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	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Gertrudes Health & Rehabilitation Center	1850 Sarazin Street Shakopee, MN 55379

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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).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 [DATE]. 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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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: R1's admission Minimum Data Set (MDS), dated [DATE], 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 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