STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Waconia and Westview Acre	333 Fifth Street West Waconia, MN 55387

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review the facility failed to provide adequate supervision creating a likelihood for potential serious harm, injury, impairment, or death for 1 of 3 residents (R1) who was assessed to be at risk for elopement on [DATE] and wore a Wander Guard bracelet (security device that prevents alerts staff if a resident at risk of wandering attempts to leaving a designated area) ^and eloped from the facility on [DATE]. The immediate jeopardy began on [DATE], when R1 exited the facility front door at 12:54 a.m., then was found by a community member lying in the parking lot of an apartment building. The facility^identified^R1 was missing when a county sheriff came to the facility at 2:56 a.m., showed R1's photo to staff, and staff discovered R1 was not in his bed.^^The facility administrator and director of nursing (DON) were notified of the immediate jeopardy on [DATE] at 5:38 p.m. The deficient practice corrected on [DATE], prior to the start of the survey and was therefore past non-compliance.^ Findings include:^ ^A Vulnerable Adult Maltreatment Report dated [DATE], reported by a community member,^indicated^emergency medical services (EMS) was called to an apartment complex^located^a block away from the facility by a resident of the apartment complex. The resident noticed a person^[R1]^lying on the ground outside the building, who had wandered unnoticed by the facility staff.^ [R1]^had a diagnosis of dementia and was supposed to be checked every two hours. Staff were unaware R1 was missing until notified by a [NAME] County deputy after R1 was taken to the emergency room.^ An Incident Report Summary dated [DATE] at 4:49 am., indicated on [DATE] staff was alerted by police^[R1]^was found on the ground in a parking lot, and was taken to a hospital to be examined, and police came to the facility to confirm it was^[R1]^who they found.^[R1's]^most recent Wander Guard assessment on [DATE],^indicated^[R1]^was not an elopement risk. On [DATE],^[R1]^was^deemed^cognitively intact.^[R1's]^diagnoses included Lewy body dementia (a progressive neurodegenerative disease in the brain that causes decline in thinking, movement, memory, and mood) with psychotic disturbance and diabetes with neuropathy (nerve damage caused by long-term high blood glucose leading to pain, numbness, and tingling).^^ ^R1's Nursing admission assessment dated [DATE], indicated R1 was admitted with a history of falls, diabetes, weakness, and was alert and oriented to person, but not oriented to place, time, or situation. R1 was slow to respond to questions, had poor word recall and increased confusion and forgetfulness, but was not at risk for elopement. Learning barriers included cognitive status and cues were^required.^^ R1's orders dated [DATE], instructed staff to administer quetiapine fumarate (antipsychotic medication) 25 milligrams (mg), give 25 mg by mouth at bedtime for repeated episodes of anxiety. The order was^discontinued^[DATE].^ ^R1's care plan^with initiation/edit dates^indicated:^ [DATE]-^a self-care deficit with ambulation,^required^assistance^of one staff, with a gait belt and walker for safe ambulation^ [DATE]-^high risk^for falls^ [DATE]-^potential for elopement, Wander Guard used to alert staff to resident's movements^^ [DATE]-^impaired cognitive function as^evidenced^by forgetfulness, poor recall, and impaired cognition^ [DATE]-^behavior problems related to Lewy Body dementia: psychosis^(collection of symptoms which disrupt a person's thoughts and^perceptions, making it difficult to distinguish what (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	is real from what is not), anxiety, hallucinations, and delusions.ˆ R1's Elopement Risk assessment dated [DATE],ˆidentifiedˆR1 had a caregiver or staff change, had a change in normal behavior, and had no learning barriers. R1 wasˆdeemedˆnot at risk for elopement. The assessment lackedˆindicationˆR1 was admitted within the last month, had a history of elopement from home, had increased confusion and forgetfulness, diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status asˆindicatedˆin the admission Nursing Assessment on [DATE].ˆ R1's Elopement Risk assessment dated [DATE] identified R1 was admitted within the previous month, had a caregiver or staff change, had a diagnosis of dementia, R1 should not leave the facility unattended, and a Wander Guard was placed to alert staff of R1's movements. ˆR1 wasˆdeemedˆan elopement risk and a care plan related to elopement wasˆinitiated. The assessment lackedˆindicationˆR1 had a history of elopement from home, had a diagnosis of dementia with psychosis,ˆand had learning barriers related to his cognitive status asˆindicatedˆin the admission Nursing Assessment on [DATE].ˆˆ ˆR1's provider orders dated [DATE]ˆinstructed staff to place a Wander Guard to R1's right wrist, check placement every shift, and check functionality daily. ˆˆˆ R1's nursing orders dated [DATE], instructed staff to place a Wander Guard to R1's right wrist, check placement every shift, and check functionality daily. The nursing order wasˆdiscontinuedˆ[DATE]. The provider order was notˆdiscontinued. ˆˆ R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 admitted to the facility on [DATE] with intact cognition, diagnoses that included dementia and diabetes, and had no wandering behavior in the 7-day look-back period.ˆˆ R1's progress notes dated [DATE] at 2:30 p.m., indicated R1's Wander Guard was found in the trash. The nurse manager was aware and indicated R1 no longer needed the Wander Guard.ˆˆ R1'sˆmedical record lackedˆindicationˆan Elopement Risk Assessment was completed to make the determination the Wander Guard was no longer needed.ˆˆ R1's progress notes dated [DATE] at 5:23 p.m., indicated R1 returned from the hospital at 5:05 p.m., the Wander Guard was not re-implemented, and staff should perform more frequent checks overnight.ˆ R1's Elopement Risk assessment dated [DATE], indicated R1 was admitted in the prior month, had no diagnoses related to elopement risk, had no learning barriers, and was not at risk for elopement. The assessment lacked indication R1 had a history of elopement from home, had a caregiver or staff change after he had returned from the hospital the day prior,ˆhad a diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status as indicated in the admission Nursing Assessment on [DATE]. The assessment lackedˆindicationˆR1's care plan was reviewed at the time of the assessment.ˆˆ R1's progress note dated [DATE] at 2:37 p.m.,ˆindicatedˆduring rounds the nurse practitioner added a diagnosis of Lewy Body dementia to R1's clinical record and diagnoses of major depression and psychosis. The medical record lackedˆindicationˆR1 was reassessed for Elopement Risk after the addition of the diagnoses.ˆˆ R1's quarterly MDS dated [DATE],ˆindicatedˆintact cognition, diagnoses included dementia, diabetes, and depression, and had no wandering behaviorˆduringˆthe 7-day look-back period.ˆˆ R1's Elopement Risk assessment dated [DATE],ˆindicatedˆresident had no history of elopement attempts in the past, no diagnoses related to elopement risk, and indicated R1 was not at risk of elopement. The assessment lackedˆindicationˆifˆR1 had a history of elopement from home, had a diagnosis of dementia with psychosis andˆdepressionˆandˆhad learning barriers related to his cognitive status asˆindicatedˆin the admission Nursing Assessment on [DATE]. The assessment lackedˆindicationˆR1's care plan was reviewed at the time of the assessment. ˆˆ R1's progress notesˆindicatedˆthe following:ˆ [DATE] at 2:42 p.m., during a care conference R1 indicated he wasˆhaving hallucinationsˆof roaches and people. R1ˆhad fallen that morning.ˆˆ [DATE] at 10:05 a.m., R1 was alert and oriented with forgetfulness.ˆˆ [DATE] at 3:41 p.m., R1's wife called the facility twice to ensure R1 was being checked on because R1 was really confused andˆdidn'tˆknow he was in the facility,ˆorˆwhat town heˆresidedˆin.ˆˆ [DATE] at 5:53 p.m., R1 had frequent delusions, was suspicious of others, and had verbal disruptions. R1 had anxiety and nervousness that impaired his quality of life and was taking antipsychotic, antidepressant, and antianxiety (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medications.^^ [DATE] at 5:50 a.m., the sheriff came to the facility and reported R1 was found in a parking lot nearby, appeared to have fallen but no injury was noted, and was transported to the emergency room. R1 was last checked and changed for incontinence on [DATE] at 11:30 p.m. Will place Wander Guard on resident when he returns from the emergency room. ^^ Review of the weather on [DATE] between 12:00 a.m. and 1:00 a.m. from the Weather Channelˆatˆhttps://weather.com,ˆrevealed the temperature in Waconia wasˆapproximately 43-45ˆdegrees Fahrenheit.^^ A photo of R1,ˆprovided by the administrator from camera footage, revealed R1ˆleftˆthe facility on [DATE] at 12:54 a.m.ˆR1 left out the front door wearing a short-sleeved shirt, shorts, and tennis shoes, and was walking with a walker.^^ R1's progress notes dated [DATE] at 5:50 a.m., indicated at 2:50 a.m., the sheriff came to the facility and reported the resident was found in a nearby parking lot and appeared to have fallen. The sheriff noted no injuries and R1 was transported by ambulance to an emergency room for evaluation. R1 was last checked and changed by staff on [DATE] at 11:30 p.m. R1's Elopement Evaluation datedˆ[DATE] at 1:23 p.m.,ˆindicated R1 had a history of elopement or attempt while at home and while at the facility. R1 had an elopement score of 2 whichˆindicatedˆa risk for elopement. R1's orders dated [DATE], instructed staff to place a Wander Guard to R1's left ankle and to check placement every shift, and function daily.^^ During an interview on [DATE] at 4:53 p.m., the nursing assistant (NA)-Aˆstatedˆhe was not aware R1's Wander Guard was removed shortly after admission but acknowledged he knew R1 should have been checked every two hoursˆbut was not on the night of [DATE], into [DATE]. NA-Aˆstatedˆheˆwas working on the night of [DATE], andˆchecked on R1 when R1 activated his call light on [DATE] at around 11:00 p.m. Then, NA-A returned to the desk to watch for call lights. Within a few minutes, ˆR1's neighbor activated his call light. When NA-Aˆwalked past R1's room, on his way to answer call light, heˆcould see R1's feet. NA-A thoughtˆR1 must have left the unit after that. NA-Aˆstatedˆthere were a lot of call lights to answer that night and heˆdidn't˜get back to R1. The sheriff came to alert staff R1 was gone, and NA-A acknowledged he did not see R1 leave the unit. NA-Aˆstatedˆhe was supposed to check R1 everyˆtwoˆhours andˆhad not.^^ During an interview on [DATE] at 8:22 a.m., licensed practical nurse (LPN)-Aˆstatedˆaround 11:00 p.m., on [DATE] NA-A checked on R1. R1 returned to his recliner afterˆNA-A was finishedˆassistingˆhim.ˆStaff were supposed to check on R1 every two hours toˆassistˆwithˆrepositioningˆbutˆhad notˆthat night. LPN-Aˆstatedˆhe was not aware R1 was missing until the sheriff came to the facility.^^ During an interview on [DATE] at 11:03 a.m., family member (FM)-Aˆstatedˆshe was made aware,ˆafterˆR1 left the facility, R1 fell and was on the ground for over an hour. R1 was found by a community member.ˆFM-Aˆstatedˆbefore R1 admitted to the facility, heˆleft their home during winter months, It was just like [R1] to do it.ˆFM-A put an alarm on the door so she would be notified if R1 attempted to leave again.ˆFM-A stated R1 walked with aˆwalker andˆsometimes used aˆwheelchair.^^ During an interview on [DATE] at 11:46 a.m., R1 stated heˆexperiencedˆhallucinationsˆsinceˆhe was fifteen years old andˆwasˆsleepwalkingˆsince he was in the military. R1ˆthought heˆwasˆsleepwalking in theˆfacility,ˆandˆthis was the reasonˆhe left the facility, on the night of [DATE]. R1ˆrecalled,ˆwhen he walked away from the facility, it wasˆcoldˆand he was wearingˆshorts and a short-sleeved shirt. He gotˆfar from the facility and was tired ofˆwalking so heˆlaidˆon the pavement in a parking lot. R1ˆthought heˆlaidˆin the parking lot for about an hour and half, someone saw him and asked him what he was doing, thenˆcalled the police. R1 was taken to the hospital. R1 stated he could sign in and out of the facility and was allowed to be out until 10:00 p.m. Staff were supposed to check on him every two hours butˆdidn't˜that night.^^ During an interview on [DATE] at 12:12 p.m., registered nurse (RN)-Bˆstated,ˆtoˆdetermineˆif R1 had a history of elopement prior to admission, the facility staff should have asked R1's familyˆabout any history or elopement. RN-B did not know if staff asked this question,ˆbutˆthought if they had, it would have been included on the assessment.ˆThe RN-Bˆstatedˆon each of R1's Elopement Risk assessments dementia with psychosis and anxiety should have been acknowledged but were not. Further, RN-Bˆstatedˆshe knew R1 had a history of (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	implemented a systemic plan that included the following actions:ˆ Upon returning to the facility R1 was assessed for injuries, depression, supervision needs, cognitive status, and safety interventions.ˆ Staff requested an evaluation by the Associated Clinic of Psychology for R1.ˆˆ R1's Elopement Risk was reassessed, and a Wander Guard was placed on R1.ˆˆ Nursing assistant NA-A and LPN-A were suspended, given written warnings for corrective action, and prior to returning to the facility to work were retrained on rounding and supervision of residents.ˆˆ RN-A was suspended, given a written warning for not performingˆaccurateˆand comprehensive assessments, and prior to returning to her role, was retrained on how to completeˆan accurateˆcomprehensive Elopement Risk Assessment.ˆˆ A facility-wide reassessment of all residents' elopement risk was performed; care plans were adjusted accordingly.ˆˆ Staff education wasˆinitiatedˆfor all nursing staff on [DATE] for elopement risk identification, resident supervision and monitoring,ˆtimelyˆimplementation of care plan interventions, the Wander Guard process and monitoring, and the expectations of reporting and response of elopement.ˆˆ Ongoing audits and monitoring plans were developed [DATE] to ensure ongoing compliance.ˆ

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to include complete and accurate information when assessing elopement risk for 1 of 3 residents (R1) reviewed for elopement. Findings include:R1's Elopement Risk assessment dated [DATE] identified R1 had a caregiver or staff change, had a change in normal behavior, and had no learning barriers. R1 was deemed not at risk for elopement. The assessment lacked indication R1 was admitted within the last month, had a history of elopement from home, had increased confusion and forgetfulness, diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status as indicated in the admission Nursing Assessment on 11/26/25.R1's Elopement Risk assessment dated [DATE], identified R1 was admitted within the previous month, had a caregiver or staff change, had a diagnosis of dementia, R1 should not leave the facility unattended, and a Wander Guard was placed to alert staff of R1's movements. R1 was deemed an elopement risk and a care plan related to elopement was initiated. The assessment lacked indication R1 had a history of elopement from home, had a diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status as indicated in the admission Nursing Assessment on 11/26/25. R1's provider orders dated 11/28/26, instructed staff to place a Wander Guard to R1's right wrist, check placement every shift, and check functionality daily. R1's nursing orders dated 11/28/26, instructed staff to place a Wander Guard to R1's right wrist, check placement every shift, and check functionality daily. The nursing order was discontinued 12/11/25. The provider order was not discontinued. R1's admission Minimum Data Set (MDS) dated [DATE] indicated R1 admitted to the facility on [DATE], with intact cognition, diagnoses that included dementia and diabetes, and had no wandering behavior in the 7-day look-back period. R1's progress notes dated 12/5/25 at 2:30 p.m., indicated R1's Wander Guard was found in the trash. The nurse manager was aware and indicated R1 no longer needed the Wander Guard. The medical record lacked indication a new Elopement Risk Assessment was completed to make the determination the Wander Guard was no longer needed. R1's progress notes dated 12/10/25 at 5:23 p.m., indicated R1 returned from the hospital at 5:05 p.m., the Wander Guard was not re-implemented, and staff should perform more frequent checks overnight.R1's Elopement Risk assessment dated [DATE], indicated R1 was admitted in the prior month, had no diagnoses related to elopement risk, had no learning barriers, and was not at risk for elopement. The assessment lacked indication R1 had a history of elopement from home, had a caregiver or staff change after he had returned from the hospital the day prior, had a diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status as indicated in the admission Nursing Assessment on 11/26/25. The assessment lacked indication R1's care plan was reviewed at the time of the assessment. R1's Elopement Risk assessment dated [DATE] indicated resident had no history of elopement attempts in the past, no related diagnoses related to elopement risk and indicated R1 was not at risk of elopement. The assessment lacked indication of R1 had a history of elopement from home, had a diagnosis of dementia with psychosis and depression and had learning barriers related to his cognitive status as indicated in the admission Nursing Assessment on 11/26/25. The assessment lacked indication R1's care plan was reviewed at the time of the assessment. During an interview on 5/7/26 at 8:22 a.m., the licensed practical nurse (LPN)-A stated to accurately perform an elopement assessment staff observed behaviors, reviewed the resident's diagnoses, and reviewed the resident's medications for side effects that may affect behaviors. The LPN-A stated when residents are newly admitted , they may not want to be in the facility and may try to leave the facility to return home. During an interview on 5/7/26 at 12:12 p.m., the registered nurse (RN)-B stated to complete an Elopement Risk Assessment staff should ask family about elopement history, but didn't think that had been done for R1. If it had, then staff would have known R1 was at risk for elopement. The RN-B stated each prior Elopement Assessment for R1 should have indicated (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 had dementia but did not. R1 had anxiety, but was not indicated on the forms, and had dementia with psychosis, which was also not indicated. The RN-B stated she was aware of R1's history of wandering from asking R1's family. Further, the RN-B stated more than one check mark on an Elopement Assessment indicated a risk for elopement, and if the forms had been completed correctly, R1 would have always been a risk for elopement. Additionally, the RN-B stated when R1's Wander Guard was found in the garbage in November 2025, staff should have performed additional assessments prior to determining the Wander Guard was no longer needed. The RN-B stated the facility had a new elopement assessment form and had been trained in how to complete the form, but the assessment did not include mood, diagnoses, and medications that were assessed using the previous form. The RN-B stated if the resident had mood, diagnoses, or medications that were indicators a resident may elope, that data should be included in a progress note after completing the form, but could be missed if the form didn't prompt to review the medical record for the data. During an interview on 5/7/26 at 2:32 p.m., the LPN-B stated to complete an Elopement Risk Assessment, staff reviewed the resident's admission paperwork and read the resident's history to determine if the resident was at risk for elopement. Staff should ask the family if the resident was at risk for elopement, and review diagnoses, mood, and medications. The LPN-B stated the new form the facility used for elopement risk assessment did not include review of diagnoses, mood, and medications, and if not prompted for that data, the LPN-B stated she would not assess that data. During an interview on 5/7/26 at 12:35 p.m., RN-A acknowledged she completed R1's Elopement Risk Assessment on 11/28/25 and missed checking the boxes that indicated R1 had a history of wandering, fear of abandonment, sleep disturbance, and diagnoses of anxiety and depression based on R1's history. The RN-A stated each of R1's Elopement Risk Assessments should have indicated a risk for elopement and should have included care plan interventions on the forms. The RN-A acknowledged she also completed R1's Elopement Risk Assessment on 12/11/25, and missed data on that assessment as well. The RN-A stated after finding R1's Wander Guard in the garbage on 12/5/25, she should have completed a new Elopement Risk Assessment right away, but waited until 12/11/25, and then did not complete the assessment correctly to indicate R1 was at risk for elopement. Additionally, the RN-A stated R1's Elopement Risk Assessment completed 3/2/26, was completed incorrectly as well. The assessment lacked data for history of elopement, mood, and diagnoses, and should have indicated a risk for elopement. The RN-A stated R1 took only eight minutes to leave the facility on 5/1/26, and R1 was more mobile than staff thought, and R1 should have been wearing a Wander Guard throughout his stay at the facility. The RN-A stated the new assessment form used by the facility to assess for Elopement Risk did not include the same elements as the previous form, and did not consider diagnoses, medications, and mood, and stated the new assessment was not a comprehensive elopement assessment. During an interview on 5/7/26 at 1:55 p.m., the director of nursing (DON) stated R1's Elopement Risk Assessment on 11/28/25, was accurate in that it deemed R1 at risk for Elopement but lacked data including indicators for mood and diagnoses that indicate risk for elopement. The DON further acknowledged R1's Elopement Risk assessment dated [DATE], also lacked data that indicated R1 had a history of wandering, hallucinations, increased confusion, and data about mood and diagnoses, that would have indicated a risk for elopement. The DON stated when R1's Wander Guard was found in the garbage on 12/5/25, R1 should have been reassessed to determine if the Wander Guard was still needed but had not. Further, the DON stated the new form the facility used to assess elopement risk did not indicate to assess for medications, diagnoses, and mood, but should but had a box at the bottom of the form where nurses could enter that information. The DON stated he was concerned about the form, and had escalated his concern to the Regional Clinical Director, and Regional Operations Director, who were going to review the new form and escalate the concern to the management team, and had not yet made a determination about the use of the new form. The Elopement policy dated 4/7/25, indicated all Skilled Nurse Facility residents would be assessed for risk of elopement through the pre-admission and/or admission process and as (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Waconia and Westview Acre	333 Fifth Street West Waconia, MN 55387

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed. The Elopement Risk assessment will be completed for all residents with the quarterly, annual, and significant change MDS assessments and triggered as needed when elopement risk is identified like in change of condition, exhibiting a new mood or behavior, or attempt to elope.