Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 7, 2026

Administrator
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE
333 FIFTH STREET WEST
WACONIA, MN 55387

RE: CCN: 245234
Cycle Start Date: March 26, 2026

Dear Administrator:

On May 5, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

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Administrator
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Re: Reinspection Results
Event ID: 1E3F6B-H1

Dear Administrator:

On May 5, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 26, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING B. WING	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST , WACONIA, Minnesota, 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 3/23/26 to 3/26/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		04/24/2026
F0000	INITIAL COMMENTS On 3/23/26 to 3/26/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: NO deficiencies were cited. H#: H52347888C (iQIES #2794438) H#: H52343600C (iQIES # 2715409) H#: H52349022C (iQIES # 2792433) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		04/24/2026

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 reverse for further 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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F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by:	F0656	Resident R10 and R25 discharged. Resident R72's and R88's care plan was reviewed and updated to ensure that all identified needs and appropriate interventions were in place. All Residents have the potential to be affected by this deficiency. All resident comprehensive care plans were reviewed and completed as needed. To ensure systemic changes are sustained education will be provided by DON or designee to nurse leadership and nurses regarding the Care Plan Policy in regards to Comprehensive Care Plans. To ensure compliance is sustained DON/designee will complete audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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F0656 SS = E	Continued from page 2 Based on record review and interview, the facility failed to develop and implement comprehensive, person-centered care plans that included all identified needs and appropriate interventions for 4 of 18 residents (R10, R25, R72, and R88) reviewed for care planning. Findings include: R10 R10's admission Minimum Data Set (MDS), dated 2/19/26, identified R10 had intact cognition and required assistance with all activities of daily living (ADLs). R10's diagnoses included anxiety disorder (excessive worry), depression (persistent sadness), PTSD (post-traumatic stress disorder; stress after trauma), and mild cognitive impairment of unknown etiology (early memory/thinking changes with unclear cause). Review of R10’s comprehensive care plan, print date of 3/26/26, failed to include person-centered interventions related to R10’s trauma history, including approaches to minimize triggers, promote emotional safety, or individualized care preferences. During interview on 3/26/26 at 9:55 a.m., the Director of Nursing (DON) and Social Services Designee (SSD) confirmed R10 had a known trauma history; however, this had not been incorporated into the care plan with personalized, resident-specific information. R25 R25’s admission MDS, dated 2/8/26, identified R25 had moderate cognitive impairment and required assistance with all ADLs. R25’s diagnoses included non-Alzheimer’s dementia (cognitive decline not caused by Alzheimer’s disease), muscle weakness (reduced strength), abnormalities of gait and mobility (difficulty walking), hypertension (high blood pressure), arthritis (joint inflammation causing pain), and insomnia (difficulty sleeping). Review of R25’s comprehensive care plan, print date of 3/26/26, revealed no interventions addressing edema management, including but not limited to monitoring, limb elevation or use of compression stockings	F0656		04/30/2026

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F0656 SS = E	Continued from page 3 During interview on 3/25/26 at 3:40 p.m., Registered Nurse (RN)-B reviewed the medical record and stated R25 had non-pitting edema in the right and left lower extremities. RN-B confirmed edema was not included on R25's care plan. During interview on 3/26/26 at 10:46 a.m., the DON stated edema should have been included on the care plan so it was clearly identified to staff and safe care could be provided. R72 R72's admission MDS, dated 2/25/26, identified R72 had intact cognition and required assistance with ADLs. R72's diagnoses included urinary tract infections (infection in the urinary system), viral hepatitis (inflammation of the liver caused by a virus), enterocolitis due to Clostridium difficile (inflammation of the intestines caused by a bacterial infection leading to diarrhea), Sjogren syndrome with vasculitis (an autoimmune disorder causing dry eyes/mouth and inflammation of blood vessels), vasculitis limited to the skin (inflammation of blood vessels affecting only the skin), and retention of urine (inability to fully empty the bladder). The MDS indicated the resident had a Stage 1 pressure ulcer (early skin injury with non-blanchable redness). Review of R72's comprehensive care plan, print date of 3/26/26, failed to include Enhanced Barrier Precautions (EBP) interventions, including use of gown and gloves for high-contact care activities, availability of personal protective equipment (PPE), or appropriate signage. During interview on 3/25/26 at 4:01 p.m., the DON confirmed R72 was on EBP; however, this had not been included in the care plan. R88 R88's admission MDS, dated 3/24/26, identified R88 had intact cognition and required assistance with ADLs. R88's diagnoses included dependence on renal dialysis (requires routine dialysis treatment to perform kidney function), chronic kidney disease stage 5 (severe kidney failure where the kidneys no longer function adequately), and presence of other	F0656		04/30/2026

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F0656 SS = E	Continued from page 4 vascular implants and grafts (surgically placed devices or vessels used to support blood flow, often for dialysis access). Review of R88's comprehensive care plan, print date of 3/26/26, failed to include EBP interventions, including use of gown and gloves for high-contact care activities, availability of PPE, or appropriate signage. During interview on 3/25/26 at 3:55 p.m., the Director of Nursing (DON) confirmed R88 was on EBP; however, this had not been included in the care plan. A facility care plan policy was requested but was not received.	F0656		04/30/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F0550	Resident R25 discharged from the facility. All residents with wanderguards have the potential to be affected by this deficiency. Residents with wanderguards were identified and reviewed to ensure that their wanderguard was not causing them distress. To ensure systemic changes are sustained education will be provided by DON or designee regarding dignity and wanderguards causing distress to nursing staff. To ensure compliance is sustained DON/designee will complete audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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F0550 SS = D	Continued from page 5 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was treated with dignity and respect by continuing use of a Wander Guard device in a manner that caused ongoing distress and failed to attempt alternative placement to reduce discomfort for 1 of 3 residents reviewed for dignity (R25). Findings include: R25's admission Minimum Data Set (MDS), dated 2/8/26, identified R25 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R25's diagnoses included non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), muscle weakness (reduced strength), abnormalities of gait and mobility (difficulty walking), hypertension (high blood pressure), arthritis (joint inflammation causing pain), and insomnia (difficulty sleeping). During observation on 03/23/2026 at 2:44 p.m., R25 was observed with a Wander Guard applied to the left wrist. R25 stated, "I have to have this on so I don't go anywhere. I have gone outside once before, but it's not like I can go anywhere." During observation on 03/24/2026 at 12:59 p.m., R25 was observed sitting in the dining room eating ice cream. R25 stated it was not going well because "they won't let me leave and I have this 'stupid thing on my wrist.'" The Wander Guard remained in place on the left wrist. During observation on 03/24/2026 at 3:26 p.m., R25 was observed waiting outside the elevator, then entered the elevator and traveled to the third floor.	F0550		04/30/2026

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F0550 SS = D	Continued from page 6 During observation on 03/24/2026 at 3:33 p.m., R25 returned to the second floor and self-propelled around the main living room area. R25 approached the surveyor, grabbed the Wander Guard, and stated, “I still have this thing on, they won’t let me leave.” During observation on 03/24/2026 at 6:48 p.m., R25 was observed in the living room area talking with two nursing assistants while self-propelling. The Wander Guard remained on the left wrist. During observation on 03/25/2026 at 8:33 a.m., R25 was observed sitting in the dining room reading a newspaper. R25 stated breakfast was good and warm. The Wander Guard remained in place on the left wrist. During observation on 03/25/2026 at 3:13 p.m., R25 was observed sitting outside the elevator waiting to go downstairs. The Wander Guard remained on the left wrist. R25 grabbed the device, shook it, and stated, “They won’t let me go home and I still have this stupid thing on.” Review of R25’s medical record and care plan lacked evidence the facility assessed or addressed the resident’s ongoing distress related to the Wander Guard. There was no documentation indicating alternative placement options or less intrusive interventions were considered or implemented. During an interview on 03/25/2026 at 3:18 p.m., Nursing Assistant (NA)-C stated R25 did not like the Wander Guard, frequently verbalized wanting it removed, and was constantly fidgeting with the device. During an interview on 03/25/2026 at 3:19 p.m., Registered Nurse (RN)-A stated the Wander Guard “really bugs him” and confirmed R25 frequently asked for it to be removed. During an interview on 03/25/2026 at 3:40 p.m., RN Case Manager (RN)-B stated Wander Guards could be placed on the wrist or ankle and should be monitored for proper placement and effectiveness.	F0550		04/30/2026

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F0550 SS = D	Continued from page 7 During an interview on 03/26/2026 at 10:46 a.m., the Director of Nursing (DON) stated Wander Guard placement should be individualized and should not cause distress to the resident. The DON acknowledged that if the device was causing distress, it could be a dignity concern and alternative placement, such as the ankle, should have been attempted. The facility's "Resident Dignity" policy, dated 12/18/25, indicated the facility would promote care for residents in a manner that maintained or enhanced each resident's dignity and respect.	F0550		04/30/2026
F0553 SS = D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative.	F0553	Resident R60 had his care conference on April 3rd, 2026. All residents have the ability to be affected by this deficiency. All residents were audited to review care conference compliance. To ensure systemic changes are sustained education will be provided to Social Workers and Nurse Leadership by DON or designee regarding the Comprehensive Care Plan and Care Conference Policy. To ensure compliance is sustained DON/designee will complete care conference audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end auAcdits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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F0553 SS = D	Continued from page 8 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to conduct the initial and quarterly care conferences for 1 of 18 residents (R60) reviewed for care conferences. Findings include: R60's annual Minimum Data Set (MDS) dated 3/6/26, indicated R60 was admitted on 2/13/25, cognitively intact, and had the following diagnoses: peripheral vascular disease (poor circulation in the limbs), benign prostatic hypertrophy (enlarged prostrate), renal insufficiency, hyperlipidemia (elevated level of fat in the blood stream), and depression. R60's medical record lacked evidence a care conference was offered or conducted since admission. On 3/25/26 at 8:03 a.m., the administrator confirmed the facility had no record of any care conferences being conducted for R60. On 3/26/26 at 9:55 a.m., the social work designee (SW)-A and the director of nursing (DON) stated care conferences were organized by the social worker in cooperation with the MDS coordinator and should have been conducted within 3 days of admission, quarterly, with a significant change, or at family request. SW-A and the DON confirmed R60 had not had any care conferences and stated they were missed during a staff change over. SW-A stated the importance of conducting care conferences were to ensure the residents received what they needed and their family members/representatives provided input into their care. The DON stated they expected the initial care conference to have been conducted within 3 days of admission and then quarterly, with a significant change or at family request. The DON stated the importance of completing care conferences was to have clear communication and collaboration with the families. The facility Comprehensive Care plan and Care Conferences Policy last reviewed 12/29/25, indicated the facility will establish a baseline care plan and provide the resident and/or representative with a written summary of the care plan, and document the	F0553		04/30/2026

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F0553 SS = D	Continued from page 9 meeting occurred with the resident and representative and any significant discussion that occurred.	F0553		04/30/2026
F0568 SS = D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to provide quarterly statements to 1 of 1 resident (R36) reviewed for personal funds. Findings include: R36's quarterly Minimum Data Set (MDS) dated 1/7/26, indicated R36 admitted 1/10/25, cognitively intact, and had the following diagnoses: heart failure, hypertension (high blood pressure), renal insufficiency, diabetes, and schizophrenia. On 3/23/26 at 1:20 p.m., R36 stated the facility was responsible for management of their money, but they had no idea what was going on with the account and the facility received their statements. On 3/26/26 at 12:12 p.m., the business office manager (BOM) stated they received monthly statements at R36's request and then met with the resident to explain and provide the documents to them. Additionally, the BOM confirmed they had no documentation to confirm conversations or explanations occurred. R36's medical record lacked evidence of agreement or statements were provided or explained to R36. On 3/26/26 at 12:50 p.m., administrator stated they	F0568	Resident R36 was provided her quarterly statement on April 2nd, 2026. All residents with Resident Trust Accounts have the ability to be affected by this deficiency. All Resident's with a Trust Account were reviewed to ensure they received their quarterly statement. To ensure systemic changes are sustained education will be provided to the Business Office Manager by Administrator or designee regarding the regulation. To ensure compliance is sustained Administrator/designee will complete audits regarding Resident Trust Statements two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. Admin or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245234	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST , WACONIA, Minnesota, 55387

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F0568 SS = D	Continued from page 10 expected personal fund account summaries were provided per regulations. It was important to provide documents to residents and document all conversations regarding accounts. Residents needed to be informed of account balances and facility needed documentation to refer back to. The facility Resident Trust Account Policy last revised 5/23/24, indicated as fiduciary of resident funds the location must hold, safeguard, manage, and account for the funds as well as ensure they are handled in accordance with state and federal regulation.	F0568		04/30/2026
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate.	F0627	Resident R82 discharged from the facility. Provider was updated on 3/26/2026 regarding resident discharging AMA. All Residents who express a plan to discharge against medical advice have the potential to be affected by this deficiency. All residents with current plans to discharge were reviewed. To ensure systemic changes are sustained education will be provided by DON or designee to nurses, nurse leadership and social workers regarding the Discharge Policy in regards to AMA discharges. To ensure compliance is sustained DON/designee will complete audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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F0627 SS = D	Continued from page 11 §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.	F0627		04/30/2026

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F0627 SS = D	Continued from page 12 §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the	F0627		04/30/2026

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F0627 SS = D	Continued from page 13 discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the	F0627		04/30/2026

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F0627 SS = D	Continued from page 14 evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, facility failed to contact provider for 1 of 2 residents (R82) who expressed a plan to discharge against medical advice (AMA). R82's care plan dated 1/9/26, indicated R82 wished to return home in community pending therapy outcomes. Interventions included facility to make arrangements with required community resources to support independence post-discharge for example home care, physical and/or occupational therapy. R82 required assistance with dressing, transfers, ambulation, bathing and toile use. R82's face sheet undated, indicated R82 had diagnoses which included diabetes, dizziness, anxiety, chronic pain, muscle weakness, falls, abnormal gait and mobility, need for assistance with personal care. Care conference progress note dated 1/26/26, at 11:35 indicated therapy planned to end 1/28/26, therapy recommended assisted living facility for medication management, eating and cognitive concerns on living at home. R82's friends expressed concerns regarding R82's living conditions. R82 expressed desire to return home with county services. Facility explained if R82 did not admit to	F0627		04/30/2026

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F0627 SS = D	Continued from page 15 assisted living facility (AL) or home with extra services R82 would be considered discharged AMA and facility would not assist with setting up home services. Facility expressed to R82 if stayed in facility while after therapy ended to arrange either an AL or home services R82 may need to privately pay for extra days to enable facility to plan. R82 had expressed continued desire to discharge home. R82 was given a Notice of Medicare Non-Coverage (NOMNC) 1/26/26, at the care conference. Progress note dated 1/21/26, at 2:45 p.m. indicated R82 informed facility staff there were people coming to take him home. Staff explained to R82 if he left AMA they would not be able to set up services or send prescriptions for medications, R82 stated understanding and agreed to stay until 1/28/26 then discharge. Progress note dated 1/28/26, at 12:10 p.m. indicated R82's daughter was notified of R82's decision, R82 discharged from the facility with all personal belongings. R82's electronic medical record (EMR) lacked documentation R82's provider was contacted regarding R82's plan to discharge, in addition R82's EMR lacked documentation facility attempted to facilitate a planned discharge. R82's EMR lacked documentation provider was notified R82 discharged AMA. During interview on 3/26/26, at 10:56 a.m. Social worker (SW)- A stated R82 was educated regarding the risks and benefits of discharge AMA versus discharge to AL or home with services. SW-A stated R82 was adamant was going to discharge to home. When interviewed on 3/26/26, at 11:09 a.m. director of nursing (DON) stated they attempted to convince R82 to remain in facility to allow them to contact the provider regarding desire to discharge to home. DON stated facility goal when a resident expressed they intended to discharge even if AMA was to contact the provider to attempt to facilitate a safe discharge for the resident rather than they discharge AMA with no assistance to obtain services or orders for medications. DON reviewed R82's EMR, DON noted facility was made aware on 1/26/26, R82 intended to	F0627		04/30/2026

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F0627 SS = D	Continued from page 16 discharge, however DON was unable to locate documentation provider had been informed, no attempt had been made to facilitate a safe planned discharge for R82. Facility Discharge and Transfer Rehab/Skilled, Therapy and Rehab policy dated 1/15/26, indicated discharge home facility would obtain an order from the physician for discharge to home with medications, arrange community resources and referrals, and coordinate a discharge plan with interdisciplinary team and resident. In addition, the policy indicated discharge AMA facility was to inform the physician of the situation.	F0627		04/30/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer.	F0628	Resident R80 and R82 discharged from the facility. Discharge Summaries were completed for R80 and R82. All Residents who discharge have the potential to be affected by this deficiency. Resident discharges were reviewed for completion of their discharge summaries. To ensure systemic changes are sustained education will be provided by DON or designee to nurse leadership regarding the Discharge and Transfer Policy regarding the Discharge Summary. To ensure compliance is sustained DON/designee will complete audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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F0628 SS = D	Continued from page 17 Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;	F0628		04/30/2026

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F0628 SS = D	Continued from page 18 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	F0628		04/30/2026

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F0628 SS = D	Continued from page 19 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by:	F0628		04/30/2026

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GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST , WACONIA, Minnesota, 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0628 SS = D	Continued from page 20 Based on record review and interview, the facility failed to ensure a discharge summary (recapitulation of stay) was completed for 1 of 1 resident (R80) reviewed for hospitalization who did not return to the facility and for 1 of 1 resident (R82) reviewed for transfer and discharge. Findings include: R80's admission Minimum Data Set (MDS), dated 1/28/26, identified R80 had intact cognition and required some assistance with activities of daily living (ADLs). R80's diagnoses included other gram-negative sepsis, hypertension, urinary tract infection, diabetes mellitus, non-Alzheimer's dementia, chronic obstructive pulmonary disease (COPD), gross hematuria, benign prostatic hyperplasia with lower urinary tract symptoms, urinary retention, unspecified hydronephrosis, hydrocele, right testicular pain, long-term use of insulin, and a personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits. Review of R80's progress notes indicated R80 was transferred from the facility to the hospital on 2/12/26, for fluid retention. Further review of the progress notes revealed R80 did not return to the facility following hospitalization and was considered discharged as of 2/13/26, when the family released the bed hold. Review of R80's electronic medical record (EMR) showed no evidence a discharge summary (recapitulation of stay) had been completed, including a summary of the resident's status at discharge or a post-discharge plan of care. During an interview on 3/25/26 at 10:18 a.m., the Director of Nursing (DON) stated the facility normally completed a discharge summary (recapitulation of stay) when a resident was discharged. The DON confirmed a discharge summary had not been completed for R80 and indicated it should have been, as the facility was expected to complete one for all residents upon discharge. The DON explained the discharge summary was important because it outlined the care provided during the resident's stay. She further stated the document was printed and sent to the physician for review and signature, at which time the physician could add additional comments.	F0628		04/30/2026

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F0628 SS = D	Continued from page 21 R82's care plan dated 1/9/26, indicated R82 wished to return home in community pending therapy outcomes. Interventions included facility to make arrangements with required community resources to support independence post-discharge for example home care, physical and/or occupational therapy. R82 required assistance with dressing, transfers, ambulation, bathing and toile use. R82's face sheet undated, indicated R82 had diagnoses which included diabetes, dizziness, anxiety, chronic pain, muscle weakness, falls, abnormal gait and mobility, need for assistance with personal care. Review of R82's progress notes from 1/6/26 to 1/28/26, identified the following: -1/21/26, at 2:45 p.m. indicated R82 informed facility staff there were people coming to take him home. Staff explained to R82 if he left AMA they would not be able to set up services or send prescriptions for medications, R82 stated understanding and agreed to stay until 1/28/26 then discharge -1/26/26, at 11:35 a.m. R82 informed facility during care conference he was going to discharge home on 1/28/26. - 1/28/26, at 12:10 p.m. R82 left the facility home by taxi with all belongings. R82's EMR lacked a discharge summary for R82's stay. During interview on 3/25/26, at 3:04 p.m. Director of nursing (DON) reviewed R82's EMR, indicated was unable to locate a discharge summary for R82. DON was unsure why there was discharge summary. Facility Discharge and Transfer – Rehab/Skilled, Therapy and Rehab policy dated 1/15/26, indicated when a resident discharge from the facility a discharge summary would be completed.	F0628		04/30/2026
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F0655	Resident R10 discharged. Resident R11's baseline care plan was opened and completed.	04/30/2026

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F0655 SS = D	Continued from page 22 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the	F0655	Continued from page 22 All Residents who admit have the potential to be affected by this deficiency. New admission care plans were reviewed and baseline care plans were completed. To ensure systemic changes are sustained education will be provided by DON or designee to nurse leadership and nurses regarding the Care Plan Policy in regards to baseline care plans. To ensure compliance is sustained DON/designee will complete audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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F0655 SS = D	Continued from page 23 facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to develop and implement a baseline care plan within 48 hours of admission for 2 of 18 residents (R10 and R11) reviewed for care planning. Findings include: R10 R10's admission Minimum Data Set (MDS) dated 2/19/26 identified R10 had intact cognition and required assistance with all activities of daily living (ADLs). R10's diagnoses included encounter for other orthopedic aftercare (follow-up care after bone/joint treatment), GERD (acid reflux), diabetes mellitus (high blood sugar), hyperlipidemia (high cholesterol), arthritis (joint inflammation), osteoporosis (weak/brittle bones), anxiety disorder (excessive worry), depression (persistent sadness), PTSD (post-traumatic stress disorder; stress after trauma), rotator cuff tear/rupture of the right shoulder (tear of shoulder tendons), hereditary ataxia (genetic condition causing poor coordination), demyelinating disease of the central nervous system (damage to nerve covering affecting signals), chondromalacia of the right shoulder (cartilage damage in the shoulder), bicipital tendinitis (inflammation of the biceps tendon), and mild cognitive impairment of unknown etiology (early memory/thinking changes with unclear cause). Review of R10’s electronic medical record (EMR) indicated R10 was admitted to the facility on 2/13/26. Further review of R10’s EMR revealed a baseline care plan had not been initiated or completed within 48 hours of admission. The ADL baseline care plan was first documented on 2/17/26, greater than 48 hours after admission. R11 R11's quarterly MDS dated 3/20/26 identified R11 had intact cognition and required assistance with ADLs. R11's diagnoses included neurocognitive disorder with Lewy bodies (a progressive brain disorder causing changes in thinking, movement,	F0655		04/30/2026

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F0655 SS = D	Continued from page 24 and behavior), non-Alzheimer's dementia (decline in memory and thinking not caused by Alzheimer's disease), and depression (persistent sadness or loss of interest). The MDS indicated R11 received antipsychotic medication. Review of R11's EMR indicated R11 was admitted to the facility on 11/26/25. Further review of R11's EMR revealed a baseline care plan had not been initiated or completed within 48 hours of admission. The ADL baseline care plan was first documented on 12/1/25, greater than 48 hours after admission. During interview on 3/25/26 at 3:25 p.m., registered nurse case manager (RN)-B indicated baseline care plans included areas such as transfer status, high-risk ("black box") medication warnings, medications, fall risk, behaviors, pain, risk for pressure ulcers, psychotropic medication use, and presence of a feeding tube. RN-B stated baseline care plans should be completed within 24–48 hours of admission. RN-B confirmed R11's ADL interventions were not initiated until 12/1/25. During interview on 3/25/26 at 4:07 p.m., the Director of Nursing (DON) indicated care plans were expected to be initiated upon admission, with assessments set up to automatically populate the care plan. The DON stated the RN manager or herself would follow up or complete the care plan, with an expectation for completion within 48 hours so staff were aware of how to provide care. The DON further stated, at a minimum, fall and ADL interventions should be in place within that timeframe. The DON confirmed R11's ADL interventions were initiated on 12/1/25, which was beyond the required 48-hour timeframe. During interview on 3/26/26 at 11:31 a.m., the DON provided consistent information regarding care plan initiation and expectations for completion within 48 hours of admission, including implementation of fall and ADL interventions. The DON confirmed R10's ADL interventions were initiated on 2/17/26, which was beyond the required 48-hour timeframe. The facility Care Plan policy was requested but was not received	F0655		04/30/2026

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F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to revise a comprehensive, person-centered care plan to reflect a change in mobility status for 1 of 1 resident (R25) reviewed for care planning related to wheelchair use. Findings include: R25's admission Minimum Data Set (MDS), dated 2/8/26, identified R25 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R25's diagnoses included non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), muscle weakness (reduced strength), abnormalities of gait and mobility (difficulty walking), hypertension (high blood pressure), arthritis (joint inflammation causing pain),	F0657	Resident R25 discharged. All Residents have the potential to be affected by this deficiency. All resident care plans were reviewed and updated with any changes in mobility status. To ensure systemic changes are sustained education will be provided by DON or designee to nurse leadership and nurses regarding the Care Plan Policy in regards to revisions that need to be made. To ensure compliance is sustained DON/designee will complete audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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F0657 SS = D	Continued from page 26 and insomnia (difficulty sleeping). Review of R25's comprehensive care plan, with a print date of 3/26/26, indicated R25 required assistance of one staff with a front wheeled walker for mobility. During the following observations, no use of a front wheeled walker was observed: 3/24/26 at 3:26 p.m., R25 was observed sitting outside the elevator in his wheelchair and was self-propelling via wheelchair to and from various locations within the facility. 3/24/26 at 6:48 p.m., R25 was observed self-propelling via wheelchair to and from various locations on the second-floor unit. 3/25/26 at 8:33 a.m., R25 was observed self-propelling via wheelchair to and from various locations on the second-floor unit. 3/25/26 at 3:13 p.m., R25 was observed sitting outside the elevator in his wheelchair and was self-propelling via wheelchair to and from various locations within the facility. Further review of R25's electronic medical record (EMR) lacked evidence the care plan had been revised to reflect R25's current use of a wheelchair for mobility assistance. During interview on 3/25/26 at 3:40 p.m., registered nurse care manager (RN)-B stated the wheelchair use had not been reflected in R25's care plan and should have been revised. During interview on 3/26/26 at 10:46 a.m., the director of nursing (DON) confirmed wheelchair use for R25's mobility had not been revised in the care plan and should have been, to ensure the care plan was clearly identified for staff to provide safe care. A facility care plan policy was requested but was not received.	F0657		04/30/2026

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F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure shaving was offered or provided for 1 of 1 residents (R15) reviewed for assistance with activities of daily living (ADLs). R15's quarterly Minimum Data Set (MDS) dated 3/4/26, indicated R15 had severe cognitive impairments and required staff assistance with ADLs. R15's diagnoses included diabetes, Parkinson's disease, dementia, anxiety and chronic pain. R15's care plan revised 3/7/26, indicated R15 had a self-care deficit related to Parkinson's disease with interventions that included resident required assistance from one staff for bathing, dressing and personal hygiene. On 3/23/26, at 11:25 a.m. observed R15 to have gray hairs on chin, above upper lip and below lower lip, about an inch in length. During follow-up observations on 3/24/26, at 12:37 p.m., 3/24/26, at 3:48 p.m., 3/24/26, at 6:55 p.m., 3/25/26, at 8:29 a.m., 3/25/26, at 4:15 p.m. and 3/26/26, at 7:16 a.m. R15 continued to have long gray hair on chin, above upper lip and below lower lip, about an inch in length. During interview on 3/26/26, at 10:18 a.m. family member (FM)-A stated they had asked the facility to shave R15, FM-A further stated R15 would be very bothered if she knew she had long hairs on her face. FM-A stated "I don't know why they don't remove the hairs for her, I would think they could easily do that for her, she has a electric razor in her drawer." When interviewed on 3/26/26, at 10:32 a.m. nursing assistant (NA)-A stated R15 did not refuse cares, if a resident was unable to request to be shaved the	F0677	Resident R15 offered assistance with shaving. All Residents who need assistance with shaving have the potential to be affected by this deficiency. All residents were reviewed and offered assistance with shaving if needed. To ensure systemic changes are sustained education will be provided by DON or designee to nursing staff regarding the Activities of Daily Living Policy and offering assistance with shaving to those who need help. To ensure compliance is sustained DON/designee will complete audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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F0677 SS = D	Continued from page 28 resident should then be shaved when they start to look “scruffy”. When interviewed on 3/26/26, at 10:36 a.m. trained medication aide (TMA)-A stated R15 was cooperative with cares, TMA-A stated she had noticed R15 had long hair on her chin but had not shaved her this morning. TMA-A observed R15 with surveyor and stated R15 did look like she should have been shaved before now for R15’s dignity When interviewed on 3/26/26, at 11:09 a.m. director of nursing (DON) stated the expectation was both men and women should be shaved when there was hair/whiskers that had grown for their comfort and dignity. Facility Activities of Daily Living – R/S, LTC policy dated 12/10/26, indicated ADLs are those necessary tasks conducted in the normal course of a resident’s daily life that included general personal, daily hygiene/grooming: care of hair, hands, face, shaving, applying makeup, skin, nail and oral care.	F0677		04/30/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure care and services were provided in accordance with professional standards of practice by not following provider-ordered edema management interventions, including assistance with application and removal of compression stockings, and by inaccurately documenting care on the Treatment Administration Record (TAR) for 1 of 3 residents (R25) reviewed for edema management. Findings include:	F0684	Resident R25 discharged. All Residents who have orders for compression stockings have the potential to be affected by this deficiency. Residents with orders for compression stockings were reviewed to ensure compliance with donning/doffing and accurate documentation. To ensure systemic changes are sustained education will be provided by DON or designee to nursing staff regarding the Activities of Daily Living Policy in regards to assisting with donning/doffing compression stockings and to nurses regarding the Medication: Documentation Policy regarding documentation. To ensure compliance is sustained DON/designee will complete audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party.	04/30/2026

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F0684 SS = D	Continued from page 29 R25's admission Minimum Data Set (MDS), dated 2/8/26, identified R25 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R25's diagnoses included non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), muscle weakness (reduced strength), abnormalities of gait and mobility (difficulty walking), hypertension (high blood pressure), arthritis (joint inflammation causing pain), and insomnia (difficulty sleeping). Review of R25's physician orders, dated 3/4/26, indicated an order for staff to apply compression (TEDS) stockings in the morning and remove them in the evening for edema management. Review of the Treatment Administration Record (TAR) from 3/1/26 through 3/26/26 indicated staff documented the application and removal of compression stockings as completed, as ordered. During observation and interview on 3/23/26 at 3:07 p.m., R25 was observed seated in his wheelchair without compression stockings in place. Observation of R25's lower extremities revealed he was wearing regular socks that were causing indentations around his lower extremities. R25 stated staff had not consistently assisted with applying the compression stockings, and he had been wearing regular socks for the past several weeks. During observation on 3/24/26 at 12:59 p.m., R25 was observed seated in his wheelchair in the dining room without compression stockings in place. Observation of his lower extremities revealed he was wearing regular socks that were causing indentations. During observation on 3/25/26 at 8:33 a.m., R25 was observed seated in his wheelchair in the living room area without compression stockings in place. Observation of his lower extremities revealed he was wearing regular socks that were causing indentations. During interview on 3/25/26 at 3:18 p.m., Nursing Assistant (NA)-C stated she was not aware R25 had compression stockings that he should have been wearing during the day.	F0684	Continued from page 29 Date of Compliance is: 4/30/2026	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245234	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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F0684 SS = D	Continued from page 30 During interview on 3/25/26 at 3:19 p.m., Registered Nurse (RN)-A stated R25 had an order for compression stockings to be applied in the morning and removed at bedtime. RN-A stated R25 did not refuse compression stockings. RN-A confirmed R25 did not have compression stockings on at that time and was wearing regular socks. RN-A confirmed the TAR indicated the compression stockings were applied and removed as ordered and acknowledged the documentation was not accurate when the stockings were not in place. During interview on 3/25/26 at 3:40 p.m., the Registered Nurse Care Manager (RN)-B stated she had not been aware of R25's edema. RN-B reviewed R25's electronic medical record (EMR) and stated R25 had non-pitting edema in the right and left lower extremities and should have been wearing compression stockings. RN-B indicated she would have expected R25 to wear them, as there was an order in place, and stated they were important to help manage his edema. RN-B confirmed staff had been documenting on the TAR that the compression stockings were applied and removed as ordered. During interview on 3/26/26 at 10:46 a.m., the Director of Nursing (DON) stated compression stockings should have had an order to be applied in the morning and removed at night and that this intervention should have been care planned. The DON stated staff were expected to assist R25 with application and removal. The DON further indicated compression stockings were important to help manage edema, promote circulation, and reduce the risk of blood clots. The DON also stated staff were expected not to document care that was not completed, as doing so would be false documentation. A facility policy regarding compression stocking application, documentation, and care planning was requested but was not received.	F0684		04/30/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F0686	Resident R2, R 15 and R72 are being monitored daily with weekly IDT review. All Residents who have active skin lesions have the potential to be affected by this deficiency. All residents who have current skin lesions were reviewed to ensure ongoing monitoring is in place.	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245234	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

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F0686 SS = D	Continued from page 31 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure ongoing monitoring of pressure ulcers for 2 of 4 residents (R2 and R15) reviewed for pressure ulcers. This had the potential to delay identification of changes in wound status and impact timely interventions to promote healing. F686 Based on observation, interview, and record review the facility failed to ensure ongoing monitoring of pressure ulcers for 3 of 4 residents (R2, R15 and R 72) reviewed for pressure ulcers. This had the potential to delay identification of changes in wound status and impact timely interventions to promote healing. Findings include: The National Pressure Ulcer Advisory Panel (NPUAP) guidelines dated 2016, identified a pressure ulcer as, " ... localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device." These are then staged according to the following criteria: - Stage I Pressure Injury: Non-blanchable erythema (redness) of intact skin. - Stage II Pressure Injury: Partial-thickness skin loss with exposed dermis. - Stage III Pressure Injury: Full-thickness skin loss, Adipose (fat) is visible, and rolled wound edges are	F0686	Continued from page 31 To ensure systemic changes are sustained, education will be provided by DON or designee to nursing staff regarding the Pressure Ulcers Policy in regards to requirements for ongoing monitoring of skin lesions. To ensure compliance is sustained DON/designee will complete audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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F0686 SS = D	Continued from page 32 often present - Stage IV Pressure Injury: Full-thickness skin and tissue loss, Exposed bone, tendon, ligament, cartilage, or muscle. - Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. The extent of damage cannot be confirmed because it is covered by slough (contains yellowish or white, soft, stringy dead tissue that acts as a barrier to healing) or eschar (thick, dry black or brown layer of dead tissue). -Deep Tissue Pressure Injury: Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration. R2 R2's quarterly Minimum Data Set (MDS) dated 1/28/26, indicated R2 was cognitively intact and was dependent on staff for activities of daily living (ADLs). R2's diagnoses included: hemiplegia (weakness, numbness or reduced muscle strength on one side of the body) and hemiparesis (inability to move muscles on one side of the body) following a stroke, pressure ulcers, anemia, muscle weakness and protein-calorie malnutrition. R2's pressure ulcer/injury care area assessment (CAA) dated 11/9/25, indicated R2 was admitted with a stage II pressure ulcer to the coccyx. R2's care plan revised 3/5/26, indicated R2 had actual impairment to skin related to immobility, R2 had an unstageable pressure ulcer to sacral/coccyx/ bilateral intergluteal cleft region with interventions that included: staff to monitor location, size and treatment of skin injury. Report abnormalities, failure to heal, s/s of infection, maceration, etc. to health care provider. Weekly skin observation by licensed nurse. Review of R2's EMR wound documentation identified: On 11/3/25, sacrum wound measured 6.5	F0686		04/30/2026

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F0686 SS = D	Continued from page 33 centimeters (cm) x 6.5cm x no depth Partial loss of skin, blanchable, 100% granulation tissue, tender to touch, scant bleeding. The next documented measurements was obtained a month later on 12/3/25, indicated sacrum/coccyx recently resolved stage 2 pressure ulcer sacral area is fragile resolved no open area all moisture-associated skin damage (MASD). On 12/13/25, right buttock wound measured 7.5cm x 3.5cm x no depth documented 10% eschar. On 12/18/25, Sacrum/coccyx/bilateral intragluteal cleft suspected deep tissue injury (SDIT) measured 9.0cm x 8.4cm x 0.2cm with 20%on granulation 80% slough worsening with unstageable condition at this time. On 12/23/25, Sacrum/coccyx/bilateral intragluteal cleft SDIT measured 8.4cm x 8.2cm x0.2cm with 20% granulation 80% slough. The next documented measurements were completed 36 days later on 1/28/26, coccyx wound measured 5.6cm x 3.0cm x 0.3cm with 40% granulation 60% slough. On 2/5/26, right intergluteal cleft 7.0cm x 2.2cm x 0.3cm with 80% granulation 20% slough. On 2/18/26, sacrum stage 3 measured 5.5cm x 1.7cm x 0.4cm with 80% granulation 20% slough. On 2/19/26, sacrum 5.0cmx2.5cmx0.3cm with Full thickness skin loss on the buttocks, no drainage, white fat tissue at the base, and non-blanchable. On 2/26/26, sacrum 5.0cm x 1.6cm x 0.4cm with 70% granulation 30% slough minimum serosanguineous On 3/5/26, unstageable wound pressure ulcer spanning coccyx and bilateral intragluteal cleft (vertical groove between buttocks) 2.7cm x 2.7cm x 0.4cm undermining (tissue under wound edges erode creating a shelf or pocket beneath skin) at 6:00 0.8cm length, 70% granulation 30% slough, surrounding skin macerated (wet, white, waterlogged tissue). On 3/12/26, unstageable wound pressure ulcer spanning coccyx and bilateral intragluteal cleft measured 3.2cmx0.8cmx1.2cm. On 3/20/26, unstageable wound pressure ulcer spanning coccyx and bilateral intragluteal cleft	F0686		04/30/2026

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F0686 SS = D	Continued from page 34 measured 2.5cm x 1.3cm x 0.7cm with 90% granulation 10% slough. Wound edges not attached appear as a cliff, surrounding skin macerated with induration (localized hardening/firming around wound typically caused by inflammation, infection, or chronic cellular immune response). During interview on 3/25/26, at 1:29 p.m. licensed practical nurse (LPN)-A stated R2's wound improved from what it had looked like, had been double the size it currently was and was no longer dark purple in color. When interviewed on 3/26/26, at 11:09 a.m. director of nursing (DON) stated the expectation was all wounds would be measured and documented on weekly. DON stated she expected the nurses/nurse managers to take ownership with their wounds. DON reviewed R2's EMR, stated unable pull data that is not in the chart. R15 R15's quarterly MDS dated 3/4/26, indicated R15 had severe cognitive impairment and required assistance with ADLSs. R15's diagnoses included: cellulits of right lower limb, pressure ulcer right heels stage 3, pressure ulcer left heel stage 3, diabetes, Parkinson's disease, dementia, hypertension, anxiety and chronic pain. R15's pressure ulcer/injury CAA dated 12/15/25, indicated R15 had pressure ulcers on her right and left heel that she was admitted with hospital documentation listing them as stage 2. Per hospital record Right heel is chronic with poor healing. right heel 1cm x 1.3cm x 0.2cm and Left heel 0.5 0cmx 0.3cm x 0.2cm. R15's care plan revised 3/8/26, indicated R15 had stage 3 pressure ulcer to right and left heels present on admission with interventions that included staff apply foam heel protectors when R15 in bed and assess/record/monitor wound healing. Report improvements and declines to the health care provider. Review of R15's EMR wound documentation identified:	F0686		04/30/2026

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F0686 SS = D	Continued from page 35 On 12/3/25, left heel stag 3 measured 1.5cmx0.4cmx0.2cm with100% slough, right heel stage 3 measured 1.3cmx1.1cmx0.2cm with 90%granulation and 10% slough. On 12/12/25, left heel stage 3, measured 0.9cmx0.4cmx0.2cm with 100% slough. right heel stage 3 measured 1.4cmx0.9cmx0.2cm with 90% granulation and 10% slough. The next documented measurements were completed 47 days later on 1/28/26, right heel stage 3 measured 0.5cmx0.3cmx0.2cm with 100% granulation, left heel stage 3 measured 0.2cmx0.2cmx0.2cm with 100% granulation. On 2/4/26, left heel stage 3 was documented as 0cmx0cmx0cm with100% epithelial. right heel stage 3 measured 0.8cmx0.5cmx0.1cm with 100% epithial wound bed. On 2/12/26, right heel 1cm x 1cm x 0cm scabbed. left heel scabbed 1.5cm x 1.5cm x 0cm. On 2/18/26, right heel 0.1cm x 0.2cm x 0.1cm 100% granulation. left heel 0.9cm x 0.4cm x 0cm 100% slough. The next documented measurements were completed 15 days later on 3/5/26, left heel stage 3 pressure ulcer scab covered measured as 0cmx0cmx0cm. Right heel stage 3 pressure ulcer 1cmx0.5cmx0cm scab covered. On 3/12/26, left heel stage 3 pressure ulcer measured 0.5cmx0.3cmx0.1cm, right heel stage 3 pressure ulcer measured 1cmx0.5cmx0.1cm. On 3/19/26, left heel stage 3 measured 0.5cmx0.3cmx0.1cm, right heel stage 3 measured 1cmx0.5cmx0.1cm. When interviewed on 3/26/26, at 11:09 a.m. director of nursing (DON) stated the expectation was all wounds would be measured and documented on weekly. DON stated she expected the nurses/nurse managers to take ownership with their wounds. DON reviewed R15's EMR, stated unable pull data that is not in the chart. Facility Pressure Ulcer/Wound Care Resource Packet-Rehab/Skilled policy stated 12/8/25, indicated wound RN assessment is required at least every seven days and as needed when skin integrity	F0686		04/30/2026

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F0686 SS = D	Continued from page 36 is impaired or open area is present.	F0686		04/30/2026
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure effective communication of necessary clinical information to the dialysis center for 1 of 1 resident (R88) reviewed for dialysis services. Findings include: R88's admission Minimum Data Set (MDS), dated 3/24/26, identified R88 had intact cognition and required assistance with activities of daily living (ADLs). R88's diagnoses included dependence on renal dialysis (requires routine dialysis treatment to perform kidney function), chronic kidney disease stage 5 (severe kidney failure where the kidneys no longer function adequately), and presence of other vascular implants and grafts (surgically placed devices or vessels used to support blood flow, often for dialysis access). Review of R88's electronic medical record (EMR) indicated R88 received routine dialysis treatments at an external dialysis center on a scheduled basis (Mondays, Wednesdays, and Fridays). Review of facility documentation, including dialysis communication forms and transfer records from 3/18/26 to 3/25/26, revealed the facility failed to send required clinical information with R88 to the dialysis center. Missing or incomplete information included, but was not limited to, vital signs, current medication list, recent changes in condition, weights, and/or physician orders. During interview on 3/24/26 at 12:13 p.m., R88 stated she went to an offsite dialysis center and reported the facility did not send any paperwork or	F0698	Resident R88 was provided with documents to bring to each of her dialysis appointments to ensure effective communication of necesary clinical information. All Residents who go to Dialysis have the potential to be affected by this deficiency. All residents who go to Dialysis were reviewed to ensure necessary clinical information is being shared with Dialysis Centers. To ensure systemic changes are sustained, education will be provided by DON or designee to nursing staff regarding the Dialysis Communication Form Process to ensure effective communication of necessary information with the Dialysis center. To ensure compliance is sustained DON/designee will complete audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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F0698 SS = D	Continued from page 37 communication form with her to her dialysis appointments. During interview on 3/25/26 at 3:55 p.m., the Director of Nursing (DON) confirmed the expectation that communication forms should accompany the resident to each dialysis appointment to ensure continuity of care. The DON acknowledged the facility did not consistently ensure this information was provided. A call to the Fresenius Dialysis Center was placed on 3/27/26 at 8:04 a.m.; a message was left, and no return call was received. The facility was requested to provide a policy regarding communication with outside providers, including dialysis centers; however, the facility did not provide the requested policy.	F0698		04/30/2026
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure a trauma-informed care approach was implemented by not completing a trauma assessment upon admission for 1 of 1 resident (R10) reviewed for trauma-informed care. Findings include: R10 R10's admission Minimum Data Set (MDS), dated 2/19/26, identified R10 had intact cognition and required assistance with activities of daily living (ADLs). R10's diagnoses included post-traumatic stress disorder (PTSD) (a mental health condition triggered by experiencing or witnessing a traumatic event), anxiety disorder (excessive worry), and	F0699	Resident R10 discharged from the facility. All Residents who admit to the facility have the potential to be affected by this deficiency. All residents were reviewed for completion of a trauma assessment. To ensure systemic changes are sustained, education will be provided by DON or designee to nursing staff and social workers regarding the Trauma Informed Care Policy in relation to the trauma assessment being completed. To ensure compliance is sustained DON/designee will complete audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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F0699 SS = D	Continued from page 38 depression (persistent feelings of sadness). Review of R10's electronic medical record (EMR) lacked evidence a trauma assessment was completed upon admission to identify past trauma, triggers, or individualized care needs related to trauma history. Review of R10's comprehensive care plan, print date 3/26/26, did not include trauma-informed interventions, approaches to minimize triggers, or strategies to promote emotional safety. During interview on 3/26/26 at 9:55 a.m., the Director of Nursing (DON) and Social Services Designee (SSD) confirmed R10 had a known history of PTSD; however, no trauma assessment had been completed at the time of admission. The DON and SSD further confirmed trauma-informed interventions had not been developed or implemented for R10. The facility's Trauma-Informed Care policy, dated 12/31/25, indicated the facility would provide trauma-informed care and avoid re-traumatizing residents. The policy further indicated staff would ensure residents who experienced trauma received culturally competent, trauma-informed care in accordance with professional standards of practice, accounting for residents' experiences and preferences to eliminate or mitigate triggers that could cause re-traumatization. The policy indicated a trauma assessment was required within five days of admission for all new residents and as needed. The trauma assessment was to be completed by Social Services while interviewing the resident and/or representative. During the interview, staff were to focus on understanding the resident's experience (what happened to the resident) rather than attempting to correct behaviors. The policy further indicated staff were to document how trauma was currently affecting the resident.	F0699		04/30/2026
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F0756	Resident R11's AIMS assessment was completed on 3/24/2026. All Residents have the potential to be affected by this deficiency. All residents were reviewed to ensure that consultant pharmacist recommendations were completed.	04/30/2026

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F0756 SS = D	Continued from page 39 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to act upon consultant pharmacist recommendations in a timely manner related to completion of an Abnormal Involuntary Movement Scale (AIMS) assessment for 1 of 3 residents (R11) reviewed for unnecessary medications. Findings include: R11's quarterly Minimum Data Set (MDS), dated 3/20/26, identified R11 had intact cognition and required assistance with activities of daily living (ADLs). R11's diagnoses included neurocognitive disorder with Lewy bodies (a progressive brain disorder causing changes in thinking, movement,	F0756	Continued from page 39 To ensure systemic changes are sustained, education will be provided by DON or designee to nurse leadership regarding the Drug Regimen Review Policy regarding completion of consultant pharmacist recommendations. To ensure compliance is sustained DON/designee will complete audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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F0756 SS = D	Continued from page 40 and behavior), non-Alzheimer's dementia (decline in memory and thinking not caused by Alzheimer's disease), and depression (persistent sadness or loss of interest). The MDS indicated R11 received antipsychotic medication. R11's physician order summary report, dated 3/4/26, included an order for Quetiapine (an antipsychotic medication used to treat mood and thought disorders) 25 milligrams (mg) to be administered at bedtime for repeated episodes of anxiety. Review of the consultant pharmacist's monthly medication regimen review (MMR), dated 12/18/25, identified a recommendation for completion of an AIMS assessment to monitor for potential side effects related to antipsychotic medication use. Subsequent MMRs, dated 1/14/26, 2/13/26, and 3/6/26, reiterated the same recommendation. Review of R11's electronic medical record (EMR) revealed no evidence that an AIMS assessment had been completed following the pharmacist's recommendation. Further review showed the recommendation remained unaddressed as of 3/20/26. During an interview on 3/20/26 at 10:15 a.m., the director of nursing (DON) confirmed the consultant pharmacist (CP) recommended completion of an AIMS assessment and acknowledged the facility had not completed the assessment or followed up on the recommendation in a timely manner. During an interview on 3/25/26 at 1:45 p.m., DON stated when MMRs were received, she divided the recommendations between two registered nurse case managers and forwarded provider-related recommendations to the providers. During an interview on 3/25/26 at 3:25 p.m., registered nurse case manager (RN-B) stated the DON printed the pharmacist recommendations and distributed them to the nurse managers, where they were placed in a drawer for follow-up. RN-B stated the nurse manager was responsible for completing the AIMS assessment and that recommendations should be followed up as soon as possible, including consideration of gradual dose reduction	F0756		04/30/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST , WACONIA, Minnesota, 55387

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F0756 SS = D	Continued from page 41 (GDR) and monitoring for adverse medication reactions. RN-B confirmed the AIMS assessment had not been completed. During an interview on 3/25/26 at 4:07 p.m., the DON stated MMR recommendations were expected to be completed prior to the next consultant pharmacist visit. The DON stated the recommendation had been assigned to the RN case manager; however, for unknown reasons, it was not completed. The DON further stated the recommendation was important as it related to monitoring the resident's medication and potential adverse effects. During an interview on 3/26/26 at 2:18 p.m., the Consultant Pharmacist (CP) stated the expectation was for facilities to respond to recommendations within the first month and no later than 60 days. The CP stated there had been no response to the recommendation in December, January, or February and reported the lack of follow-up may have been related to turnover in the DON position, resulting in the recommendation not being addressed. Review of the facility policy titled "Medication: Drug Regimen Review," dated 12/1/25, indicated drug regimen review included identifying and preventing clinically significant medication issues. The policy further indicated the consultant pharmacist would complete a written report noting any irregularities, which would be provided to the DON, and the facility must ensure recommendations were acted upon and documented within 30 calendar days.	F0756		04/30/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	Resident R46 discharged. Resident's R11 and R88 had enhanced barrier precautions initiated. All Residents who have the need for enhanced barrier precautions have the potential to be affected by this deficiency. All residents on enhanced barrier precautions were reviewed for compliance. To ensure systemic changes are sustained, education will be provided by DON or designee to all staff regarding the Standard, Enhanced Barrier, Transmission-Based Precautions Policy regarding enhanced barrier precautions. To ensure compliance is sustained DON/designee will complete audits two (2) times a week. Audit	04/30/2026

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F0880 SS = D	Continued from page 42 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880	Continued from page 42 results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. DON or designee is responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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F0880 SS = D	Continued from page 43 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to establish and implement an infection prevention and control program to prevent the spread of infection by not initiating Enhanced Barrier Precautions (EBP) per Centers for Disease Control (CDC) guidance. when indicated and failing to ensure staff followed EBP during resident care for 3 of 6 residents reviewed for infection control (R11, R46, and R88). Findings include: Review of CDC guidelines dated 8/12/22, identified EBP are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. CDC guidelines updated 6/28/24 identified examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally inserted central catheters (PICCs)), indwelling urinary catheters, feeding tubes, and tracheostomy tubes. R11 R11's quarterly Minimum Data Set (MDS), dated 3/20/26, identified R11 had intact cognition and required assistance with activities of daily living (ADLs). R11's diagnoses included neurocognitive disorder with Lewy bodies (a progressive brain disorder causing changes in thinking, movement, and behavior), non-Alzheimer’s dementia (decline in memory and thinking not caused by Alzheimer’s disease), and depression (persistent sadness or loss of interest). The MDS also identified R11 had a stage 2 pressure ulcer. Review of R11’s electronic medical record (EMR) identified the presence of a wound requiring ongoing	F0880		04/30/2026

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F0880 SS = D	Continued from page 44 care. Further review of the comprehensive care plan, with a print date of 3/26/26, and physician orders, dated 3/4/26, indicated an order for EBP precautions and wound orders to cleanse with wound cleanser and apply mepilex every other day to the pressure ulcer, and EBP interventions were included in the care plan. However, there was no evidence of implementation, including no documentation of staff use of gown and gloves for high-contact care and no placement of appropriate signage or personal protective equipment (PPE) outside of R11's room. During observations on 3/24/26 at 4:57 p.m. and 3/25/26 at 8:46 a.m., there was no appropriate signage or PPE placed outside R11's room to indicate the resident was on precautions. During interview on 3/25/26 at 3:07 p.m., Nursing Assistant (NA)-D stated she would know if a resident was on precautions based on signage posted outside the resident's room, stating, "I just look before I walk in the room." NA-D confirmed R11 was not on EBP precautions, as there was no signage posted outside the room. During interview on 3/25/26 at 3:25 p.m., the registered nurse case manager (RN-B) stated the facility maintained signage on resident doors and a printed list identifying residents on precautions. RN-B indicated the care plan included an EBP section and confirmed R11 was being followed by the wound nurse practitioner (NP) and that the wound was healing; however, R11 should have been on EBP precautions and was included on the facility's EBP list. RN-B accompanied the surveyor to R11's room and confirmed EBP precautions were not in place. RN-B further stated EBP was important to protect staff and residents from infection. R46 R46's admission MDS, dated 3/3/26, identified R46 had intact cognition and required assistance with all ADLs. R46's diagnoses included sepsis due to E. coli (a serious bloodstream infection caused by bacteria), renal failure (impaired kidney function), obstructive uropathy (blockage of urine flow), urinary tract infections (infection in the urinary system), and presence of urogenital implants (devices placed in the urinary or reproductive system). The MDS also indicated R46 had an indwelling catheter (a tube	F0880		04/30/2026

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F0880 SS = D	Continued from page 45 inserted into the bladder to drain urine). Review of R46's care plan, with a print date of 3/26/26, indicated the resident was on EBP precautions due to the presence of the indwelling catheter, including interventions for staff to use a gown and gloves during high-contact resident care. During observation on 3/23/26 at 3:20 p.m., NA-C and an orientee were observed providing direct care to R46, including assisting with toileting, peri-care, and transferring, without donning a gown and/or gloves in accordance with EBP requirements. No PPE was observed in use during the care interaction. During interview on 3/23/26 at 3:43 p.m., NA-C stated she was not sure if R46 was on precautions because she did not normally work on that floor. NA-C stated she believed the resident was on EBP precautions due to having a catheter and that staff were to wear gloves and a gown whenever assisting with care. NA-C confirmed she and the orientee did not wear a gown or gloves when assisting R46 and should have. During interview on 3/25/26 at 3:38 p.m., RN-B stated staff were expected to wear a gown and gloves whenever they anticipated coming into contact with the resident. During interview on 3/25/26 at 3:55 p.m., the DON confirmed staff were expected to follow EBP precautions, including use of gown and gloves for high-contact care, and acknowledged the observed care was not provided in accordance with facility policy. R88 R88's admission MDS, dated 3/24/26, identified R88 had intact cognition and required assistance with ADLs. R88's diagnoses included dependence on renal dialysis (requires routine dialysis treatment to perform kidney function), chronic kidney disease stage 5 (severe kidney failure where the kidneys no longer function adequately), and presence of other vascular implants and grafts (surgically placed devices or vessels used to support blood flow, often for dialysis access).	F0880		04/30/2026

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F0880 SS = D	Continued from page 46 Review of R88's EMR identified the presence of a dialysis shunt. Further review of the comprehensive care plan, with a print date of 3/26/26, and physician orders, dated 3/18/26, failed to include initiation of EBP precautions related to the presence of the dialysis shunt. There was no documentation indicating assessment for EBP implementation, use of gown and gloves for high-contact care, or placement of appropriate signage and PPE outside of R88's room. During observations on 3/23/26 at 11:12 a.m., 3/24/26 at 4:59 p.m., and 3/25/26 at 2:53 p.m., there was no appropriate signage or PPE placed outside R88's room to indicate the resident was on precautions. During interview on 3/25/26 at 3:55 p.m., the director of nursing (DON) stated R88 should have been on EBP precautions due to the presence of a tunneled catheter. She indicated there should have been signage outside the door and EBP supplies available in a cupboard outside the room. The DON stated it was important to prevent infection transmission to the resident and to staff and confirmed gloves and a gown should be worn during care. The facility Standard, Enhanced Barrier, and Transmission-Based Precautions policy, dated 7/7/25, indicated Enhanced Barrier Precautions (EBP) were implemented to reduce the transmission of multidrug-resistant organisms (MDROs) for residents who were infected or colonized with a CDC-targeted or epidemiologically significant MDRO, or when additional precautions were warranted. The policy indicated EBP were used for residents with chronic wounds (e.g., pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomies), regardless of known MDRO status. The policy indicated staff were to wear a gown and gloves during high-contact resident care activities, including transfers, dressing, bathing, hygiene care, toileting, linen changes, wound care, and care or use of indwelling medical devices. The policy indicated EBP were intended to remain in place for the duration of the resident's stay; however, for residents with a wound or indwelling medical device only, precautions could be discontinued if the wound resolved or the device	F0880		04/30/2026

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F0880 SS = D	Continued from page 47 was removed	F0880		04/30/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/23/26 to 3/26/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: NO deficiencies were cited.	20000		04/30/2026

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

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20000	Continued from page 1 H#: H52347888C (iQIES #2794438) H#: H52343600C (iQIES # 2715409) H#: H52349022C (iQIES # 2792433) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		04/30/2026
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each	20555	Corrected	04/30/2026

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20555	Continued from page 2 resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to conduct the initial and quarterly care conferences for 1 of 18 residents (R60) reviewed for care conferences. R60’s annual Minimum Data Set (MDS) dated 3/6/26, indicated R60 was admitted on 2/13/25, cognitively intact, and had the following diagnoses: peripheral vascular disease (poor circulation in the limbs), benign prostatic hypertrophy (enlarged prostrate), renal insufficiency, hyperlipidemia (elevated level of fat in the blood stream), and depression. R60’s medical record lacked evidence a care conference was offered or conducted since admission. On 3/25/26 at 8:03 a.m., the administrator confirmed the facility had no record of any care conferences being conducted for R60. On 3/26/26 at 9:55 a.m., the social work designee (SW)-A and the director of nursing (DON) stated care conferences were organized by the social worker in cooperation with the MDS coordinator and should have been conducted within 3 days of admission, quarterly, with a significant change, or at family request. SW-A and the DON confirmed R60 had not had any care conferences and stated they were missed during a staff change over. SW-A stated the importance of conducting care conferences were to ensure the residents received what they needed and their family members/representatives provided input into their care. The DON stated they expected the initial care conference to have been conducted within 3 days of admission and then quarterly, with a significant change or at family request. The DON stated the importance of completing care conferences was to have clear communication and collaboration with the families. The facility Comprehensive Care plan and Care	20555		04/30/2026

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20555	Continued from page 3 Conferences Policy last reviewed 12/29/25, indicated the facility will establish a baseline care plan and provide the resident and/or representative with a written summary of the care plan, and document the meeting occurred with the resident and representative and any significant discussion that occurred. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating a comprehensive care plan within 7 days after a comprehensive assessment to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system and perform measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure oversight occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		04/30/2026
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to revise a comprehensive, person-centered care plan to reflect a change in mobility status for 1 of 1 resident (R25) reviewed for care planning related to wheelchair use. Findings include:	20570	Corrected	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/26/2026**

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GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	**333 FIFTH STREET WEST , WACONIA, Minnesota, 55387**

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20570	Continued from page 4 R25's admission Minimum Data Set (MDS), dated 2/8/26, identified R25 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R25's diagnoses included non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), muscle weakness (reduced strength), abnormalities of gait and mobility (difficulty walking), hypertension (high blood pressure), arthritis (joint inflammation causing pain), and insomnia (difficulty sleeping). Review of R25's comprehensive care plan, with a print date of 3/26/26, indicated R25 required assistance of one staff with a front wheeled walker for mobility. During the following observations, no use of a front wheeled walker was observed: 3/24/26 at 3:26 p.m., R25 was observed sitting outside the elevator in his wheelchair and was self-propelling via wheelchair to and from various locations within the facility. 3/24/26 at 6:48 p.m., R25 was observed self-propelling via wheelchair to and from various locations on the second-floor unit. 3/25/26 at 8:33 a.m., R25 was observed self-propelling via wheelchair to and from various locations on the second-floor unit. 3/25/26 at 3:13 p.m., R25 was observed sitting outside the elevator in his wheelchair and was self-propelling via wheelchair to and from various locations within the facility. Further review of R25's electronic medical record (EMR) lacked evidence the care plan had been revised to reflect R25's current use of a wheelchair for mobility assistance. During interview on 3/25/26 at 3:40 p.m., registered nurse care manager (RN)-B stated the wheelchair use had not been reflected in R25's care plan and should have been revised. During interview on 3/26/26 at 10:46 a.m., the director of nursing (DON) confirmed wheelchair use for R25's mobility had not been revised in the care plan and should have been, to ensure the care plan	20570		04/30/2026

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20570	Continued from page 5 was clearly identified for staff to provide safe care. A facility care plan policy was requested but was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20570		04/30/2026
20850	Adequate and Proper Nursing Care; Shaving CFR(s): MN Rule 4658.0520 Subp. 2 D Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure shaving was offered or provided for 1 of 1 residents (R15) reviewed for assistance with activities of daily living (ADLs). R15's quarterly Minimum Data Set (MDS) dated 3/4/26, indicated R15 had severe cognitive impairments and required staff assistance with ADLs. R15's diagnoses included diabetes, Parkinson's disease, dementia, anxiety and chronic pain. R15's care plan revised 3/7/26, indicated R15 had a self-care deficit related to Parkinson's disease with interventions that included resident required assistance from one staff for bathing, dressing and personal hygiene.	20850	Corrected	04/30/2026

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20850	Continued from page 6 On 3/23/26, at 11:25 a.m. observed R15 to have gray hairs on chin, above upper lip and below lower lip, about an inch in length. During follow-up observations on 3/24/26, at 12:37 p.m., 3/24/26, at 3:48 p.m., 3/24/26, at 6:55 p.m., 3/25/26, at 8:29 a.m., 3/25/26, at 4:15 p.m. and 3/26/26, at 7:16 a.m. R15 continued to have long gray hair on chin, above upper lip and below lower lip, about an inch in length. During interview on 3/26/26, at 10:18 a.m. family member (FM)-A stated they had asked the facility to shave R15, FM-A further stated R15 would be very bothered if she knew she had long hairs on her face. FM-A stated “I don’t know why they don’t remove the hairs for her, I would think they could easily do that for her, she has a electric razor in her drawer.” When interviewed on 3/26/26, at 10:32 a.m. nursing assistant (NA)-A stated R15 did not refuse cares, if a resident was unable to request to be shaved the resident should then be shaved when they start to look “scruffy”. When interviewed on 3/26/26, at 10:36 a.m. trained medication aide (TMA)-A stated R15 was cooperative with cares, TMA-A stated she had noticed R15 had long hair on her chin but had not shaved her this morning. TMA-A observed R15 with surveyor and stated R15 did look like she should have been shaved before now for R15’s dignity When interviewed on 3/26/26, at 11:09 a.m. director of nursing (DON) stated the expectation was both men and women should be shaved when there was hair/whiskers that had grown for their comfort and dignity. Facility Activities of Daily Living – R/S, LTC policy dated 12/10/26, indicated ADLs are those necessary tasks conducted in the normal course of a resident’s daily life that included general personal, daily hygiene/grooming: care of hair, hands, face, shaving, applying makeup, skin, nail and oral care. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could	20850		04/30/2026

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20850	Continued from page 7 review/revise policies and procedures related to ensuring staff provide the necessary grooming services for shaving residents and educate staff on these policies. A system to monitor for compliance could be developed. TIME PERIOD FOR CORRECTION: Twenty (21) days.	20850		04/30/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure ongoing monitoring of pressure ulcers for 3 of 4 residents (R2, R15 and R 72) reviewed for pressure ulcers. This had the potential to delay identification of changes in wound status and impact timely interventions to promote healing. Findings include: The National Pressure Ulcer Advisory Panel (NPUAP) guidelines dated 2016, identified a pressure ulcer as, " ... localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device." These are then staged according to the following criteria: - Stage I Pressure Injury: Non-blanchable erythema (redness) of intact skin.	20900	Corrected	04/30/2026

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20900	Continued from page 8 - Stage II Pressure Injury: Partial-thickness skin loss with exposed dermis. - Stage III Pressure Injury: Full-thickness skin loss, Adipose (fat) is visible, and rolled wound edges are often present - Stage IV Pressure Injury: Full-thickness skin and tissue loss, Exposed bone, tendon, ligament, cartilage, or muscle. - Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. The extent of damage cannot be confirmed because it is covered by slough (contains yellowish or white, soft, stringy dead tissue that acts as a barrier to healing) or eschar (thick, dry black or brown layer of dead tissue). -Deep Tissue Pressure Injury: Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration. R2 R2's quarterly Minimum Data Set (MDS) dated 1/28/26, indicated R2 was cognitively intact and was dependent on staff for activities of daily living (ADLs). R2's diagnoses included: hemiplegia (weakness, numbness or reduced muscle strength on one side of the body) and hemiparesis (inability to move muscles on one side of the body) following a stroke, pressure ulcers, anemia, muscle weakness and protein-calorie malnutrition. R2's pressure ulcer/injury care area assessment (CAA) dated 11/9/25, indicated R2 was admitted with a stage II pressure ulcer to the coccyx. R2's care plan revised 3/5/26, indicated R2 had actual impairment to skin related to immobility, R2 had an unstageable pressure ulcer to sacral/coccyx/ bilateral intergluteal cleft region with interventions that included: staff to monitor location, size and treatment of skin injury. Report abnormalities, failure to heal, s/s of infection, maceration, etc. to health care provider. Weekly skin observation by licensed	20900		04/30/2026

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20900	Continued from page 9 nurse. Review of R2's EMR wound documentation identified: On 11/3/25, sacrum wound measured 6.5 centimeters (cm) x 6.5cm x no depth Partial loss of skin, blanchable, 100% granulation tissue, tender to touch, scant bleeding. The next documented measurements was obtained a month later on 12/3/25, indicated sacrum/coccyx recently resolved stage 2 pressure ulcer sacral area is fragile resolved no open area all moisture-associated skin damage (MASD). On 12/13/25, right buttock wound measured 7.5cm x 3.5cm x no depth documented 10% eschar. On 12/18/25, Sacrum/coccyx/bilateral intragluteal cleft suspected deep tissue injury (SDIT) measured 9.0cm x 8.4cm x 0.2cm with 20%on granulation 80% slough worsening with unstageable condition at this time. On 12/23/25, Sacrum/coccyx/bilateral intragluteal cleft SDIT measured 8.4cm x 8.2cm x0.2cm with 20% granulation 80% slough. The next documented measurements were completed 36 days later on 1/28/26, coccyx wound measured 5.6cm x 3.0cm x 0.3cm with 40% granulation 60% slough. On 2/5/26, right intergluteal cleft 7.0cm x 2.2cm x 0.3cm with 80% granulation 20% slough. On 2/18/26, sacrum stage 3 measured 5.5cm x 1.7cm x 0.4cm with 80% granulation 20% slough. On 2/19/26, sacrum 5.0cmx2.5cmx0.3cm with Full thickness skin loss on the buttocks, no drainage, white fat tissue at the base, and non-blanchable. On 2/26/26, sacrum 5.0cm x 1.6cm x 0.4cm with 70% granulation 30% slough minimum serosanguineous On 3/5/26, unstageable wound pressure ulcer spanning coccyx and bilateral intragluteal cleft (vertical groove between buttocks) 2.7cm x 2.7cm x 0.4cm undermining (tissue under wound edges erode creating a shelf or pocket beneath skin) at 6:00 0.8cm length, 70% granulation 30% slough, surrounding skin macerated (wet, white, waterlogged tissue).	20900		04/30/2026

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20900	Continued from page 10 On 3/12/26, unstageable wound pressure ulcer spanning coccyx and bilateral intragluteal cleft measured 3.2cmx0.8cmx1.2cm. On 3/20/26, unstageable wound pressure ulcer spanning coccyx and bilateral intragluteal cleft measured 2.5cm x 1.3cm x 0.7cm with 90% granulation 10% slough. Wound edges not attached appear as a cliff, surrounding skin macerated with induration (localized hardening/firming around wound typically caused by inflammation, infection, or chronic cellular immune response). During interview on 3/25/26, at 1:29 p.m. licensed practical nurse (LPN)-A stated R2's wound improved from what it had looked like, had been double the size it currently was and was no longer dark purple in color. When interviewed on 3/26/26, at 11:09 a.m. director of nursing (DON) stated the expectation was all wounds would be measured and documented on weekly. DON stated she expected the nurses/nurse managers to take ownership with their wounds. DON reviewed R2's EMR, stated unable pull data that is not in the chart. R15 R15's quarterly MDS dated 3/4/26, indicated R15 had severe cognitive impairment and required assistance with ADLSs. R15's diagnoses included: cellulits of right lower limb, pressure ulcer right heels stage 3, pressure ulcer left heel stage 3, diabetes, Parkinson's disease, dementia, hypertension, anxiety and chronic pain. R15's pressure ulcer/injury CAA dated 12/15/25, indicated R15 had pressure ulcers on her right and left heel that she was admitted with hospital documentation listing them as stage 2. Per hospital record Right heel is chronic with poor healing. right heel 1cm x 1.3cm x 0.2cm and Left heel 0.5 0cmx 0.3cm x 0.2cm. R15's care plan revised 3/8/26, indicated R15 had stage 3 pressure ulcer to right and left heels present on admission with interventions that included staff apply foam heel protectors when R15 in bed and	20900		04/30/2026

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20900	Continued from page 11 assess/record/monitor wound healing. Report improvements and declines to the health care provider. Review of R15's EMR wound documentation identified: On 12/3/25, left heel stag 3 measured 1.5cmx0.4cmx0.2cm with100% slough, right heel stage 3 measured 1.3cmx1.1cmx0.2cm with 90%granulation and 10% slough. On 12/12/25, left heel stage 3, measured 0.9cmx0.4cmx0.2cm with 100% slough. right heel stage 3 measured 1.4cmx0.9cmx0.2cm with 90% granulation and 10% slough. The next documented measurements were completed 47 days later on 1/28/26, right heel stage 3 measured 0.5cmx0.3cmx0.2cm with 100% granulation, left heel stage 3 measured 0.2cmx0.2cmx0.2cm with 100% granulation. On 2/4/26, left heel stage 3 was documented as 0cmx0cmx0cm with100% epithelial. right heel stage 3 measured 0.8cmx0.5cmx0.1cm with 100% epithial wound bed. On 2/12/26, right heel 1cm x 1cm x 0cm scabbed. left heel scabbed 1.5cm x 1.5cm x 0cm. On 2/18/26, right heel 0.1cm x 0.2cm x 0.1cm 100% granulation. left heel 0.9cm x 0.4cm x 0cm 100% slough. The next documented measurements were completed 15 days later on 3/5/26, left heel stage 3 pressure ulcer scab covered measured as 0cmx0cmx0cm. Right heel stage 3 pressure ulcer 1cmx0.5cmx0cm scab covered. On 3/12/26, left heel stage 3 pressure ulcer measured 0.5cmx0.3cmx0.1cm, right heel stage 3 pressure ulcer measured 1cmx0.5cmx0.1cm. On 3/19/26, left heel stage 3 measured 0.5cmx0.3cmx0.1cm, right heel stage 3 measured 1cmx0.5cmx0.1cm. When interviewed on 3/26/26, at 11:09 a.m. director of nursing (DON) stated the expectation was all wounds would be measured and documented on weekly. DON stated she expected the nurses/nurse managers to take ownership with their wounds. DON	20900		04/30/2026

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20900	Continued from page 12 reviewed R15's EMR, stated unable pull data that is not in the chart. Facility Pressure Ulcer/Wound Care Resource Packet-Rehab/Skilled policy stated 12/8/25, indicated wound RN assessment is required at least every seven days and as needed when skin integrity is impaired or open area is present. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		04/30/2026
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to establish and implement an infection prevention and control program to prevent the spread of infection by not initiating Enhanced Barrier Precautions (EBP) per Centers for Disease Control (CDC) guidance. when indicated and failing to ensure staff followed EBP during resident care for 3 of 6 residents reviewed for infection control (R11, R46, and R88). Review of CDC guidelines dated 8/12/22, identified EBP are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. CDC guidelines updated 6/28/24 identified examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally inserted central catheters (PICCs)), indwelling urinary catheters,	21375	Corrected	04/30/2026

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21375	Continued from page 13 feeding tubes, and tracheostomy tubes. R11 R11's quarterly Minimum Data Set (MDS), dated 3/20/26, identified R11 had intact cognition and required assistance with activities of daily living (ADLs). R11's diagnoses included neurocognitive disorder with Lewy bodies (a progressive brain disorder causing changes in thinking, movement, and behavior), non-Alzheimer's dementia (decline in memory and thinking not caused by Alzheimer's disease), and depression (persistent sadness or loss of interest). The MDS also identified R11 had a stage 2 pressure ulcer. Review of R11's electronic medical record (EMR) identified the presence of a wound requiring ongoing care. Further review of the comprehensive care plan, with a print date of 3/26/26, and physician orders, dated 3/4/26, indicated an order for EBP precautions and wound orders to cleanse with wound cleanser and apply mepilex every other day to the pressure ulcer, and EBP interventions were included in the care plan. However, there was no evidence of implementation, including no documentation of staff use of gown and gloves for high-contact care and no placement of appropriate signage or personal protective equipment (PPE) outside of R11's room. During observations on 3/24/26 at 4:57 p.m. and 3/25/26 at 8:46 a.m., there was no appropriate signage or PPE placed outside R11's room to indicate the resident was on precautions. During interview on 3/25/26 at 3:07 p.m., Nursing Assistant (NA)-D stated she would know if a resident was on precautions based on signage posted outside the resident's room, stating, "I just look before I walk in the room." NA-D confirmed R11 was not on EBP precautions, as there was no signage posted outside the room. During interview on 3/25/26 at 3:25 p.m., the registered nurse case manager (RN-B) stated the facility maintained signage on resident doors and a printed list identifying residents on precautions. RN-B indicated the care plan included an EBP section and confirmed R11 was being followed by the wound nurse practitioner (NP) and that the	21375		04/30/2026

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21375	Continued from page 14 wound was healing; however, R11 should have been on EBP precautions and was included on the facility's EBP list. RN-B accompanied the surveyor to R11's room and confirmed EBP precautions were not in place. RN-B further stated EBP was important to protect staff and residents from infection. R46 R46's admission MDS, dated 3/3/26, identified R46 had intact cognition and required assistance with all ADLs. R46's diagnoses included sepsis due to E. coli (a serious bloodstream infection caused by bacteria), renal failure (impaired kidney function), obstructive uropathy (blockage of urine flow), urinary tract infections (infection in the urinary system), and presence of urogenital implants (devices placed in the urinary or reproductive system). The MDS also indicated R46 had an indwelling catheter (a tube inserted into the bladder to drain urine). Review of R46's care plan, with a print date of 3/26/26, indicated the resident was on EBP precautions due to the presence of the indwelling catheter, including interventions for staff to use a gown and gloves during high-contact resident care. During observation on 3/23/26 at 3:20 p.m., NA-C and an orientee were observed providing direct care to R46, including assisting with toileting, peri-care, and transferring, without donning a gown and/or gloves in accordance with EBP requirements. No PPE was observed in use during the care interaction. During interview on 3/23/26 at 3:43 p.m., NA-C stated she was not sure if R46 was on precautions because she did not normally work on that floor. NA-C stated she believed the resident was on EBP precautions due to having a catheter and that staff were to wear gloves and a gown whenever assisting with care. NA-C confirmed she and the orientee did not wear a gown or gloves when assisting R46 and should have. During interview on 3/25/26 at 3:38 p.m., RN-B stated staff were expected to wear a gown and gloves whenever they anticipated coming into contact with the resident. During interview on 3/25/26 at 3:55 p.m., the DON	21375		04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	**333 FIFTH STREET WEST , WACONIA, Minnesota, 55387**

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21375	Continued from page 15 confirmed staff were expected to follow EBP precautions, including use of gown and gloves for high-contact care, and acknowledged the observed care was not provided in accordance with facility policy. R88 R88's admission MDS, dated 3/24/26, identified R88 had intact cognition and required assistance with ADLs. R88's diagnoses included dependence on renal dialysis (requires routine dialysis treatment to perform kidney function), chronic kidney disease stage 5 (severe kidney failure where the kidneys no longer function adequately), and presence of other vascular implants and grafts (surgically placed devices or vessels used to support blood flow, often for dialysis access). Review of R88's EMR identified the presence of a dialysis shunt. Further review of the comprehensive care plan, with a print date of 3/26/26, and physician orders, dated 3/18/26, failed to include initiation of EBP precautions related to the presence of the dialysis shunt. There was no documentation indicating assessment for EBP implementation, use of gown and gloves for high-contact care, or placement of appropriate signage and PPE outside of R88's room. During observations on 3/23/26 at 11:12 a.m., 3/24/26 at 4:59 p.m., and 3/25/26 at 2:53 p.m., there was no appropriate signage or PPE placed outside R88's room to indicate the resident was on precautions. During interview on 3/25/26 at 3:55 p.m., the director of nursing (DON) stated R88 should have been on EBP precautions due to the presence of a tunneled catheter. She indicated there should have been signage outside the door and EBP supplies available in a cupboard outside the room. The DON stated it was important to prevent infection transmission to the resident and to staff and confirmed gloves and a gown should be worn during care. The facility Standard, Enhanced Barrier, and Transmission-Based Precautions policy, dated 7/7/25, indicated Enhanced Barrier Precautions (EBP) were implemented to reduce the transmission	21375		04/30/2026

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21375	Continued from page 16 of multidrug-resistant organisms (MDROs) for residents who were infected or colonized with a CDC-targeted or epidemiologically significant MDRO, or when additional precautions were warranted. The policy indicated EBP were used for residents with chronic wounds (e.g., pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomies), regardless of known MDRO status. The policy indicated staff were to wear a gown and gloves during high-contact resident care activities, including transfers, dressing, bathing, hygiene care, toileting, linen changes, wound care, and care or use of indwelling medical devices. The policy indicated EBP were intended to remain in place for the duration of the resident's stay; however, for residents with a wound or indwelling medical device only, precautions could be discontinued if the wound resolved or the device was removed SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should re-educate nursing staff to appropriately implement correct precautions when assisting residents on Enhanced Barrier Precautions (EBP). The DON or designee could review and revise policies to ensure appropriateness. The DON or designee should perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		04/30/2026
21530	Drug Regimen Review CFR(s): MN Rule 4658.1310 A.B.C A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.	21530	Corrected	04/30/2026

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21530	Continued from page 17 B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to act upon consultant pharmacist recommendations in a timely manner related to completion of an Abnormal Involuntary Movement Scale (AIMS) assessment for 1 of 3 residents (R11) reviewed for unnecessary medications. Findings include: R11's quarterly Minimum Data Set (MDS), dated 3/20/26, identified R11 had intact cognition and required assistance with activities of daily living (ADLs). R11's diagnoses included neurocognitive disorder with Lewy bodies (a progressive brain disorder causing changes in thinking, movement, and behavior), non-Alzheimer’s dementia (decline in memory and thinking not caused by Alzheimer’s disease), and depression (persistent sadness or loss of interest). The MDS indicated R11 received antipsychotic medication. R11’s physician order summary report, dated 3/4/26, included an order for Quetiapine (an antipsychotic medication used to treat mood and thought disorders) 25 milligrams (mg) to be	21530		04/30/2026

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21530	Continued from page 18 administered at bedtime for repeated episodes of anxiety. Review of the consultant pharmacist's monthly medication regimen review (MMR), dated 12/18/25, identified a recommendation for completion of an AIMS assessment to monitor for potential side effects related to antipsychotic medication use. Subsequent MMRs, dated 1/14/26, 2/13/26, and 3/6/26, reiterated the same recommendation. Review of R11's electronic medical record (EMR) revealed no evidence that an AIMS assessment had been completed following the pharmacist's recommendation. Further review showed the recommendation remained unaddressed as of 3/20/26. During an interview on 3/20/26 at 10:15 a.m., the director of nursing (DON) confirmed the consultant pharmacist (CP) recommended completion of an AIMS assessment and acknowledged the facility had not completed the assessment or followed up on the recommendation in a timely manner. During an interview on 3/25/26 at 1:45 p.m., DON stated when MMRs were received, she divided the recommendations between two registered nurse case managers and forwarded provider-related recommendations to the providers. During an interview on 3/25/26 at 3:25 p.m., registered nurse case manager (RN-B) stated the DON printed the pharmacist recommendations and distributed them to the nurse managers, where they were placed in a drawer for follow-up. RN-B stated the nurse manager was responsible for completing the AIMS assessment and that recommendations should be followed up as soon as possible, including consideration of gradual dose reduction (GDR) and monitoring for adverse medication reactions. RN-B confirmed the AIMS assessment had not been completed. During an interview on 3/25/26 at 4:07 p.m., the DON stated MMR recommendations were expected to be completed prior to the next consultant pharmacist visit. The DON stated the recommendation had been assigned to the RN case manager; however, for unknown reasons, it was not completed. The DON	21530		04/30/2026

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21530	Continued from page 19 further stated the recommendation was important as it related to monitoring the resident's medication and potential adverse effects. During an interview on 3/26/26 at 2:18 p.m., the Consultant Pharmacist (CP) stated the expectation was for facilities to respond to recommendations within the first month and no later than 60 days. The CP stated there had been no response to the recommendation in December, January, or February and reported the lack of follow-up may have been related to turnover in the DON position, resulting in the recommendation not being addressed. Review of the facility policy titled "Medication: Drug Regimen Review," dated 12/1/25, indicated drug regimen review included identifying and preventing clinically significant medication issues. The policy further indicated the consultant pharmacist would complete a written report noting any irregularities, which would be provided to the DON, and the facility must ensure recommendations were acted upon and documented within 30 calendar days. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		04/30/2026
21805	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 5 Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was treated with dignity and respect by continuing use of a	21805	Corrected	04/30/2026

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21805	Continued from page 20 Wander Guard device in a manner that caused ongoing distress and failed to attempt alternative placement to reduce discomfort for 1 of 3 residents reviewed for dignity (R25). Findings include: R25's admission Minimum Data Set (MDS), dated 2/8/26, identified R25 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R25's diagnoses included non-Alzheimer's dementia (cognitive decline not caused by Alzheimer's disease), muscle weakness (reduced strength), abnormalities of gait and mobility (difficulty walking), hypertension (high blood pressure), arthritis (joint inflammation causing pain), and insomnia (difficulty sleeping). During observation on 03/23/2026 at 2:44 p.m., R25 was observed with a Wander Guard applied to the left wrist. R25 stated, "I have to have this on so I don't go anywhere. I have gone outside once before, but it's not like I can go anywhere." During observation on 03/24/2026 at 12:59 p.m., R25 was observed sitting in the dining room eating ice cream. R25 stated it was not going well because "they won't let me leave and I have this 'stupid thing on my wrist.'" The Wander Guard remained in place on the left wrist. During observation on 03/24/2026 at 3:26 p.m., R25 was observed waiting outside the elevator, then entered the elevator and traveled to the third floor. During observation on 03/24/2026 at 3:33 p.m., R25 returned to the second floor and self-propelled around the main living room area. R25 approached the surveyor, grabbed the Wander Guard, and stated, "I still have this thing on, they won't let me leave." During observation on 03/24/2026 at 6:48 p.m., R25 was observed in the living room area talking with two nursing assistants while self-propelling. The Wander Guard remained on the left wrist. During observation on 03/25/2026 at 8:33 a.m., R25 was observed sitting in the dining room reading a newspaper. R25 stated breakfast was good and warm. The Wander Guard remained in place on the	21805		04/30/2026

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21805	Continued from page 21 left wrist. During observation on 03/25/2026 at 3:13 p.m., R25 was observed sitting outside the elevator waiting to go downstairs. The Wander Guard remained on the left wrist. R25 grabbed the device, shook it, and stated, “They won’t let me go home and I still have this stupid thing on.” Review of R25’s medical record and care plan lacked evidence the facility assessed or addressed the resident’s ongoing distress related to the Wander Guard. There was no documentation indicating alternative placement options or less intrusive interventions were considered or implemented. During an interview on 03/25/2026 at 3:18 p.m., Nursing Assistant (NA)-C stated R25 did not like the Wander Guard, frequently verbalized wanting it removed, and was constantly fidgeting with the device. During an interview on 03/25/2026 at 3:19 p.m., Registered Nurse (RN)-A stated the Wander Guard “really bugs him” and confirmed R25 frequently asked for it to be removed. During an interview on 03/25/2026 at 3:40 p.m., RN Case Manager (RN)-B stated Wander Guards could be placed on the wrist or ankle and should be monitored for proper placement and effectiveness. During an interview on 03/26/2026 at 10:46 a.m., the Director of Nursing (DON) stated Wander Guard placement should be individualized and should not cause distress to the resident. The DON acknowledged that if the device was causing distress, it could be a dignity concern and alternative placement, such as the ankle, should have been attempted. The facility’s “Resident Dignity” policy, dated 12/18/25, indicated the facility would promote care for residents in a manner that maintained or enhanced each resident’s dignity and respect. SUGGESTED METHOD OF CORRECTION: The	21805		04/30/2026

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21805	Continued from page 22 administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		04/30/2026

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 16, 2026

Administrator
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE
333 FIFTH STREET WEST
WACONIA, MN 55387

RE: CCN:245234
Cycle Start Date: March 26, 2026

Dear Administrator:

On March 26, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 26, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 26, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific

deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 16, 2026

Administrator
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE
333 FIFTH STREET WEST
WACONIA, MN 55387

Re: State Nursing Home Licensing Orders
Event ID: 1E3F6B-H1

Dear Administrator:

The above facility survey was completed on March 26, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245234	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST , WACONIA, Minnesota, 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/25/2026. At the time of this survey, Good Samaritan Society- Waconia And Westview Acre was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		04/26/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245234	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. The original building was constructed in 1979, is three-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2015 addition is three stories in height, has a partial basement and a tunnel leading to the medical facility, is fully fire sprinkler protected and was determined to be of Type II(111) construction. In April 2016, Floors 2 and 3 have been remodeled 14 beds on each floor, and the center core areas on these floors, including the nurse station and related service areas, commons/dining areas, an Oxygen Room, and a neighborhood kitchen with a Denlar hood on each floor. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. All building surveyed as one. The facility has a capacity of 75 beds and had a census of 70 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		
K0222 SS = E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use	K0222	Doors leading into the stairwells on second and third floor were equipped with the required signage for delayed egress doors. All SNF maintenance staff will be trained by 4/30/2026 on the NFPA requirements for egress doors. The administrator or designee will complete audits two	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245234	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026

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K0222 SS = E	Continued from page 2 of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance	K0222	Continued from page 2 (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. The Administrator or designee is the responsible party. Date of Compliance is: 4/30/2026	

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K0222 SS = E	Continued from page 3 with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install the delayed egress system per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1 and 7.2.1.6.1.1 (4). This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 03/25/2026 between 09:45 AM and 12:30 PM, it was revealed by observation that the doors leading into the stairwells on the second and third floors are equipped with delayed egress systems; however, the required signage was not posted on the doors. An interview with the Administrator and the Maintenance Mechanic verified this deficient finding at the time of discovery.	K0222		
K0353 SS = E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any	K0353	The sprinkler located in the laundry chute within the soiled utility room across from resident room 314 was replaced on 3/27/2026. All SNF maintenance staff will be trained by 4/30/2026 on the NFPA requirements for the Sprinkler System – Maintenance and Testing. The administrator or designee will complete sprinkler head audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. The Administrator or designee is the responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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K0353 SS = E	Continued from page 4 non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.1, 5.2.1.1.2, and 5.2.1.1.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 03/25/2026 at 11:36 AM, it was revealed by observation that the sprinkler located in the laundry chute within the soiled utility room across from resident room 314 appeared to be bent. It is a corrosion-resistant sprinkler with a protective wax coating; however, the coating was damaged and peeling off. An interview with the Administrator and the Maintenance Mechanic verified this deficient finding at the time of discovery.	K0353		
K0363 SS = D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device	K0363	The garbage can that was propping the door to resident room 326 open was removed. All SNF maintenance staff will be trained by 4/30/2026 on the NFPA requirements for the Corridor Doors, specifically related to items propping them open. The administrator or designee will complete corridor door audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. The Administrator or designee is the responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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K0363 SS = D	Continued from page 5 capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/25/2026 at 11:29 AM, it was revealed by observation that the door to resident room 326 was propped open with a trash can. An interview with the Administrator and the Maintenance Mechanic verified this deficient finding at the time of discovery.	K0363		
K0711 SS = F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2.	K0711	The fire safety plan was updated to include the transmission of alarms to the fire department. All SNF maintenance staff will be trained by 4/30/2026 on the NFPA requirements for the Evacuation and Relocation Plan, specific to the inclusion of transmission of alarms to the fire safety plan. The administrator or designee will complete fire safety plan audits one (1) time a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. The Administrator or designee is the responsible party.	04/30/2026

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K0711 SS = F	Continued from page 6 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/25/2026 between 09:45 AM and 12:30 PM, it was revealed by a review of the available documentation that the fire safety plan that was presented at the time of the survey did not include Transmission of alarms to fire department. An interview with the Administrator and the Maintenance Mechanic verified this deficient finding at the time of discovery.	K0711	Continued from page 6 Date of Compliance is: 4/30/2026	
K0914 SS = E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	K0914	Electrical receptacles located in resident rooms will be tested by 4/30/2026. All SNF maintenance staff will be trained by 4/30/2026 on the NFPA requirements regarding electrical receptacles located in resident rooms. The administrator or designee will complete electrical receptacle audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. The Administrator or designee is the responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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K0914 SS = E	Continued from page 7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/25/2026 between 09:45 AM and 12:30 PM, it was revealed by a review of the available documentation that at the time of the survey, the facility could not provide documentation showing that the electrical receptacles located in the resident room had been tested within the last year. An interview with the Administrator and the Maintenance Mechanic verified this deficient finding at the time of discovery.	K0914		
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances	K0921	A patient care-related electrical appliance and equipment (PCREE) inspection and testing log was developed and implemented at the facility. All SNF maintenance staff will be trained by 4/30/2026 on requirements for testing patient care-related electrical appliances and equipment (PCREE). The administrator or designee will complete PCREE audits two (2) times a week. Audit results will be reviewed monthly by the QAPI committee for the need to increase, decrease or end audits to ensure compliance is sustained. Any deficient practice will be identified and corrected at time of occurrence. The Administrator or designee is the responsible party. Date of Compliance is: 4/30/2026	04/30/2026

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K0921 SS = F Bldg. 01	Continued from page 8 receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect patient care related electrical appliances and equipment (PCREE) per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2, 10.3, and 10.5.2.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/25/2026 between 09:45 AM and 12:30 PM, it was revealed by a review of the available documentation that at the time of the survey, the facility could not provide documentation showing that the patient care-related electrical appliances and equipment (PCREE) in the facility had been inspected or tested. An interview with the Administrator and the Maintenance Mechanic verified this deficient finding at the time of discovery.	K0921		