., R1's family member (FM)-A was interviewed via telephone. FM-A explained R1 had admitted to the care center in June 2025 from the hospital after having a stroke and needing therapy services. FM-A stated R1 had a "small sore" on her coccyx when she admitted to the care center which the nurse identified on their initial skin check adding they had assumed the care center would address and prevent it from worsening. FM-A expressed several concerns about R1's care while at the facility and added aloud, "The attention to her really lacked." FM-A explained they were unsure what all treatment(s) had been done for the coccyx wound as they hadn't been told about it again until 7/21/25, when R1 was re-hospitalized for it. FM-A stated R1 would often complain about soreness "on her backside" though adding they'd seen a small container of "silly putty [looking]" cream on her bedside table only a few times. FM-A stated they were unsure what it was. R1's corresponding Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 7/4/25, identified R1 had several factors which triggered the CAA to be completed including being frequently incontinent, dependent for mobility, and having MASD. The CAA outlined R1 had restricted mobility, a psychological or psychiatric problem, and urinary urgency. The CAA identified R1 consumed multiple psychotropic medications and listed a section labeled, "Analysis of Findings," which identified, " ... is frequently incontinent of bladder [related to] impaired mobility and communication ... Requires assist with toileting hygiene and transfer ... I/O [intake/output] monitored per policy ... All medications administered per orders and monitored for side effects and	F0684	Continued from page 5 Date of Compliance: August 26th, 2025 This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0684 SS = D	Continued from page 6 effectiveness ... PRODUCT used to promote skin integrity and dignity. Resident does have MASD. This places resident at risk for falls and pressure injury. Goal is for resident to maintain current level of continence through review date." The CAA concluded with dictation directing to care plan and no referrals were needed. The CAA lacked information on what type of incontinence R1 demonstrated during the review period (i.e., functional, urge) or what other interventions were considered to promote continence despite R1 having MASD. R1's Skin Risk Observation with Braden Scale, dated 6/23/25, identified R1 had chronic incontinence, cardiovascular disease, and repeated hospitalizations. The evaluation outlined R1 required substantial assistance with most ADL(s) and had active skin problems including a stage II pressure injury and MASD. The corresponding Braden scale scored R1 as a 12.0 which had dictation, "HIGH RISK." A section labeled, "Interventions," was provided which identified staff would elevate R1's affected extremities and reposition her every 2 to 3 hours. The completed evaluation lacked what, if any, interventions would be done for R1's continence despite R1 having MASD and being recorded with, "Chronic Incontinence." R23's progress note, dated 6/23/25, identified R1 admitted to the care center on that same date. The note listed a section labeled, "Skin:," which outlined R1 as having a blister on her right heel which the hospital reported as a stage II pressure injury along with an additional skin impairment recorded as, " ... 0.1 cm [centimeters] X [by] 0.1 cm X 0.1 cm and 0.2 cm X 0.3cm [sic] X 0.1 cm wounds noted on sacral region [which] hospital reported as moisture-associated [MASD]." R1's Clinical Documentation (Admission) evaluation, dated 6/23/25, identified R1 demonstrated no behaviors and included a section labeled, "BOWEL and BLADDER." This section had several questions to be answered by the staff member completing the evaluation, and it outlined R1 used no appliances for voiding, was frequently incontinent of bowel and bladder, and had no constipation present. The section continued and identified R1's last bowel movement as 6/23/25, and R1 as having active bowel sounds. The section concluded with a subsection reading, "Comments ...[;]" however, this was left blank. R1's corresponding Bladder evaluation, dated 6/27/25, identified R1 used no appliances for voiding and was rated as, "Always incontinent (no episodes of continent voiding)." The evaluation outlined R1 did not recognize the appropriate time or place to void, did not feel the	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0684 SS = D	Continued from page 7 urge to urinate, and demonstrated one risk factor for incontinence which was recorded as, "Impaired Mobility." The options to select other risk factors, including severe cognitive impairment, were left blank despite R1 being recorded as having such on the MDS. The evaluation listed several other sections to be completed with data including what, if any, potentially reversible causes of incontinence were present, contributing medical diagnoses which could be affecting continence, medications which could affect continence, an incontinence symptoms profile (i.e., type of incontinence), and a summary of the evaluation and decision-making for program placement. However, these sections were each left blank and not completed. The evaluation concluded with a section labeled, "Section 9 - Bladder Assessment Summary," however, this also was left blank and not completed. R1's corresponding Bowel evaluation, dated 6/27/25, identified R1 did not use an appliance for defecation. The section labeled, "Bowel Continence," was answered with a radio-button response, "Not assessed." The entire remainder of the evaluation, including sections to review symptoms, medication use, risk factors, and treatment decisions, were left blank and not completed. The evaluation concluded with a section labeled, "Section 7 - Bowel Summary," however, this was left blank and not completed. R1's Bowel & Bladder Function care plan, dated 7/11/25, identified R1 experiences bowel and bladder incontinence due to impaired mobility, hemiplegia, and impaired communication. A goal was listed which read, "I will maintain current level of continence," along with interventions to help R1 meet this goal including assisting with toileting, initiating barrier cream in accordance with standing orders, reporting signs of a potential infection and, "Provide individualized toileting interventions based on needs/patterns." These interventions were all initiated on, "07/11/2025." However, R1's medical record was reviewed and lacked evidence R1's bowel and bladder status had been comprehensively evaluated or assessed to determine what type(s) of incontinence R1 demonstrated; nor what, if any, interventions for voiding had been considered (i.e., fluid management, timed toileting program, potential appliance use) despite R1 being recorded as having active MASD on her coccyx upon admission (6/23/25) which could worsen with ongoing exposure to incontinent urine or feces. When interviewed on 8/1/25 at 10:23 a.m., nursing assistant (NA)-A stated they recalled working with R1 while she was at the care center, and described her as "total" help for cares. NA-A stated R1 had a wound	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245610	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/01/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0684 SS = D	Continued from page 8 which "just smelled so gross" on the day R1 was sent back to the hospital for it adding, "it wasn't always like that." NA-A stated R1 had been incontinent of bowel and bladder throughout her admission but verified R1 could use the toilet if helped. NA-A stated R1 had difficulty holding herself up though and used a mechanical lift for transfers so, as a result, she (R1) often "just went [voided] in the bed." NA-A stated they did not recall ever using a barrier cream for R1 either, as most of the time her coccyx was covered with a dressing due to the wound. On 8/1/25 at 1:03 p.m., registered nurse manager (RN)-B and the director of nursing (DON) were interviewed, and both verified they had a chance to reviewed R1's medical record. RN-B stated the floor nurse had asked them to observe R1's coccyx wound on 7/10/25, which was the first time they had seen it. RN-B stated they then alerted the DON to the wound. DON stated there was some conflicting charting from the hospital on the potential origin of the wound but expressed cares had been done for it such as repositioning and nutritional supplements. RN-B verified R1 was able to use the toilet for voiding with assistance, and the DON explained a comprehensive review of R1's voiding and elimination would be done using the "bowel and bladder observations" in the medical record. DON reviewed R1's completed Bowel and Bladder evaluations, respectively, and verified they were not completed in their entirety adding, "My expectation would be it's filled out." DON verified those evaluations would be the tools used to demonstrate what, if any, interventions for R1 had been considered for her voiding and elimination. DON stated continence and voiding were important to assess as "incontinence does directly affect your skin" adding further, "We want to make sure we're toileting appropriately." A facility-provided Resident Examination and Assessment policy, dated 10/2023, identified each resident would have a thorough examination and assessment completed upon admission with three (3) parts being completed including a physical exam, reporting a refusal, and documenting a refusal in the medical record. However, the policy lacked information on how a comprehensive bowel and/or bladder evaluation would be completed.	F0684		