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	01/15/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure frozen food items were stored in a manner to reduce the risk of cross contamination and potential foodborne illness in a walk-in freezer. The facility failed to ensure scoops were not stored in 2 of 3 bulk containers to prevent cross contamination. The facility also failed to ensure hair and beard nets were used in the food preparation area and kitchen utensils sanitizing area. In addition, the facility failed to consistently monitor the dishwasher machine temperature. This had the potential to affect all 98 residents, staff, and visitors who consumed food from the facility kitchen.Findings include:On 1/12/26 at 1:19 p.m., an initial kitchen tour was completed with cook/kitchen supervisor (C)- A, the following was observed: Walk-in freezer- One speed rack had 2 trays of uncovered, unlabeled, uncooked hamburger patties. One of the trays had 5 frozen hamburger patties and the other one had 7 - A second speed rack had one tray of 15 uncooked fish filets which were uncovered, and unlabeled.Bulk containers- The lids of a triple bulk container used to store flour, white rice, and brown rice contained debris of flour and rice. Scoops were observed inside the flour and white rice bins. Hair nets- Dietary aid (DA)-A was sanitizing and storing dishes and cookware was not wearing a hair net. High temp dish machine -The log labeled January 2026 had no temperatures recorded on January 1st, 2nd, 3rd and 7th. On January 5th, 2 out of three temps were recorded, and on January 6th, 8th, 9th, 11th and 12th only one of three were recorded. -During the initial tour DA-A was actively using the dish machine. A cycle was observed and the wash cycle temp indicated 150 degrees Fahrenheit (F) while the rinse cycle indicated 180 degrees F. C-A stated the wash temp was low and it should be160 degrees. CA-A did not provide additional instruction to DA-A who continued to use the dish machine. On 1/12/26 at 4:15 p.m. a subsequent kitchen tour was completed. At 4:19 p.m. C-B was setting up the steam table, gathering serving tools, and removing buns from a plastic bag for dinner and placing them on an open tray next to the steam table. C-B had a full beard, about 1 inch long below his chin. C-B stated, I didn't know I had to wear a beard net.During interview on 1/12/26 at 4:23 p.m., food service director (FSD) stated C-A had updated him regarding the concerns found during the initial kitchen tour. Regarding the use of hair and beard nets, FSD stated, my staff knows better. FSD added the kitchen staff needs to use hair and beard nets. During this interview C-B entered the FSD's office and asked where he could find the beard nets. FSD pointed to a shelf in his office, C-B took one and started to put it on as he left FSD's office. During a subsequent visit to the kitchen on 1/13/26 at 12:01 p.m., FSD stated the dishwasher broke while the staff was washing the breakfast plates that morning. FSD stated they were going to use disposable plates and cups until the wash machine was repaired. Food Storing and kitchen sanitary, and cleaning schedule policies were requested but not received. During observation and interview on 1/14/26 at 11:13 a.m. dietary aid DA-A was washing pots and stainless-steel bins. The dish machine cycle was observed, and the wash cycle indicated 109.6 degrees, and the rinse cycle temp was 194 degrees. DA-A stated he had not paid attention to the temperatures. The dish machine temperature log had no documentation of the morning temp. The Ecolab Service Call Summary dated 1/14/26 at 9:47 p.m., indicated Scale issues are causing issues that require deliming until Softener is repaired. The document indicated the wash temperature was (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	162 degrees F and rinse temperature was 183 degrees, both In Range. Additional comments included Machine Condition: Issue Found, and Lime scale buildup due to down water softener. Will need to delime more frequently in the interim.The Ecolab Extra Service Request dated 1/14/26 at 9:44 p.m., indicated the facility requested service for the EC-44 Dish Machine as it was In constant wash cycle and wasting chemicals; attempted flipping delime switch. Service Comments included Found a metal lid tucked behind first paddle. During observation and interview on 1/15/26 at 9:31 a.m., breakfast dishes were being washed in the dish machine and the cycle was observed. The wash temperature rose to 108 degrees F, and the rinse temperature rose to 194.3 degrees. DA-B confirmed the wash temperature was low. DA-B prepared to load another tray of dishware for machine washing. During interview on 1/15/26 at 9:50 a.m., FSD responded to the following concerns:Wash machine - FSD stated he was not informed about the wash machine temperatures observed that morning at 9:31 a.m. FSD stated they were having problems with the wash machine. FSD stated an engine component broke 6 weeks ago, but the technician forgot to fill the component with oil and the machine broke again on Tuesday 1/13/26. FSD added, yesterday 1/14/26 the wash cycle was stuck and would not go to the rinse cycle. FSD stated every time the wash machine was serviced, the ECOLAB technician emailed a service report. Hair and beard nets - FSD stated he had talked repeatedly to the staff about the use of hair and beard nets. FSD stated on a regular basis I found staff not wearing hair nets. FSD stated he expected staff to wear hair and beard nets to prevent hair falling in the food, cooking or serving gear. Food storage - FSD stated storing uncovered food in the freezer was honestly, lazy. All items on the speed racks should be individually covered or cover the whole cart with a proofing bag. FSD stated it was unsanitary because something can land on it.Bulk containers - FSD stated the scoops should not be left inside the containers because it was a concern for cross contamination. During interview on 1/15/26 at 1:08 p.m., FSD stated the water softener had been down for weeks, and with that not functioning properly, lime and scale had built up in the heating element of the dishwasher. He stated the water softener was back online as of last Friday, but the dishwasher might not be getting soft water yet as it took a while to work through the system. He stated the scaling was building up pretty badly and the heating element didn't run consistently because of that. They used lime away and a descaler and reached out to Ecolab tech and there will be a deep scrub on the heating element. FSD stated they had not had a scrub done previously, and it has been an ongoing situation. FSD stated the heating element fluctuated from time to time, and it was a difficult problem because it was inconsistent. When staff notice the temperature is out of range, they should address the temperature and delime it and go back to normal operation. He stated the facility did not have a 3-compartment sink, and they found the issue on Tuesday and then used full disposable dishware. He indicated the service tech was in the facility this afternoon. During interview on 1/15/26 at 1:00 p.m., the administrator stated storing uncovered fish filets and hamburger patties was concerning, not only for cleanliness but because it could affect the patients. Administrator stated she expected the staff to wear hair and beard nets because it was a standard practice, so they did not get hair in the food. Regarding the storage of scoops on dry goods, the administrator stated the scoops should be stored outside of them. Regarding the wash machine, the administrator stated the facility needed to have an appropriate temperature to be in regulation. The Ecolab EC-44 Dishmachine brochure dated 2012, indicated a required wash temperature of 160 degrees F and a rinse temperature of 180 degrees F. The undated facility policy titled Dishwashing Procedures, indicated the facility will implement dishwashing practices that prevent the spread of food-borne illness. The dish machine will be operated in accordance with the manufacturer's instructions.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure a resident was appropriately assessed and had an appropriate order in place to self-administer nebulizer medication for 1 of 1 resident (R80) reviewed for self-administration of medications. Findings include: R80's significant change Minimum Data Set (MDS), dated [DATE], indicated R80 was cognitively intact and required partial to moderate assistance with most activities of daily living. R80's active orders, printed 1/15/26, contained an order for albuterol sulfate for nebulization once a day in the morning and three times a day as needed for difficulty breathing, shortness of breath, wheezing and/or bronchospasm prevention. R80's care plan, dated 10/30/25, indicated, I [R80] will independently administer respiratory treatments as ordered and I will receive assistance setting up, disassembling, and cleaning respiratory equipment from a licensed nurse. with interventions to include, acquire physician's order for self-administration of respiratory treatments and, perform a self-administration medication assessment per facility protocol.R80's electronic medical record lacked an order and an assessment for self-administration of her respiratory treatments (i.e. albuterol sulfate via nebulization).During an interview on 1/14/26 at 10:30 a.m., licensed practical nurse (LPN)-A stated R80 administered her nebulizer independently. She indicated licensed staff would put the medication in the nebulizer and leave R80 with the medication who would turn off the nebulizer machine on her own when the medication was gone, stating he checked back with her in 10-15 minutes after starting the nebulizer. During observation on 1/14/26 at 11:45 a.m., LPN-A entered R80's room, handed her the hand-held nebulizer mouthpiece, already filled with the albuterol medication, turned on the nebulizer machine, and left R80 to self-administer the medication independently. During an interview on 1/15/26 at 9:08 a.m., the assistant director of nursing (ADON) confirmed there was not an order or assessment in place for R80 to self-administer her nebulizer medication and that it would be expected to have those in place prior to self-administration of any medications. A facility policy titled Self-Administration of Medications, revised 4/10/25, indicated each resident will be assessed for the ability to physically and mentally self-administer any medication and, if deemed appropriate, a physician order would be obtained to self-administer the assessed medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to accommodate resident needs by ensuring the call light was accessible for 1 of 1 resident (R26) reviewed for call lights.Findings include: R26's quarterly Minimum Data Set (MDS) dated [DATE], identified R26 with impaired cognition, no rejection of cares or wandering, impairment in lower extremity range of motion, required a walker or wheelchair for mobility, and needed partial to moderate assistance with dressing, transfers, and hygiene. Diagnoses include heart failure, kidney disease, arthritis, depression and anxiety. During observation and interview with R26 on 1/12/26 at 5:01 p.m., R26 was lying in bed with call light out of reach on nightstand next to head of bed. R26 stated she could not see it and wanted assistance to get up out of bed to go to dinner. Normally I use the call light if I need help. If it is out of reach then I make noise to get attention to get [staff] to answer my pleas. During observation and interview with nursing assistant (NA)-B on 1/12/26 at 5:04 p.m., NA-B verified R26's call light was out of reach, It should be in reach to ask for help. During interview with NA-D on 1/15/26 at 6:52 a.m., NA-D stated it was important to place the call light next to patients at all times. If out of reach the residents can fall. For safety.During interview with registered nurse (RN)-G on 1/15/26 at 7:04 a.m., RN-B stated, [staff] always make sure [call light] is in reach and [residents] know how to use it.During interview with director of nursing (DON) on 1/15/26 at 9:57 a.m., DON stated expectation of staff to place the call light call within reach at all times so residents can call for help if needed.Facility policy titled Call Lights-Call System Activation and Response dated 5/28/2024 identified:Each resident is provided with a means to call staff directly for assistance. The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and document review, the facility failed to ensure resident rooms were maintained at a comfortable temperature between 71 and 81 degrees Fahrenheit for 1 of 1 residents (R57) reviewed who indicated their rooms were cold.Findings Include:R57's admission Minimum Data Set (MDS) assessment, dated 12/22/25, indicated a diagnosis of cerebral infarction (stroke) with intact cognition.During an interview on 1/12/26 at 5:19 p.m., R57 stated his room was cold. R57 was observed wearing a winter coat while sitting in a recliner chair in his room between the bed and the window which he reported was where he spent the majority of his time. R57 stated he had reported his concerns to staff and had been told this room is always like this. R57 stated, I am froze. The thermostat on the wall indicated 72.9 degrees Fahrenheit (F). At 5:50 p.m., surveyor obtained temperatures in the room: 66.2 degrees F by the tv, 68.3 degrees F around the chair R57 was sitting in, and 67.7 degrees F between the chair and the wall.During an interview on 1/12/26 at 5:58 p.m., nursing assistant (NA)-C stated R57 had complained of his room being cold about a week or so ago. NA-C stated he thought a form had been filled out for maintenance to look at R57's room temperature. NA-C verified that R57 was wearing a winter coat due to being cold when he brought him to the bathroom this evening.During a follow up interview on 1/13/25 at 9:55 a.m., R57 stated he did not use his personal refrigerator as it was cold enough in the room to keep items on the counter to keep them cold. On 1/14/26 at 10:46 a.m., surveyor obtained temperatures in R57's room. It was 66.5 degrees F around R57's chair.During an interview on 1/14/26 at 12:20 p.m., director of maintenance (DOM) stated that he had received a complaint of R57's room being cold last week and had the vendor come out and look at his room. DOM stated after the vendor was out, the room was above 71 degrees F. The next day, DOM check the room temperature via computer as temperatures can be checked from the thermostats via computer without having to disrupt the residents. He stated the computer indicated the room was above 71 degrees F. DOM and surveyor obtained temperatures in R57's room: the area around R57 was 69.7 degrees F, and the middle of the room was 70.2 degrees. R57's thermostat indicated 72.3. DOM stated R57's room temperatures are not within the required 71-81 degrees F and would call the vendor out again.During an interview on 1/15/26 at 11:15 a.m., administrator stated temperatures are to be between 71-81 degrees F. Administrator stated the vendor came out yesterday for R57's room and switched the wires. Administrator stated the room was currently temping at 74 degrees F where the resident sits.A facility policy on room temperatures was requested and not received.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide and document an appropriate diagnosis for a prescribed psychotropic medication for 1 of 5 (R100) residents and failed to provide appropriate side effect monitoring (i.e., orthostatic blood pressure) with antipsychotic medication consumption for 1 of 3 (R49) residents reviewed for unnecessary medication use. Findings include: R100's quarterly Minimum Data Set (MDS), dated [DATE], indicated R100 was admitted to the care facility on 6/14/22 and was cognitively intact. The MDS further indicated R100 had no documented hallucinations or delusions during the look-back period. R100's Diagnoses List, indicated R100 had diagnoses including vascular dementia, history of stroke and adjustment order with anxiety. R100's Physician Order Report, dated 12/1/25 - 12/31/25, indicated an order, dated 9/11/25, for Abilify 5 milligrams (mg) once a day for bothersome and frightening hallucinations. R100's Consultant Pharmacist Recommendation to Physician, printed 12/29/25, indicated, this resident [R100] is receiving antipsychotic agent Aripiprazole [Abilify] (currently listed on the MAR for hallucinations), but lacks an allowable diagnosis to support its use. R100's progress note, dated 1/13/26, indicated the nurse practitioner reviewed the pharmacist recommendation from December and due to R100 not having an appropriate diagnosis for antipsychotic medication the Abilify was discontinued. During an interview on 1/14/26 at 12:25 p.m., the assistant director of nursing (ADON) stated it would be expected that the nurse managers review psychotropic medications for an appropriate diagnosis when ordered, stating the pharmacist will also review medications and inform the facility staff if there is not an appropriate diagnosis attached to the medication order, confirming R100's Abilify, ordered 9/11/25, did not have an appropriate diagnosis. A facility policy titled Psychotropic Medication Use, reviewed 9/7/23 indicated psychotropic medications are ordered by the medical provider to treat a specific condition as diagnosed and documented in the medical record. R49's admission Minimum Data Set (MDS) assessment, dated 10/20/25, indicated R49 had intact cognition with no hallucinations or delusions and no behavioral symptoms including physical or verbal behavioral symptoms directed at others, or behavioral symptoms not directed toward others. Further it indicted R49 received an antipsychotic medication. R49's January 2026 Medication and Treatment Administration Record (MAR)/TAR), printed 1/15/26, included the following orders: -aripiprazole (antipsychotic medication used to treat mental/mood disorder) 10 milligram (mg) tablet – give 10 mg by mouth at bedtime for moderate episode of recurrent major depressive disorder (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with a start date of 10/14/25. Medication was documented as administered every day in January. -orthostatic blood pressure related to antipsychotic use once a month on the 14th with a start date of 10/14/25. The MAR/TAR indicated a signature of completion. The document lacked documentation of the blood pressures. -per therapy recommendations: discontinue assist of 2 with [NAME] steady assist of 1 with [NAME] steady for all transfers. Knee brace as needed for comfort with a start date of 1/5/26. -per therapy recommendations: discontinue ceiling lift assist of 2 with [NAME] steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26. R49's December 2025 MAR/TAR included the following orders: -aripiprazole (antipsychotic medication used to treat mental/mood disorder) 10 milligram (mg) tablet – give 10 mg by mouth at bedtime for moderate episode of recurrent major depressive disorder with a start date of 10/14/25. Medication was documented as administered every day in December. -orthostatic blood pressure related to antipsychotic use once a month on the 14th with a start date of 10/14/25. The MAR/TAR indicated a signature of completion. The document lacked documentation of the blood pressures. -per therapy recommendations: discontinue ceiling lift assist of 2 with [NAME] steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26. -per therapy recommendations: discontinue ceiling lift. Assist of 2 staff with [NAME] steady for all transfer.[NAME] on right lower extremity at all times except skin checks. Please support right lower extremity to maintain right knee during extension during transfers. No ambulation at this time with a start date of 12/16/25 and discontinue date of 12/18/25. -per therapy recommendations: discontinue ceiling lift. Assist of 2 with [NAME] steady for all transfers. No ambulation at this time. Knee brace as needed for comfort with a start date of 12/16/25 and discontinue date of 1/7/26. R49's care plan, printed 1/15/26, identified the following: -Under Activities of Daily Living (ADL)s Functional category, the care plan identified R49 had a self-deficit with ambulation, transferring, mobility, oral cares, grooming and bathing and indicated Resident has a tendency to self-transfer, self-ambulate, and not use her call button for assistance. -Under the Mood state category, the care plan identified R49 had a diagnosis of major depressive disorder and to obtain monthly orthostatic blood pressure per pharmacy recommendations. R49's blood pressure and pulse logs for 12/1/25 to 1/15/26 were reviewed. The document lacked evidence of orthostatic blood pressure being completed and documented. R49's progress notes for 12/1/25 to 1/15/26 were reviewed. The document lacked evidence of (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orthostatic static pressures being completed and documented. During an interview on 1/15/26, R49 was observed sitting in her wheelchair. R49 stated things were going well, denied any concerns and engaged in the conversation. During an interview on 1/15/26 at 10:20 a.m., licensed practical nurse (LPN)-B stated if a resident needed to have orthostatic blood pressures taken then an order was put in the electronic medical record (EMR). LPN-B stated the orders would show up under the treatments and documented on the MAR/TAR, and the vital signs would flow over to the vital signs section of the EMR. LPN-B stated some residents who were on antipsychotic medications had orders for orthostatic blood pressures to be taken but not all residents. LPN-B was not sure how it was decided who needed to have orthostatic blood pressures taken when a resident was on antipsychotic medications and stated the health unit coordinator or nurse manager put the orders in. LPN-B verified R49 had an order to have orthostatic blood pressures taken monthly and verified it was signed off for 12/14/25 and 1/14/26 as completed. LPN-B verified there were not blood pressures on the MAR/TAR and no blood pressures entered in the vital signs section of the EMR on 12/14/25 or 1/14/26. LPN-B stated, it looks like they weren't done. LPN-B stated R49 was able to stand with assist of 1 and EZ stand (device that assists person to stand). LPN-B stated there was a risk of orthostatic hypotension when a person took antipsychotic medication(s). During an interview on 1/15/26 at 11:04 a.m., director of nursing (DON) stated the expectation would be any resident on an antipsychotic medication should be getting orthostatic blood pressures done monthly. DON stated it's important to monitor orthostatic blood pressures as antipsychotic medications can affect blood pressures which can increase falls. DON could not find any orthostatic blood pressures documented for R49 the last few months. A facility policy titled Psychotropic Medication Use, reviewed 9/7/23, indicated When psychotropic medications are ordered, the IDT identifies target behaviors, medication side effects to be monitored and implements a resident centered care plan with both non-pharmacologic and pharmacological interventions.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure a resident's preferences were care planned to ensure preferences were honored for 1 of 1 resident (R127) reviewed who preferred to have female only caregivers. Findings include:R127's admission Minimum Data Set (MDS), dated [DATE], indicated R127 was admitted to the care facility on 1/4/26 and was cognitively intact. The MDS further indicated R127 required substantial assistance with toileting and partial to moderate assistance with bathing. R127's progress notes, dated 1/4/26, indicated R127, strongly prefers female caregivers. Patient was instructed that the facility does its best to fulfill these requests but that there was no guarantee that we could provide all female caregivers throughout her stay. Patient understood but stated 'I will just do it myself if there is not female to support me.' R127's care plan and care guide sheets used to direct resident care lacked mention of any care preferences voiced by R127, including the preference for female only caregivers. During an interview on 1/12/26 at 3:48 a.m., R127 stated she had told multiple staff members, multiple times, that she prefers female caregivers, but that male staff keep coming in and she has to remind that that she would prefer a female. During an interview on 1/15/26 at 8:32 a.m., nursing assistant (NA)-J stated R127 did like men caring for her and if there was a man working on the unit they would try to switch assignments. NA-J stated when a resident voiced a preference such as female only care givers staff would pass it along shift to shift via word of mouth. During an interview on 1/15/25 at 8:39 a.m., clinical manager and registered nurse (RN)-H stated she was unaware that R127 had a preference for female only caregivers, stating she would have expected such a preference to be communicated to her to ensure it was care planned. RN-H stated if she was aware R127 had a preference for female only caregivers she would generally talk with staffing and ensure if there were no female nursing assistants working on the unit that the float NA was a female. During an interview on 1/15/26 at 8:45 a.m., licensed social worker (LSW)-A stated R127's preference for female only care givers was communicated to them through the hospital prior to R127 being admitted to the care facility. The Social Services Director (SSD) stated in the same interview that it would be expected that those preferences would be communicated to the nurse manager and care planned as floor staff often float to different units, so it is important to have care plans up to date to ensure preferences are honored and care needs are met. A facility policy titled Comprehensive Assessments and Care Planning, revised 9/27/23, indicated the comprehensive assessment and care plan must include a resident's customary routine and preferences.

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	01/15/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and document review, the facility failed to ensure 1 of 4 residents (R45) reviewed for activities of daily living (ADLs) and were dependent on staff for their ADLs, routinely had their fingernails cleaned and trimmed.Findings include:R45's quarterly Minimum Data Set (MDS) 10/25/25, indicated R45 had intact cognition and was diagnosed with arthritis. R45 was dependent on staff for toileting hygiene, lower body dressing, and putting on and taking off footwear. The MDS indicated R45's most recent admission/entry to the facility was on 7/23/25. R45's Weekly Skin Checks dated 11/7/25 through 1/9/25, included a section with the question Was nail care completed? with the options of fingernails trimmed, toenails trimmed, refused, or not necessary. All checks from this period were either checked as not necessary or left blank. R45's care plan dated 1/9/25, indicated she had a self-deficit with ADLs such as grooming, bathing, and oral care. R45's medical record was reviewed and did not indicate R45 had refused toenail care. During an interview and observation on 1/12/26 at 2:43 p.m., R45 was observed sitting in a chair in her room. R45 stated that she felt like her toenails needed to be trimmed and confirmed that they were not causing her pain. R45 stated she didn't think anyone had offered to help her cut her toenails since she was admitted in July of this year. R45's toenails were observed to have grown past the end of her toes, with a varying nail length, and some toenail curling was observed. During an interview on 1/13/26 at 12:45 p.m., registered nurse (RN)-B stated that R45 was not a diabetic, so the aides could assist her with cutting her finger and toenails. When asked when the last time toenail clipping was completed or where it was documented RN-B stated she was not sure. During an interview and observation on 1/13/26 at 12:47 p.m., nursing assistant (NA)-C stated he had assisted R45 with her personal care this morning. NA-C was observed to lift R45's blanket, look at her toes, and state her toenails looked like they could use a trim. R45's toenails were observed to have grown past the end of her toes, with a varying nail length, and some toenail curling was observed. NA-C stated he didn't work on this unit very often, so he was not sure if R45 refused to get her toenails trimmed or the last time toenail trimming was completed. NA-C confirmed he had not offered to cut R45's toenails. During an interview on 1/14/26 at 8:22 a.m., RN-C, the clinical manager for the unit, stated she had reviewed R45's records and did not find evidence that R45 had gotten nail care or refused it recently. RN-C stated staff should either document nail care/nail care refusals in a progress note or on the weekly skin check observation form. RN-C stated she saw that staff had been documenting that it was not applicable to the question of whether R45 had her nails done. RN-C stated that after assessing R45's nails, she felt that they should have been previously cut, so she talked with R45 this week, and R45 had consent to having her toenails trimmed. RN-C stated she was unable to cut all of her toenails, so she was going to ensure a consult was made with podiatry for additional nail care. RN-C stated the nurse was supposed to assess the resident's nails on bath days and ensure that nail care was completed as necessary.The facility's Activities of Daily Living policy dated 7/21 was received but did not include guidance regarding nail care.

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	01/15/2026

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

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure communication and collaboration was maintained with a dialysis provider for 1 of 1 resident (R7) reviewed for dialysis. Findings include: R7's quarterly Minimum Data Set (MDS), dated [DATE], indicated R7 was admitted to the care facility on 5/10/24 and was cognitively intact. The MDS further indicated R7 required substantial to maximum assistance with activities of daily living and received dialysis. R7's Orders, dated 11/20/25 directed staff to monitor R7's dialysis fistula and to document R7's vital signs and monitor for shortness of breath, chest pain, nausea and vomiting or seizure activity prior to dialysis. R7's care plan, dated 5/13/24, directed staff to, obtain Dialysis care plan and coordination of care communication sheet. Check for orders or changes from Dialysis Unit. The care plan further indicated R7 went to dialysis three times a week, on Mondays, Wednesdays, and Fridays. R7's electronic medical record contained only one dialysis communication sheet (Dialysis Run Sheet), dated 10/15/25. R7's paper medical record contain multiple dialysis communication sheets (Dialysis Run Sheets), with the most current being dated 8/25/25. During an interview on 1/14/26 at 8:46 a.m., licensed practical nurse (LPN)-A stated R7 left around 5:00 a.m. for dialysis and arrived back to the care facility around 10:00 a.m. LPN-A stated the facility staff sent along an envelope with the dialysis communication sheet in it but that the facility staff often did not receive the sheet back from dialysis. During an interview on 1/14/26 at 12:25 p.m., the assistant director of nursing (ADON) stated it was expected that staff send the dialysis communication sheet with residents to dialysis, and the nurse was expected to review the sheet for new orders or residents' status when they returned from dialysis. During a follow up interview on 1/15/26 at 9:08 a.m., the ADON confirmed the most current dialysis communication sheet for R7 was from October, stating, we send the sheet and it doesn't always come back.During an interview on 1/15/26 at 10:50 a.m., the director of nursing confirmed it would be expected that the nurses are following up with the dialysis communication sheets, stating, we try our best but there is always communication breakdown.A facility policy titled Dialysis Services via Contracted Vendor, revised 5/28/24, indicated, the licensed nurses have ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.