

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/24/2025
NAME OF PROVIDER OR SUPPLIER  Good Samaritan Society - Waconia and Westview Acre		STREET ADDRESS, CITY, STATE, ZIP CODE  333 Fifth Street West Waconia, MN 55387	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and document review, the facility failed to maintain resident supervision and safety to prevent accidents for 1 of 1 resident (R2) who was at a high risk for elopement, left the facility unsupervised, and was found across the street in another assisted living (AL) parking lot. This resulted in an immediate Jeopardy (IJ) situation for R2. The IJ began on 7/18/25, when R2 was admitted to the facility and was identified to be a high risk for falls and elopement but the facility failed to implement safety measures and increased supervision resulting in an elopement from the facility on 7/19/25, when R2 wandered onto the elevator; walked through the attached assisted living, crossed the parking lot, crossed a busy street, and was found by police in the parking lot across the street from the facility. The IJ was removed on 7/19/25, and the deficient practice corrected on 7/19/25, prior to the start of the survey and was therefore issued at Past Noncompliance. Findings include: R2's admission Record identified R2 was admitted to the facility on [DATE] at 2:15 p.m. The Minimum Data Set (MDS) was not completed yet due to R2's recent admission date of 7/18/25. R2's Diagnoses List identified diagnoses of Alzheimer's disease and dementia. R2's Brief Interview for Mental Status dated 7/18/25, indicated R2 had severe cognitive impairment. R2's admission elopement assessment dated [DATE] at 8:00 p.m., identified R2 was at high risk for elopement related to R2's recent admission, caregiver change, disorientation to place, increased confusion and forgetfulness, recent room change, not understanding what is being said, inability to communicate needs, advanced dementia, wandering, and loss of self-control. In addition, the assessment identified diagnoses of Alzheimer's disease, dementia, and anxiety disorder and were risk factors for elopement. Interventions identified were to attempt non-pharmacological interventions and minimize potential of resident behavior problems by modifying environmental factors and daily routine. R2's Fall Risk assessment dated [DATE], indicated R2 was at a high risk for falls related to one or more falls in past three months, medications, severely impaired cognitive status, restlessness, delirium, confusion, poor memory, history of depression, disorientation, difficulty following instructions, restlessness, and poor sleep pattern. R1's Care plan initiated 7/18/25, did not identify R2 as an elopement risk or identify safety interventions to prevent or mitigate the risk of elopement until after R2's elopement on 7/19/25. R2's care plan did not identify the risk for falls or fall interventions until 7/19/25. R2's admission progress note on 7/18/25 at 2:15 p.m., identified R2 was admitted following hospitalization for mental status changes, left sided weakness, confusion, impaired speech, nasal fracture, periorbital (around the eyes) bruising due to a fall. R2's facility Progress Notes dated 7/18/25 at 11:17 p.m., identified R2 required assist of one staff with all cares and standby assist with a walker. The progress note indicated R2 was a high fall risk due to cognitive issues, a high risk of elopement, and needed to be monitored at all times. R2's Health Status progress note on 7/19/25 at 11:16 p.m., noted R2 eloped from the facility at 4:10-4:15 p.m. when staff noticed he was no longer in his room. Police officer found R2 wandering across the street at another AL facility. After the elopement, staff placed a wanderguard on R2 and implemented frequent checks. During observation on 7/23/25 at 12:20 p.m., R2 was seated at a table in the common area with his spouse. Wanderguard noted on his wrist. During an interview on 7/23/25 at 2:25 p.m., registered nurse (RN)-A identified she was the nurse that admitted R2 to the facility on a Friday afternoon (7/18/25). RN-A indicated on 7/18/25, R2 followed his wife down the facility elevators to the first floor exit doors. Staff responded and brought him back to the third floor and determined he was at high risk for elopement at that time. RN-A stated she did not apply a wanderguard because she did not know where the wanderguard bracelets were kept or how to activate them. RN-A further indicated the nurse managers usually applied them and stated she informed nurse manager (NM)-A that R2 was at risk for elopement and needed a wanderguard however, understood that NM-A had to leave and would apply one the next Monday (7/21/25), when she returned. RN-A indicated she wrote a progress note and passed the information to the next shift. RN-A confirmed a wanderguard had not been placed on R2 on 7/18/25. During an interview on 7/23/25 at 2:50 p.m., RN-C indicated the nurse managers applied the wanderguard and he had not been trained on activating the wanderguard until after R2 eloped from the facility on 7/19/25. During an interview on 7/23/25 at 4:00 p.m., the director of nursing (DON) stated she was notified by phone on 7/19/25, about R2's elopement when staff were unable to locate R2 in the facility. The police found him in the parking lot across the street from the facility at approximately 5:25 p.m. The DON stated a dietary aide saw R2 get on the elevator on 7/19/25, however, thought he was a visitor. R2 was identified as an elopement risk upon</p>		