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

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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 Via Email

August 13, 2025

Administrator
Shingle Creek Option
5624 73rd Ave No
Brooklyn Park, MN 55429

RE: Event ID: 1FOU11

Dear Administrator:

On July 24, 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 Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. At the time of the survey, the survey team noted one or more deficiencies.

Federal certification deficiencies are delineated on the electronically delivered form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC). **A provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview.**

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Failure to submit an acceptable written plan of correction for all Health Federal deficiencies within ten calendar days may result in additional remedies and/or decertification including a loss of federal reimbursement.

Your PoC must include:

- 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 PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

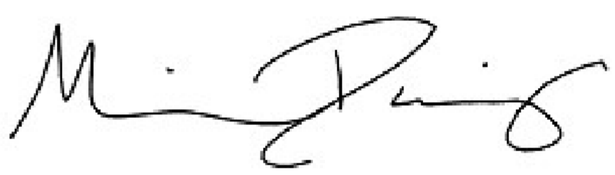
DEPARTMENT CONTACT:

Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by 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

Feel free to contact me with any questions related to this letter.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G382	A. BUILDING _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHINGLE CREEK OPTION	5624 73RD AVE NO BROOKLYN PARK, MN 55429

(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
W 000	INITIAL COMMENTS On 7/24/25, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The following complaint was reviewed: HG3829950C (MN00114667) with a deficiency issued at W148. 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.	W 000		
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to notify the family/legal guardian of a reportable incident for 1 of 1 client (C1) who had fallen and sustained injury. Findings include: C1's emergency information form undated, indicated C1 had mental retardation and autism. C1's Accident and Incident Report dated 7/19/25,	W 148		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G382	A. BUILDING _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 148	Continued From page 1 indicated C1 had 3 falls which resulted in C1's left 3rd and 4th toes to be, "extremely swollen, red, and appeared slightly crooked. No swelling was present earlier in the day." C1's medical record lacked documentation for C1's guardian being updated about falls and injuries on 7/19/25. During an interview on 7/23/25 at 12:34 p.m., C1's guardian stated she was not updated on the falls or injuries until 7/21/25. During an interview on 7/23/25 at 2:54 p.m., registered nurse (RN)-A stated she contacted C1's guardian on 7/21/25, about the falls and injuries on 7/19/25. RN-A stated she should have called C1's guardian on 7/20/25, to update her on C1's falls and injuries. During an interview on 7/23/25 at 2:29 p.m., the executive director (ED)-A stated C1's guardian should have been updated by 7/20/25, by the supervisor or ED-A. The facility Illness and Injury Policy (Non-Emergency) undated, indicated appropriate notification to health care providers and other authorized persons shall be made promptly.	W 148		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

August 13, 2025

Administrator
Shingle Creek Option
5624 73rd Ave No
Brooklyn Park, MN 55429

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: 1FOU11

Dear Administrator:

The above facility survey was completed on July 24, 2025 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility 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 144.56.

Attached 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 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.

Feel free to contact me with any questions related to this letter.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01430	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHINGLE CREEK OPTION	5624 73RD AVE NO BROOKLYN PARK, MN 55429

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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 or MN Statute indicated below. When a rule or statute 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. On 7/24/25, a complaint investigation was conducted. Your facility was found to be in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). The following complaint was reviewed. HG3829950C (MN00114667)	5 000		

accepted 9/18/25
LeAnn Huseth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G382	A. BUILDING _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHINGLE CREEK OPTION	5624 73RD AVE NO BROOKLYN PARK, MN 55429

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W 000	INITIAL COMMENTS On 7/24/25, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The following complaint was reviewed: HG3829950C (MN00114667) with a deficiency issued at W148. 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.	W 000		
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to notify the family/legal guardian of a reportable incident for 1 of 1 client (C1) who had fallen and sustained injury. Findings include: C1's emergency information form undated, indicated C1 had mental retardation and autism. C1's Accident and Incident Report dated 7/19/25,	W 148	W 148 The Resident Fall Report Form was updated on July 19th 2025 to include directions to staff to inform the Facility RN following any falls by residents and the immediately inform the Facility RN, the Executive Director and the guardians of the resident if injury (or suspected injury) was caused by the fall. All staff were retrained on reporting procedures and the update to the Resident Fall Report Form on July 19th, 2025, by the Facility RN. Signatures of the retrained staff are maintained by the Facility RN. All incoming staff will be trained on the Resident Fall Report Form and reporting procedures as part of their Medication Certification Training by the Facility RN. Signatures of all staff who have completed this training will be maintained by the Facility RN.	

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

Executive Director 8/20/2025

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 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.