



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 2, 2026

Administrator

Good Samaritan Society - Waconia and Westview Acre

333 Fifth Street West

Waconia, MN 55387

RE: CCN: 245234

Cycle Start Date: May 12, 2026

Dear Administrator:

On June 2, 2026, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted immediate jeopardy (Level J), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On May 2, 2026, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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)).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 12, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 12, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 12, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - Waconia and Westview Acre is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 12, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met.

Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon St.
Marshall, MN 56258
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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.

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 12, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter.

Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644

Washington, D.C. 20201

202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

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.

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.

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



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June 2, 2026

Administrator

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

Re: State Nursing Home Licensing Orders

Event ID: 231037-H1

Dear Administrator:

The above facility survey was completed on May 12, 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 Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon St.
Marshall, MN 56258
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 B. WING		(X3) DATE SURVEY COMPLETED 05/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE				STREET ADDRESS, CITY, STATE, ZIP CODE 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
F0000	INITIAL COMMENTS From 5/6/26 to 5/8/26 and 5/12/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52341781C (3002301) and H52341781C (302280) with deficiencies issued at F689 and F842. 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 that substantial compliance with the regulations has been attained.			F0000			06/02/2026
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review the facility failed to provide adequate			F0689	"Past Noncompliance - no plan of correction required"		06/02/2026

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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F0689 SS = SQC-J	Continued from page 1 supervision creating a likelihood for potential serious harm, injury, impairment, or death for 1 of 3 residents (R1) who was assessed to be at risk for elopement on 11/28/26 and wore a Wander Guard bracelet (security device that prevents alerts staff if a resident at risk of wandering attempts to leaving a designated area) and eloped from the facility on 5/2/25. The immediate jeopardy began on 5/2/26, when R1 exited the facility front door at 12:54 a.m., then was found by a community member lying in the parking lot of an apartment building. The facility identified R1 was missing when a county sheriff came to the facility at 2:56 a.m., showed R1's photo to staff, and staff discovered R1 was not in his bed. The facility administrator and director of nursing (DON) were notified of the immediate jeopardy on 5/7/26 at 5:38 p.m. The deficient practice corrected on 5/2/26, prior to the start of the survey and was therefore past non-compliance. Findings include: A Vulnerable Adult Maltreatment Report dated 5/2/26, reported by a community member, indicated emergency medical services (EMS) was called to an apartment complex located a block away from the facility by a resident of the apartment complex. The resident noticed a person [R1] lying on the ground outside the building, who had wandered unnoticed by the facility staff. "[R1] had a diagnosis of dementia and was supposed to be checked every two hours. Staff were unaware R1 was missing until notified by a Carver County deputy after R1 was taken to the emergency room." An Incident Report Summary dated 5/2/26 at 4:49 am., indicated on 5/2/26 staff was alerted by police [R1] was found on the ground in a parking lot, and was taken to a hospital to be examined, and police came to the facility to confirm it was [R1] who they found. [R1's] most recent Wander Guard assessment on 3/2/26, indicated [R1] was not an elopement risk. On 3/2/26, [R1] was deemed cognitively intact. [R1's] diagnoses included Lewy body dementia (a progressive neurodegenerative disease in the brain that causes decline in thinking, movement, memory, and mood) with psychotic disturbance and diabetes with neuropathy (nerve damage caused by long-term high blood glucose leading to pain, numbness, and tingling). R1's Nursing Admission Assessment dated			F0689			06/02/2026

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F0689 SS = SQC-J	Continued from page 2 11/26/25, indicated R1 was admitted with a history of falls, diabetes, weakness, and was alert and oriented to person, but not oriented to place, time, or situation. R1 was slow to respond to questions, had poor word recall and increased confusion and forgetfulness, but was not at risk for elopement. Learning barriers included cognitive status and cues were required. R1's orders dated 11/26/25, instructed staff to administer quetiapine fumarate (antipsychotic medication) 25 milligrams (mg), give 25 mg by mouth at bedtime for repeated episodes of anxiety. The order was discontinued 12/11/25. R1's care plan with initiation/edit dates indicated: 11/26/25- a self-care deficit with ambulation, required assistance of one staff, with a gait belt and walker for safe ambulation 11/26/25- high risk for falls 11/28/25- potential for elopement, Wander Guard used to alert staff to resident's movements 11/30/25- impaired cognitive function as evidenced by forgetfulness, poor recall, and impaired cognition 1/9/26- behavior problems related to Lewy Body dementia: psychosis (collection of symptoms which disrupt a person's thoughts and perceptions, making it difficult to distinguish what is real from what is not), anxiety, hallucinations, and delusions. R1's Elopement Risk Assessment dated 11/27/25, identified R1 had a caregiver or staff change, had a change in normal behavior, and had no learning barriers. R1 was deemed not at risk for elopement. The assessment lacked indication R1 was admitted within the last month, had a history of elopement from home, had increased confusion and forgetfulness, diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status as indicated in the Admission Nursing Assessment on 11/26/25. R1's Elopement Risk Assessment dated 11/28/25 identified R1 was admitted within the previous month, had a caregiver or staff change, had a			F0689			06/02/2026

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F0689 SS = SQC-J	Continued from page 3 diagnosis of dementia, R1 should not leave the facility unattended, and a Wander Guard was placed to alert staff of R1's movements. R1 was deemed an elopement risk and a care plan related to elopement was initiated. The assessment lacked indication R1 had a history of elopement from home, had a diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status as indicated in the Admission Nursing Assessment on 11/26/25. R1's provider orders dated 11/28/25 instructed staff to place a Wander Guard to R1's right wrist, check placement every shift, and check functionality daily. R1's nursing orders dated 11/28/25, instructed staff to place a Wander Guard to R1's right wrist, check placement every shift, and check functionality daily. The nursing order was discontinued 12/11/25. The provider order was not discontinued. R1's admission Minimum Data Set (MDS) dated 11/30/25, indicated R1 admitted to the facility on 11/26/25 with intact cognition, diagnoses that included dementia and diabetes, and had no wandering behavior in the 7-day look-back period. R1's progress notes dated 12/5/25 at 2:30 p.m., indicated R1's Wander Guard was found in the trash. The nurse manager was aware and indicated R1 no longer needed the Wander Guard. R1's medical record lacked indication an Elopement Risk Assessment was completed to make the determination the Wander Guard was no longer needed. R1's progress notes dated 12/10/25 at 5:23 p.m., indicated R1 returned from the hospital at 5:05 p.m., the Wander Guard was not re-implemented, and staff should perform more frequent checks overnight. R1's Elopement Risk Assessment dated 12/11/25, indicated R1 was admitted in the prior month, had no diagnoses related to elopement risk, had no learning barriers, and was not at risk for elopement. The assessment lacked indication R1 had a history of elopement from home, had a caregiver or staff change after he had returned from the hospital the day prior, had a diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status as indicated in the Admission Nursing Assessment on 11/26/25. The assessment lacked indication R1's care plan was reviewed at the time of the assessment.			F0689			06/02/2026

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 05/12/2026	
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F0689 SS = SQC-J	Continued from page 4 R1's progress note dated 1/7/26 at 2:37 p.m., indicated during rounds the nurse practitioner added a diagnosis of Lewy Body dementia to R1's clinical record and diagnoses of major depression and psychosis. The medical record lacked indication R1 was reassessed for Elopement Risk after the addition of the diagnoses. R1's quarterly MDS dated 3/2/26, indicated intact cognition, diagnoses included dementia, diabetes, and depression, and had no wandering behavior during the 7-day look-back period. R1's Elopement Risk Assessment dated 3/2/26, indicated resident had no history of elopement attempts in the past, no diagnoses related to elopement risk, and indicated R1 was not at risk of elopement. The assessment lacked indication if R1 had a history of elopement from home, had a diagnosis of dementia with psychosis and depression and had learning barriers related to his cognitive status as indicated in the Admission Nursing Assessment on 11/26/25. The assessment lacked indication R1's care plan was reviewed at the time of the assessment. R1's progress notes indicated the following: 3/10/26 at 2:42 p.m., during a care conference R1 indicated he was having hallucinations of roaches and people. R1 had fallen that morning. 3/13/26 at 10:05 a.m., R1 was alert and oriented with forgetfulness. 3/14/26 at 3:41 p.m., R1's wife called the facility twice to ensure R1 was being checked on because R1 was really confused and didn't know he was in the facility, or what town he resided in. 3/24/26 at 5:53 p.m., R1 had frequent delusions, was suspicious of others, and had verbal disruptions. R1 had anxiety and nervousness that impaired his quality of life and was taking antipsychotic, antidepressant, and antianxiety medications. 5/2/26 at 5:50 a.m., the sheriff came to the facility and reported R1 was found in a parking lot nearby,			F0689			06/02/2026

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F0689 SS = SQC-J	Continued from page 5 appeared to have fallen but no injury was noted, and was transported to the emergency room. R1 was last checked and changed for incontinence on 5/1/26 at 11:30 p.m. Will place Wander Guard on resident when he returns from the emergency room. Review of the weather on 5/2/26 between 12:00 a.m. and 1:00 a.m. from the Weather Channel at https://weather.com, revealed the temperature in Waconia was approximately 43-45 degrees Fahrenheit. A photo of R1, provided by the administrator from camera footage, revealed R1 left the facility on 5/2/26 at 12:54 a.m. R1 left out the front door wearing a short-sleeved shirt, shorts, and tennis shoes, and was walking with a walker. R1's progress notes dated 5/2/26 at 5:50 a.m., indicated at 2:50 a.m., the sheriff came to the facility and reported the resident was found in a nearby parking lot and appeared to have fallen. The sheriff noted no injuries and R1 was transported by ambulance to an emergency room for evaluation. R1 was last checked and changed by staff on 5/1/26 at 11:30 p.m. R1's Elopement Evaluation dated 5/2/26 at 1:23 p.m., indicated R1 had a history of elopement or attempt while at home and while at the facility. R1 had an elopement score of 2 which indicated a risk for elopement. R1's orders dated 5/6/26, instructed staff to place a Wander Guard to R1's left ankle and to check placement every shift, and function daily. During an interview on 5/6/26 at 4:53 p.m., the nursing assistant (NA)-A stated he was not aware R1's Wander Guard was removed shortly after admission but acknowledged he knew R1 should have been checked every two hours but was not on the night of 5/1/26, into 5/2/26. NA-A stated he was working on the night of 5/1/26, and checked on R1 when R1 activated his call light on 5/1/26 at around 11:00 p.m. Then, NA-A returned to the desk to watch for call lights. Within a few minutes, R1's neighbor activated his call light. When NA-A walked past R1's room, on his way to answer call light, he could see R1's feet. NA-A thought R1 must have left the unit after that. NA-A stated there were a lot of call lights to answer that night and he didn't get back to R1. The sheriff came to alert staff R1 was gone, and NA-A acknowledged he did not see R1 leave the unit. NA-A stated he was supposed to check R1			F0689			06/02/2026

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F0689 SS = SQC-J	Continued from page 6 every two hours and had not. During an interview on 5/7/26 at 8:22 a.m., licensed practical nurse (LPN)-A stated around 11:00 p.m., on 5/1/26 NA-A checked on R1. R1 returned to his recliner after NA-A was finished assisting him. Staff were supposed to check on R1 every two hours to assist with repositioning but had not that night. LPN-A stated he was not aware R1 was missing until the sheriff came to the facility. During an interview on 5/7/26 at 11:03 a.m., family member (FM)-A stated she was made aware, after R1 left the facility, R1 fell and was on the ground for over an hour. R1 was found by a community member. FM-A stated before R1 admitted to the facility, he left their home during winter months, “It was just like [R1] to do it.” FM-A put an alarm on the door so she would be notified if R1 attempted to leave again. FM-A stated R1 walked with a walker and sometimes used a wheelchair. During an interview on 5/7/26 at 11:46 a.m., R1 stated he experienced hallucinations since he was fifteen years old and was sleepwalking since he was in the military. R1 thought he was sleepwalking in the facility, and this was the reason he left the facility, on the night of 5/2/26. R1 recalled, when he walked away from the facility, it was cold and he was wearing shorts and a short-sleeved shirt. He got far from the facility and was tired of walking so he laid on the pavement in a parking lot. R1 thought he laid in the parking lot for about an hour and half, someone saw him and asked him what he was doing, then called the police. R1 was taken to the hospital. R1 stated he could sign in and out of the facility and was allowed to be out until 10:00 p.m. Staff were supposed to check on him every two hours but didn’t that night. During an interview on 5/7/26 at 12:12 p.m., registered nurse (RN)-B stated, to determine if R1 had a history of elopement prior to admission, the facility staff should have asked R1’s family about any history or elopement. RN-B did not know if staff asked this question, but thought if they had, it would have been included on the assessment. The RN-B stated on each of R1’s Elopement Risk assessments dementia with psychosis and anxiety should have been acknowledged but were not. Further, RN-B stated she knew R1 had a history of wandering after asking R1’s wife. RN-B stated she knew R1 was at risk of elopement and had previously had a Wander Guard; R1 was at risk but the facility indicated he			F0689			06/02/2026

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F0689 SS = SQC-J	Continued from page 7 was not. If R1’s forms had been completely accurate, R1 would have been assessed to be at risk for elopement. The RN-B stated she does assess a resident's medications when completing the Elopement Risk Assessment and knew R1’s quetiapine was prescribed for anxiety but acknowledged when she completed some of R1’s Elopement Risk Assessments, she failed to indicate R1 had anxiety. During an interview on 5/7/26 at 12:35 p.m., RN-A stated upon admission, R1’s wife indicated R1 had a lot of trauma in his life and was having increased confusion. R1’s wife was worried about R1 when she was sleeping because he would get up and wander around the house. RN-A stated based on the information from R1’s wife, the elopement risk form should have indicated R1 had a fear of abandonment, sleep disturbance, and anxiety. Further, RN-A stated each of R1’s Elopement Risk Assessments should have indicated a risk for elopement with care planned interventions. RN-A acknowledged only the assessments on 11/28/25, and 5/2/26, indicated a risk for elopement. RN-A indicated R1 was deemed at risk on 11/28/25 when R1 returned from a visit at home and got lost going to his room on 2nd floor but instead went to 3rd floor. RN-A stated when R1’s Wander Guard was found in the garbage; the interdisciplinary team discussed the event but did not perform an assessment to determine if R1 had changes in his condition and no longer needed the Wander Guard. RN-A stated a new elopement risk assessment should have been completed before the decision was made to not replace the Wander Guard. Further, RN-A stated the team should have performed a new Elopement Risk Assessment after the nurse practitioner added diagnoses of depression, Lewy Body dementia, and psychosis to R1’s diagnoses list. RN-A stated she was informed by the administrator when R1 left the facility he was wearing shorts and a T-Shirt and left around midnight. R1 was supposed to be checked by staff every two hours but he was not. R1 could have died outside, it was cold, and he was not dressed appropriately for the weather. R1’s fall could have resulted broken a hip. “[R1] should have had a Wander Guard all along.” During an interview on 5/7/26 at 1:24 p.m., the administrator stated per video, on 5/2/26 at 12:47 a.m., R1 walked out of his room, at 12:48 a.m., R1 went down the elevator, and at 12:54 a.m., walked out the front door. The police reported to the administrator, a call was made to the police		F0689			06/02/2026	

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F0689 SS = SQC-J	Continued from page 8 department on 5/2/26 at 2:43 a.m. The officer pulled up to the facility at 2:56 a.m. Staff did not know R1 was gone. Staff indicated NA-A last assisted R1 on 5/1/26 at 10:58 p.m. R1's care plan indicated R1 was supposed to be checked every two hours. Administrator stated it was hard to say what could have happened to R1, but the mind goes to anything, but thankfully nothing bad happened. During an interview on 5/7/26 at 1:55 p.m., the director of nursing (DON) stated R1 had a care planned intervention to be turned and repositioned and toileted every two hours. That task was not completed during the night, and the staff had not checked on R1 until the sheriff came to the facility. The facility identified the elopement assessment completed after R1 removed his Wander Guard was not immediately completed, and R1 was having increased delusions and hallucinations. When staff found R1's Wander Guard in the garbage on 12/5/25, staff should have assessed how it was removed, had a conversation about putting it back on, and discussed it with his family. To know R1's history of wandering prior to admission, staff would have to interview the family. During an interview on 5/7/26 at 4:08 p.m., the nurse practitioner (NP)-A stated R1 had a history of Lewy Body dementia and did not have the physical or mental capacity to be outside on his own, which was why R1 required 24-hour care. The Elopement policy dated 4/7/25, indicated all Skilled Nurse Facility residents would be assessed for risk of elopement through the pre-admission and/or admission process and as needed. The Elopement Risk assessment will be completed for all resident with the quarterly, annual, and significant change MDS assessments and triggered as needed when elopement risk is identified like in change of condition, exhibiting a new mood or behavior, or attempt to elope. The past non-compliance immediate jeopardy began on 5/2/26. The immediate jeopardy was removed and the deficient practice corrected 5/2/26, after the facility implemented a systemic plan that included the following actions: Upon returning to the facility R1 was assessed for injuries, depression, supervision needs, cognitive			F0689			06/02/2026

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F0689 SS = SQC-J	Continued from page 9 status, and safety interventions. Staff requested an evaluation by the Associated Clinic of Psychology for R1. R1's Elopement Risk was reassessed, and a Wander Guard was placed on R1. Nursing assistant NA-A and LPN-A were suspended, given written warnings for corrective action, and prior to returning to the facility to work were retrained on rounding and supervision of residents. RN-A was suspended, given a written warning for not performing accurate and comprehensive assessments, and prior to returning to her role, was retrained on how to complete an accurate comprehensive Elopement Risk Assessment. A facility-wide reassessment of all residents' elopement risk was performed; care plans were adjusted accordingly. Staff education was initiated for all nursing staff on 5/2/26 for elopement risk identification, resident supervision and monitoring, timely implementation of care plan interventions, the Wander Guard process and monitoring, and the expectations of reporting and response of elopement. Ongoing audits and monitoring plans were developed 5/2/26 to ensure ongoing compliance.			F0689			06/02/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records.			F0842	An accurate elopement assessment was completed for R1. All residents have the potential to be affected by this deficiency. All Resident elopement assessment were reviewed to ensure accuracy. To ensure systemic changes are sustained all nursing staff were educated on the new PCC elopement comprehensive assessments to include the review of medications, diagnoses, and any recent significant changes to all new admissions, quarterly and with significant change in condition. The DNS will also review organization policy on		06/17/2026

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F0842 SS = D	Continued from page 10 §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.			F0842	Continued from page 10 elopement to ensure comprehensive assessment is completed to all residents. 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.		06/17/2026

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F0842 SS = D	Continued from page 11 §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to include complete and accurate information when assessing elopement risk for 1 of 3 residents (R1) reviewed for elopement. Findings include: R1's Elopement Risk Assessment dated 11/27/25 identified R1 had a caregiver or staff change, had a change in normal behavior, and had no learning barriers. R1 was deemed not at risk for elopement. The assessment lacked indication R1 was admitted within the last month, had a history of elopement from home, had increased confusion and forgetfulness, diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status as indicated in the Admission Nursing Assessment on 11/26/25. R1's Elopement Risk Assessment dated 11/28/25, identified R1 was admitted within the previous month, had a caregiver or staff change, had a diagnosis of dementia, R1 should not leave the facility unattended, and a Wander Guard was placed to alert staff of R1's movements. R1 was deemed an elopement risk and a care plan related to elopement was initiated. The assessment lacked indication R1 had a history of elopement from home, had a diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status as indicated in the Admission Nursing Assessment on 11/26/25. R1's provider orders dated 11/28/26, instructed staff to place a Wander Guard to R1's right wrist, check			F0842			06/17/2026

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F0842 SS = D	Continued from page 12 placement every shift, and check functionality daily. R1’s nursing orders dated 11/28/26, instructed staff to place a Wander Guard to R1's right wrist, check placement every shift, and check functionality daily. The nursing order was discontinued 12/11/25. The provider order was not discontinued. R1’s admission Minimum Data Set (MDS) dated 11/30/25 indicated R1 admitted to the facility on 11/26/25, with intact cognition, diagnoses that included dementia and diabetes, and had no wandering behavior in the 7-day look-back period. R1’s progress notes dated 12/5/25 at 2:30 p.m., indicated R1’s Wander Guard was found in the trash. The nurse manager was aware and indicated R1 no longer needed the Wander Guard. The medical record lacked indication a new Elopement Risk Assessment was completed to make the determination the Wander Guard was no longer needed. R1’s progress notes dated 12/10/25 at 5:23 p.m., indicated R1 returned from the hospital at 5:05 p.m., the Wander Guard was not re-implemented, and staff should perform more frequent checks overnight. R1’s Elopement Risk Assessment dated 12/11/25, indicated R1 was admitted in the prior month, had no diagnoses related to elopement risk, had no learning barriers, and was not at risk for elopement. The assessment lacked indication R1 had a history of elopement from home, had a caregiver or staff change after he had returned from the hospital the day prior, had a diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status as indicated in the Admission Nursing Assessment on 11/26/25. The assessment lacked indication R1’s care plan was reviewed at the time of the assessment. R1’s Elopement Risk Assessment dated 3/2/26 indicated resident had no history of elopement attempts in the past, no related diagnoses related to elopement risk and indicated R1 was not at risk of elopement. The assessment lacked indication of R1 had a history of elopement from home, had a diagnosis of dementia with psychosis and depression and had learning barriers related to his cognitive status as indicated in the Admission Nursing Assessment on 11/26/25. The assessment lacked indication R1’s care plan was reviewed at the time of the assessment. During an interview on 5/7/26 at 8:22 a.m., the			F0842			06/17/2026

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F0842 SS = D	Continued from page 13 licensed practical nurse (LPN)-A stated to accurately perform an elopement assessment staff observed behaviors, reviewed the resident's diagnoses, and reviewed the resident's medications for side effects that may affect behaviors. The LPN-A stated when residents are newly admitted, they may not want to be in the facility and may try to leave the facility to return home. During an interview on 5/7/26 at 12:12 p.m., the registered nurse (RN)-B stated to complete an Elopement Risk Assessment staff should ask family about elopement history, but didn't think that had been done for R1. If it had, then staff would have known R1 was at risk for elopement. The RN-B stated each prior Elopement Assessment for R1 should have indicated R1 had dementia but did not. R1 had anxiety, but was not indicated on the forms, and had dementia with psychosis, which was also not indicated. The RN-B stated she was aware of R1's history of wandering from asking R1's family. Further, the RN-B stated more than one check mark on an Elopement Assessment indicated a risk for elopement, and if the forms had been completed correctly, R1 would have always been a risk for elopement. Additionally, the RN-B stated when R1's Wander Guard was found in the garbage in November 2025, staff should have performed additional assessments prior to determining the Wander Guard was no longer needed. The RN-B stated the facility had a new elopement assessment form and had been trained in how to complete the form, but the assessment did not include mood, diagnoses, and medications that were assessed using the previous form. The RN-B stated if the resident had mood, diagnoses, or medications that were indicators a resident may elope, that data should be included in a progress note after completing the form, but could be missed if the form didn't prompt to review the medical record for the data. During an interview on 5/7/26 at 2:32 p.m., the LPN-B stated to complete an Elopement Risk Assessment, staff reviewed the resident's admission paperwork and read the resident's history to determine if the resident was at risk for elopement. Staff should ask the family if the resident was at risk for elopement, and review diagnoses, mood, and medications. The LPN-B stated the new form the facility used for elopement risk assessment did not include review of diagnoses, mood, and medications, and if not prompted for that data, the LPN-B stated she would not assess that data. During an interview on 5/7/26 at 12:35 p.m., RN-A			F0842			06/17/2026

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F0842 SS = D	Continued from page 14 acknowledged she completed R1’s Elopement Risk Assessment on 11/28/25 and missed checking the boxes that indicated R1 had a history of wandering, fear of abandonment, sleep disturbance, and diagnoses of anxiety and depression based on R1's history. The RN-A stated each of R1’s Elopement Risk Assessments should have indicated a risk for elopement and should have included care plan interventions on the forms. The RN-A acknowledged she also completed R1’s Elopement Risk Assessment on 12/11/25, and missed data on that assessment as well. The RN-A stated after finding R1’s Wander Guard in the garbage on 12/5/25, she should have completed a new Elopement Risk Assessment right away, but waited until 12/11/25, and then did not complete the assessment correctly to indicate R1 was at risk for elopement. Additionally, the RN-A stated R1’s Elopement Risk Assessment completed 3/2/26, was completed incorrectly as well. The assessment lacked data for history of elopement, mood, and diagnoses, and should have indicated a risk for elopement. The RN-A stated R1 took only eight minutes to leave the facility on 5/1/26, and R1 was more mobile than staff thought, and R1 should have been wearing a Wander Guard throughout his stay at the facility. The RN-A stated the new assessment form used by the facility to assess for Elopement Risk did not include the same elements as the previous form, and did not consider diagnoses, medications, and mood, and stated the new assessment was not a comprehensive elopement assessment. During an interview on 5/7/26 at 1:55 p.m., the director of nursing (DON) stated R1’s Elopement Risk Assessment on 11/28/25, was accurate in that it deemed R1 at risk for Elopement but lacked data including indicators for mood and diagnoses that indicate risk for elopement. The DON further acknowledged R1’s Elopement Risk Assessment dated 3/2/26, also lacked data that indicated R1 had a history of wandering, hallucinations, increased confusion, and data about mood and diagnoses, that would have indicated a risk for elopement. The DON stated when R1’s Wander Guard was found in the garbage on 12/5/25, R1 should have been reassessed to determine if the Wander Guard was still needed but had not. Further, the DON stated the new form the facility used to assess elopement risk did not indicate to assess for medications, diagnoses, and mood, but should but had a box at the bottom of the form where nurses could enter that information. The DON stated he was concerned about the form, and had escalated his concern to the Regional Clinical Director, and Regional Operations Director, who were going to review the			F0842			06/17/2026

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 05/12/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE				STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST , WACONIA, Minnesota, 55387			
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F0842 SS = D	Continued from page 15 new form and escalate the concern to the management team, and had not yet made a determination about the use of the new form. The Elopement policy dated 4/7/25, indicated all Skilled Nurse Facility residents would be assessed for risk of elopement through the pre-admission and/or admission process and as needed. The Elopement Risk assessment will be completed for all residents with the quarterly, annual, and significant change MDS assessments and triggered as needed when elopement risk is identified like in change of condition, exhibiting a new mood or behavior, or attempt to elope.			F0842			06/17/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/12/2026	
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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 5/6/26 through 5/8/26 and 5/12/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were 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: H52341781C (3002301 and 3002280) with no licensing		20000			06/02/2026	

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/12/2026	
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20000	Continued from page 1 order issued. As a result of the survey licensing order was issued at 0625. 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 14-01, available at 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.		20000			06/02/2026	
20625	Clinical Record Contents; In General CFR(s): MN Rule 4658.0450 Subp. 1 A-P Subpart 1. In general. Each resident's clinical record, including nursing notes, must include:		20625	Corrected		06/02/2026	

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20625	Continued from page 2 A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and			20625			06/02/2026

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20625	Continued from page 3 P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to include complete and accurate information when assessing elopement risk for 1 of 3 residents (R1) reviewed for elopement. Findings include: R1’s Elopement Risk Assessment dated 11/27/25 identified R1 had a caregiver or staff change, had a change in normal behavior, and had no learning barriers. R1 was deemed not at risk for elopement. The assessment lacked indication R1 was admitted within the last month, had a history of elopement from home, had increased confusion and forgetfulness, diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status as indicated in the Admission Nursing Assessment on 11/26/25. R1’s Elopement Risk Assessment dated 11/28/25, identified R1 was admitted within the previous month, had a caregiver or staff change, had a diagnosis of dementia, R1 should not leave the facility unattended, and a Wander Guard was placed to alert staff of R1’s movements. R1 was deemed an elopement risk and a care plan related to elopement was initiated. The assessment lacked indication R1 had a history of elopement from home, had a diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status as indicated in the Admission Nursing Assessment on 11/26/25. R1’s provider orders dated 11/28/26, instructed staff to place a Wander Guard to R1’s right wrist, check placement every shift, and check functionality daily. R1’s nursing orders dated 11/28/26, instructed staff to place a Wander Guard to R1’s right wrist, check placement every shift, and check functionality daily. The nursing order was discontinued 12/11/25. The provider order was not discontinued. R1’s admission Minimum Data Set (MDS) dated 11/30/25 indicated R1 admitted to the facility on 11/26/25, with intact cognition, diagnoses that included dementia and diabetes, and had no		20625			06/02/2026	

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20625	Continued from page 4 wandering behavior in the 7-day look-back period. R1’s progress notes dated 12/5/25 at 2:30 p.m., indicated R1’s Wander Guard was found in the trash. The nurse manager was aware and indicated R1 no longer needed the Wander Guard. The medical record lacked indication a new Elopement Risk Assessment was completed to make the determination the Wander Guard was no longer needed. R1’s progress notes dated 12/10/25 at 5:23 p.m., indicated R1 returned from the hospital at 5:05 p.m., the Wander Guard was not re-implemented, and staff should perform more frequent checks overnight. R1’s Elopement Risk Assessment dated 12/11/25, indicated R1 was admitted in the prior month, had no diagnoses related to elopement risk, had no learning barriers, and was not at risk for elopement. The assessment lacked indication R1 had a history of elopement from home, had a caregiver or staff change after he had returned from the hospital the day prior, had a diagnosis of dementia with psychosis, and had learning barriers related to his cognitive status as indicated in the Admission Nursing Assessment on 11/26/25. The assessment lacked indication R1’s care plan was reviewed at the time of the assessment. R1’s Elopement Risk Assessment dated 3/2/26 indicated resident had no history of elopement attempts in the past, no related diagnoses related to elopement risk and indicated R1 was not at risk of elopement. The assessment lacked indication of R1 had a history of elopement from home, had a diagnosis of dementia with psychosis and depression and had learning barriers related to his cognitive status as indicated in the Admission Nursing Assessment on 11/26/25. The assessment lacked indication R1’s care plan was reviewed at the time of the assessment. During an interview on 5/7/26 at 8:22 a.m., the licensed practical nurse (LPN)-A stated to accurately perform an elopement assessment staff observed behaviors, reviewed the resident’s diagnoses, and reviewed the resident’s medications for side effects that may affect behaviors. The LPN-A stated when residents are newly admitted, they may not want to be in the facility and may try to leave the facility to return home. During an interview on 5/7/26 at 12:12 p.m., the registered nurse (RN)-B stated to complete an Elopement Risk Assessment staff should ask family			20625			06/02/2026

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20625	Continued from page 5 about elopement history, but didn't think that had been done for R1. If it had, then staff would have known R1 was at risk for elopement. The RN-B stated each prior Elopement Assessment for R1 should have indicated R1 had dementia but did not. R1 had anxiety, but was not indicated on the forms, and had dementia with psychosis, which was also not indicated. The RN-B stated she was aware of R1's history of wandering from asking R1's family. Further, the RN-B stated more than one check mark on an Elopement Assessment indicated a risk for elopement, and if the forms had been completed correctly, R1 would have always been a risk for elopement. Additionally, the RN-B stated when R1's Wander Guard was found in the garbage in November 2025, staff should have performed additional assessments prior to determining the Wander Guard was no longer needed. The RN-B stated the facility had a new elopement assessment form and had been trained in how to complete the form, but the assessment did not include mood, diagnoses, and medications that were assessed using the previous form. The RN-B stated if the resident had mood, diagnoses, or medications that were indicators a resident may elope, that data should be included in a progress note after completing the form, but could be missed if the form didn't prompt to review the medical record for the data. During an interview on 5/7/26 at 2:32 p.m., the LPN-B stated to complete an Elopement Risk Assessment, staff reviewed the resident's admission paperwork and read the resident's history to determine if the resident was at risk for elopement. Staff should ask the family if the resident was at risk for elopement, and review diagnoses, mood, and medications. The LPN-B stated the new form the facility used for elopement risk assessment did not include review of diagnoses, mood, and medications, and if not prompted for that data, the LPN-B stated she would not assess that data. During an interview on 5/7/26 at 12:35 p.m., RN-A acknowledged she completed R1's Elopement Risk Assessment on 11/28/25 and missed checking the boxes that indicated R1 had a history of wandering, fear of abandonment, sleep disturbance, and diagnoses of anxiety and depression based on R1's history. The RN-A stated each of R1's Elopement Risk Assessments should have indicated a risk for elopement and should have included care plan interventions on the forms. The RN-A acknowledged she also completed R1's Elopement Risk Assessment on 12/11/25, and missed data on that assessment as well. The RN-A stated after finding			20625			06/02/2026

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20625	Continued from page 6 R1’s Wander Guard in the garbage on 12/5/25, she should have completed a new Elopement Risk Assessment right away, but waited until 12/11/25, and then did not complete the assessment correctly to indicate R1 was at risk for elopement. Additionally, the RN-A stated R1’s Elopement Risk Assessment completed 3/2/26, was completed incorrectly as well. The assessment lacked data for history of elopement, mood, and diagnoses, and should have indicated a risk for elopement. The RN-A stated R1 took only eight minutes to leave the facility on 5/1/26, and R1 was more mobile than staff thought, and R1 should have been wearing a Wander Guard throughout his stay at the facility. The RN-A stated the new assessment form used by the facility to assess for Elopement Risk did not include the same elements as the previous form, and did not consider diagnoses, medications, and mood, and stated the new assessment was not a comprehensive elopement assessment. During an interview on 5/7/26 at 1:55 p.m., the director of nursing (DON) stated R1’s Elopement Risk Assessment on 11/28/25, was accurate in that it deemed R1 at risk for Elopement but lacked data including indicators for mood and diagnoses that indicate risk for elopement. The DON further acknowledged R1’s Elopement Risk Assessment dated 3/2/26, also lacked data that indicated R1 had a history of wandering, hallucinations, increased confusion, and data about mood and diagnoses, that would have indicated a risk for elopement. The DON stated when R1’s Wander Guard was found in the garbage on 12/5/25, R1 should have been reassessed to determine if the Wander Guard was still needed but had not. Further, the DON stated the new form the facility used to assess elopement risk did not indicate to assess for medications, diagnoses, and mood, but should but had a box at the bottom of the form where nurses could enter that information. The DON stated he was concerned about the form, and had escalated his concern to the Regional Clinical Director, and Regional Operations Director, who were going to review the new form and escalate the concern to the management team, and had not yet made a determination about the use of the new form. The Elopement policy dated 4/7/25, indicated all Skilled Nurse Facility residents would be assessed for risk of elopement through the pre-admission and/or admission process and as needed. The Elopement Risk assessment will be completed for all residents with the quarterly, annual, and significant change MDS assessments and triggered		20625			06/02/2026	

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20625	Continued from page 7 as needed when elopement risk is identified like in change of condition, exhibiting a new mood or behavior, or attempt to elope. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee person could review policies and procedures and provide education for accurate and comprehensive elopement risk assessments, and about accuracy of documentation requirements. The DON or designee could revise as necessary, educate staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: twenty-one (21) days.			20625			06/02/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 1, 2026

Administrator

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

RE: CCN: 245234

Cycle Start Date: May 12, 2026

Dear Administrator:

On June 2, 2026, we notified you a remedy was imposed. On June 26, 2026 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 17, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 12, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 2, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 12, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 17, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 1, 2026

Administrator

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

Re: Reinspection Results
Event ID: 231037-H2

Dear Administrator:

On June 26, 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 May 12, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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

