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	12/18/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 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 record review the facility failed to ensure a resident was free from abuse for 1 of 3 (R1) residents when registered nurse (RN)-A witnessed nursing assistant (NA)-A respond to R1 by punching him in the leg when providing cares.Findings include: R1's care plan dated 12/4/25 indicated R1 was to use the Sara Steady lift for transferring from the bed to the chair and to the toilet. R1 was not to ambulate, pivot transfers only. R1's care plan dated 12/8/25 indicated R1 was to receive care in pairs until further notice with the of nursing assistants and nursing. No other guidance was documented. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status (BIMS) score was 13 indicating R1's was cognitively intact. R1 did not have any physical or verbal behavior symptoms toward others. R1 was dependent upon staff for eating, showing, lower body dressing and personal hygiene. He required maximal assistance with oral and toileting hygiene, upper body dressing, rolling in bed and transferring from lying to sitting and sitting to standing. R1's diagnoses were sepsis (life-threatening infection in the blood), alcohol-induced chronic pancreatitis (inflammation of the pancreas), lymphedema (swelling of lymphatic fluid in the arms or legs) and osteoarthritis of the right hip. The facilities Witness Investigation Form dated 12/14/25 at 1:15 p.m. an interview with NA-A indicated NA-A was providing cares to R1 who wanted to get in his chair. NA-A got R1's pants on and when she assisted him to get up, he became aggressive. NA-A gently grabbed his hand and stated she was there to help. RN-A entered the room right when NA-A placed her hand on R1's hand. NA-A described R1's aggressiveness as he was raising his voice. NA-A denied R1 hitting out at her and was not combative and denied she struck R1. NA-A stated cares in pairs meant two people were to be in his room and she did not know why there was not two staff in his room. She stated when a resident becomes aggressive staff is to grab another staff member, document, and redirect. The facilities Witness Investigation Form dated 12/14/25 at 1:57 p.m., indicated an interview with RN-A indicated she was near R1's door and heard yelling, she thought it was the television, but then realized it was R1 and NA-A's voices then she saw NA-A's arm pull back and punch into R1's left knee. The facilities Witness Investigation Form dated 12/14/25 at 2:00 p.m. an interview with R1 indicated R1 stated he did not feel safe and the facility because a caregiver slugged him. He stated he wanted to transfer from his bed to his wheelchair and that NA-A slugged him and he slugged her back. RN-A then entered the room. R1 showed the interviewers how the interaction occurred by placing his hand at his side and moved it across the truck of his body with a closed fist. Upon observation and interview on 12/17/25 at 10:20 a.m. R1 stated he was abused when a staff member slugged him, and he slugged her back. NA-A was in the process of transferring him from his bed to his wheelchair. NA-A and R1 began arguing about how she was lifting him. She was not using that machine, and lifting him under his arms and she would not stop. He stated as he was sitting on the side of his bed with his pants around his ankle NA-A made a fist with her right hand and walloped him on his left knee. The next thing he knew was RN-A came into the room, NA-A left, and RN-A finished his cares. He demonstrated with his right hand by making a fist and thrusting his arm out towards the surveyor. R1 denied any pain or emotional concerns during the interview. He stated he was not harmed. Upon interview on 12/17/25 at 2:03 p.m. RN-A stated on 12/14/25 she was outside of R1's room setting up medications on her cart and heard yelling in R1's room, thinking it was the television until she realized it was R1 and NA-A. She stated she rushed to the room and just as she pushed open the curtain, she witnessed R1 seated on the edge of his bed, tilted to the right side as NA-A was supporting his body with her left hand. She closed the fist of her right hand and punched his left knee. RN-A immediately asked NA-A what she was doing? NA-A responded that R1 had hit her. RN-A responded that did not mean she could hit him back. NA-A was removed from the room and away from all the other residents while RN-A notified the charge nurse. RN-A with the assistance of the physical therapy assistant (PTA)-A completed R1's cares. RN-A asked for assistance with cares as R1 was to have all his cares completed in pairs. Upon interview on 12/17/25 at 2:45 p.m. PTA-A stated she did not witness R1 being punched on 12/14/25. She spent time with him after her and RN-A got him up. She completed his physical therapy walking. During the walk R1 told her that an NA had punched him he punched her back. He did not feel safe at the facility. Upon interview on 12/17/25 at 3:27 p. m. NA-A stated she was caring for R1 on 12/14/25 and she answered his call light. He was requesting to get up and sit in his wheelchair. She stated she put R1's pants on up to his knees as he was lying in bed then she pivoted him to be seated on the side of the bed before standing him up, pulling up his pants and

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 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 record review the facility failed to thoroughly investigate allegations of witnessed physical abuse for 1 of 3 residents (R1) reviewed for abuse investigation when the facility did not interview any residents to determine if they were abused. Registered nurse (RN)-A witnessed nursing assistant (NA)-A respond to R1 by punching him in the leg when providing cares.Findings include: R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status (BIMS) score was 13 indicating R1's was cognitively intact. R1 did not have any physical or verbal behavior symptoms toward others. R1 was dependent upon staff for eating, showing, lower body dressing and personal hygiene. He required maximal assistance with oral and toileting hygiene, upper body dressing, rolling in bed and transferring from lying to sitting and sitting to standing. R1's diagnoses were sepsis (life-threatening infection in the blood), alcohol-induced chronic pancreatitis (inflammation of the pancreas), lymphedema (swelling of lymphatic fluid in the arms or legs) and osteoarthritis of the right hip. The facilities Witness Investigation Form dated 12/14/25 at 1:15 p.m. an interview with NA-A indicated NA-A was providing cares to R1 who wanted to get in his chair. NA-A got R1's pants on and when she assisted him to get up, he became aggressive. NA-A gently grabbed his hand and stated she was there to help. RN-A entered the room right when NA-A placed her hand on R1's hand. NA-A described R1's aggressiveness as he was raising his voice. NA-A denied R1 hitting out at her and was not combative and denied she struck R1. NA-A stated cares in pairs meant two people were to be in his room and she did not know why there was not two staff in his room. She stated when a resident becomes aggressive staff is to grab another staff member, document, and redirect. The facilities Witness Investigation Form dated 12/14/25 at 1:57 p.m., an interview with RN-A indicated she was near R1's door and heard yelling, she thought it was the television, but then realized it was R1 and NA-A's voices then she saw NA-A's arm pull back and punch into R1's left knee. The facilities Witness Investigation Form dated 12/14/25 at 2:00 p.m. an interview with R1 indicated R1 stated he did not feel safe and the facility because a caregiver slugged him. He stated he wanted to transfer from his bed to his wheelchair and that NA-A slugged him and he slugged her back. RN-A then entered the room. R1 showed the interviewers how the interaction occurred by placing his hand at his side and moved it across the truck of his body with a closed fist. An untitled, facility form dated 12/15/25 indicated sixteen staff members were asked if they had ever physically mistreated any resident? Have they ever seen or heard other staff physically mistreat any resident? And what to do if they would see staff mistreat any resident? The form did not indicate any specific questions regarding R1 or NA-A. In addition, the questions asked not indicate what they would do if they heard allegations of abuse. The investigation did not include any resident interviews to ask if they were abused. Upon review of the facilities investigation dated 12/14/25 revealed fifteen residents on the 300 unit, the cognitive unit where R1 resided were given a skin and pain assessment. A progress notes on all fifteen residents indicated emotional and psychological state at baseline. The investigation failed to indicate any questions regarding safety, treatment, and/or abuse on the unit. In addition, no residents from other units who worked with NA-A were interviewed and no families were interviewed. Upon interview on 12/17/25 at 4:40 p.m. the director of nursing, DON stated NA-A was immediately pulled off the floor on 12/14/25 after RN-A witnessed her punch R1. All staff who worked the day shift on the 300 unit were interviewed about the incident. On 12/15/25 sixteen other staff members were asked if they had ever physically mistreated a resident, witnessed another staff member mistreat a resident, and what they would do if they did. She stated the facility did not interview residents on other units where NA-A had worked and was not certain of the reasons. The facility did not ask the residents on the 300 unit if they had ever been harmed because the 300 unit was a cognitive unit, and the residents may not be able to provide correct responses. Upon interview on 12/18/25 at 9:15 a.m. RN-B stated he worked on 12/14/25 training as a charge nurse. His role in the investigation was to conduct the skin and pain assessments on the fifteen residents on the 300 unit. He stated the documentation in the progress notes that indicated each resident was emotional and psychological state at baseline was his observation during the skin and pain assessments. He stated the reason the residents were not asked abuse was to not frighten the residents that abuse may have occurred. Upon interview on 12/18/25 at 11:09 a.m. the Administrator stated the facility kept residents safe during their investigation was by removing NA-A immediately from the floor. She stated the reason residents from other units were not interviewed was because she felt NA-A's witnessed punching of R1 was an isolated incident

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 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 observation, interview, and record review the facility failed to implement the care plan for 1 of 3 residents (R1) reviewed for care plan interventions when R1 was to have cares in pairs (two staff with resident) and was to be transferred using a Sara Steady (a mechanical sit to stand machine) and was observed with staff transferring without the device. Findings include: R1's care plan dated 12/4/25 indicated R1 was to use the Sara Steady lift for transferring from the bed to the chair and to the toilet. R1 was not to ambulate, pivot transfers only. R1's care plan dated 12/8/25 indicated R1 was to receive care in pairs (two staff with resident) until further notice with the discipline of nursing assistants and nursing. No other guidance was documented with the intervention. R1's care plan dated 12/8/25 indicated R1 tended to make accusations and comments against staff of other ethnicities due to cognitive impairments, resident becomes forgetful and does not remember that he made these comments of accusations. Staff to continue to redirect resident when comments are made to continue to provide supportive care. This concern did not indicate cares in pairs as an intervention. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Inventory of Mental Status (BIMS) score was 13 indicating R1's was cognitively intact. R1 did not have any physical or verbal behavior symptoms toward others. R1 was dependent upon staff for eating, showing, lower body dressing and personal hygiene. He required maximal assistance with oral and toileting hygiene, upper body dressing, rolling in bed and transferring from lying to sitting and sitting to standing. R1's diagnoses were sepsis (life-threatening infection in the blood), alcohol-induced chronic pancreatitis (inflammation of the pancreas), lymphedema (swelling of lymphatic fluid in the arms or legs) and osteoarthritis of the right hip. Upon observation and interview on 12/17/25 at 10:20 a.m. R1 stated he was abused when a staff member slugged him, and he slugged her back. NA-A was in the process of transferring him from his bed to his wheelchair. NA-A and R1 began arguing about how she was lifting him. He stated she was not using that machine, and was lifting him under his arms. R1 stated he was not aware if was to have one or two staff caring for him. He stated it changed often, as sometimes staff would care for him alone and other times they would not. Upon interview on 12/17/25 at 2:03 p.m. RN-A stated on 12/14/25 she witnessed R1 seated on the edge of his bed, tilted to the right side as NA-A was supporting his body with her left hand. She closed the fist of her right hand and punched his left knee. RN-A with the assistance of the physical therapy assistant (PTA)-A completed R1's cares. RN-A asked for assistance with cares as R1 was to have all his cares completed in pairs. RN-A stated NA-A was caring for R1 alone and not using the lifting device. RN-A stated if a care plan only indicated care in pairs then all staff must have any cares they provide witnessed by another staff member including medication administration and feeding, RN-A fed R1 lunch in his doorway on 12/14/25 as R1 liked to eat in his room. Upon interview on 12/17/25 at 2:45 p.m. PTA-A stated she was not aware that R1 was on care in pairs and she was not sure if that pertained to therapy staff or just nursing staff. Upon interview on 12/17/25 at 3:27 p.m. NA-A stated she was caring for R1 on 12/14/25 and she answered his call light. He was requesting to get up and sit in his wheelchair. She stated she put R1's pants on up to his knees as he was lying in bed then she pivoted him to be seated on the side of the bed before standing him up, pulling up his pants and attempting to stand him. She stated she was in the room with R1 by herself and attempted to transfer him without the mechanical Sara Steady lift. She admitted she did not read his care plan before tending to his needs. Upon interview on 12/17/25 at 3:02 p.m. RN-C the ADON stated NA-A was not following the care plan when the abuse allegations occurred. She stated R1 was cares in pairs. She stated she thought cares in pairs were just for direct care and just for nursing and did not include feeding. R1 had behaviors as he voiced his opinion and he did not like people that were not the same ethnicity, therefore therapy would be able to go in alone because they did not have any therapists that were of a different ethnicity. Upon interview on 3/17/25 at 3:31 p.m. RN-D the clinical manager stated the reason R1 was on cares in pairs was on a prior admission to the facility R1 had made accusations against staff of a different ethnicity. She defined cares in pairs as you have to always have two people in the room unless otherwise indicated. She was certain if it was okay for therapy to be in there alone when they were dressing him. Upon observation on 12/18/25 at 8:28 a.m. NA-B was in R1's room and he asked to use the bathroom. NA-B told R1 that she needs to get the assistance of another staff member. NA-B got NA-C. They assisted R1 to sit on the side of the bed, put a gait belt around his waist, stood him up and him ambulate eight steps to his wheelchair. Upon observation and interview on 12/18/25 at 8:47 a.m. NA-B looked in a binder on the