Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2025

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

RE: CCN: 245234
Cycle Start Date: July 24, 2025

Dear Administrator:

On July 24, 2025, 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).

REMOVAL OF IMMEDIATE JEOPARDY

On July 19, 2025, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 listed below to the CMS location.

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

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money

penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 24, 2025. This prohibition is not subject to appeal. 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.

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

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, your facility is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 24, 2025. 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

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

Re: State Nursing Home Licensing Orders
Event ID: 1D1C2D-H1

Dear Administrator:

The above facility was surveyed on July 24, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 **07/24/2025**

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
F0000	INITIAL COMMENTS On 7/23/25 and 7/24/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaints were reviewed H52349388C (MN2560500) andH52349990C (MN2566880) and a deficiency was issued at F689 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F0000		
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 observation, interview, and document review, the facility failed to maintain resident supervision and safety to prevent accidents for 1 of 1 resident (R2) who was at a high risk for elopement, left the facility unsupervised, and was found across the street in another assisted living (AL) parking lot. This resulted in an immediate Jeopardy (IJ) situation for R2.	F0689	"Past Noncompliance - no plan of correction required"	

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	F0689		

The IJ began on 7/18/25, when R2 was admitted to the facility and was identified to be a high risk for falls and elopement but the facility failed to implement safety measures and increased supervision resulting in an elopement from the facility on 7/19/25, when R2 wandered onto the elevator; walked through the attached assisted living, crossed the parking lot, crossed a busy street, and was found by police in the parking lot across the street from the facility. The IJ was removed on 7/19/25, and the deficient practice corrected on 7/19/25, prior to the start of the survey and was therefore issued at Past Noncompliance.

Findings include:

R2's Admission Record identified R2 was admitted to the facility on 7/18/25 at 2:15 p.m. The Minimum Data Set (MDS) was not completed yet due to R2's recent admission date of 7/18/25.

R2’s Diagnoses List identified diagnoses of Alzheimer’s disease and dementia.

R2's Brief Interview for Mental Status dated 7/18/25, indicated R2 had severe cognitive impairment.

R2’s admission elopement assessment dated 7/18/25 at 8:00 p.m., identified R2 was at high risk for elopement related to R2’s recent admission, caregiver change, disorientation to place, increased confusion and forgetfulness, recent room change, not understanding what is being said, inability to communicate needs, advanced dementia, wandering, and loss of self-control. In addition, the assessment identified diagnoses of Alzheimer’s disease, dementia, and anxiety disorder and were risk factors for elopement. Interventions identified were to attempt non-pharmacological interventions and minimize potential of resident behavior problems by modifying environmental factors and daily routine.

R2's Fall Risk Assessment dated 7/18/25, indicated R2 was at a high risk for falls related to one or more falls in past three months, medications, severely impaired cognitive status, restlessness, delirium, confusion, poor memory, history of depression, disorientation, difficulty following instructions,

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F0689 SS = SQC-J	Continued from page 2 restlessness, and poor sleep pattern. R1's Care plan initiated 7/18/25, did not identify R2 as an elopement risk or identify safety interventions to prevent or mitigate the risk of elopement until after R2's elopement on 7/19/25. R2's care plan did not identify the risk for falls or fall interventions until 7/19/25. R2's Admission progress note on 7/18/25 at 2:15 p.m., identified R2 was admitted following hospitalization for mental status changes, left sided weakness, confusion, impaired speech, nasal fracture, periorbital (around the eyes) bruising due to a fall. R2's facility Progress Notes dated 7/18/25 at 11:17 p.m., identified R2 required assist of one staff with all cares and standby assist with a walker. The progress note indicated R2 was a high fall risk due to cognitive issues, a high risk of elopement, and needed to be monitored at all times. R2's Health Status progress note on 7/19/25 at 11:16 p.m., noted R2 eloped from the facility at 4:10-4:15 p.m. when staff noticed he was no longer in his room. Police officer found R2 wandering across the street at another AL facility. After the elopement, staff placed a wanderguard on R2 and implemented frequent checks. During observation on 7/23/25 at 12:20 p.m., R2 was seated at a table in the common area with his spouse. Wanderguard noted on his wrist. During an interview on 7/23/25 at 2:25 p.m., registered nurse (RN)-A identified she was the nurse that admitted R2 to the facility on a Friday afternoon (7/18/25). RN-A indicated on 7/18/25, R2 followed his wife down the facility elevators to the first floor exit doors. Staff responded and brought him back to the third floor and determined he was at high risk for elopement at that time. RN-A stated she did not apply a wanderguard because she did not know where the wanderguard bracelets were kept or how to activate them. RN-A further indicated the nurse managers usually applied them and stated she informed nurse manager (NM)-A that R2 was at risk for elopement and needed a wanderguard however, understood that NM-A had to leave and would apply one the next Monday (7/21/25), when she returned.	F0689		

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F0689 SS = SQC-J	Continued from page 3	F0689		

RN-A indicated she wrote a progress note and passed the information to the next shift. RN-A confirmed a waderguard had not been placed on R2 on 7/18/25.

During an interview on 7/23/25 at 2:50 p.m., RN-C indicated the nurse managers applied the wanderguard and he had not been trained on activating the wanderguard until after R2 eloped from the facility on 7/19/25.

During an interview on 7/23/25 at 4:00 p.m., the director of nursing (DON) stated she was notified by phone on 7/19/25, about R2's elopement when staff were unable to locate R2 in the facility. The police found him in the parking lot across the street from the facility at approximately 5:25 p.m. The DON stated a dietary aide saw R2 get on the elevator on 7/19/25, however, thought he was a visitor. R2 was identified as an elopement risk upon admission (7/18/25), however, RN-A misinterpreted what NM-A said and did not place a wanderguard on R2 or inform NM-A that she was not aware of the policy and procedure on wanderguard application and activation. In addition, 15-minute checks were not implemented.

During an observation of the route on 7/23/25 at 4:15 p.m., the DON stated the camera footage identified the route R2 had taken and the timeline of events on 7/19/25. R2 entered the third-floor elevators at approximated 4:10-4:15 p.m.; exited the elevators on first floor to the facility lobby, bypassed the main entrance and continued down the hallway to the attached assisted living (AL) hallway; exited the main entrance of the AL; entered the AL parking lot; crossed the approximate ¼ block long parking lot; crossed a busy street shared with a medical center and had a blind curve a short distance away. R2 was found by police in the parking lot of the AL across the street at approximately 5:20 – 5:25 p.m.

During an interview on 7/23/25 at 4:50 p.m., NM-A indicated RN-A notified her on 7/18/25, that R2 was actively exit seeking and needed a wanderguard. RN-A asked NM-A to apply one and NM-A stated she had to leave and offered to come back if needed. NM-A stated she was not aware RN-A did not know how to apply the wanderguard nor did RN-A ask NM-A to return and apply one. NM-A assumed RN-A had applied a wanderguard to R2 on 7/18/25, and was notified by the DON on 7/19/25, that R2 had eloped from the facility and did not have a

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F0689 SS = SQC-J	Continued from page 4 wanderguard on. NM-A indicated a wanderguard was immediately placed on R2 when he returned to the facility on 7/19/25. NM-A stated that wanderguard policies, procedures, and instructions were not part of the nurse's orientation however, it had been added after R2's elopement. During an interview on 7/24/25 at 9:47 a.m., dietary aide (DA)-A stated she was working the evening of 7/19/25, when she noticed a unknown man (later identified as R2) "waddling" down the hallway to the elevator without a walker or wheelchair. DA-A indicated she thought it was a visitor so did not think more about it until she overheard the nursing staff at approximately 4:20 p.m. saying that R2 was missing. DA-A stated she did not know that there was a new resident in the facility until that time. During an interview on 7/24/25 at 10:16 a.m., RN-B identified she was working on 7/19/25, when R2 eloped. RN-B indicated she was informed by RN-A that R2 had wandered off third floor for ½ hour the day prior (7/18/25), had not placed a wanderguard on R2 because NM-A would place the wanderguard on Monday (7/21/25). RN-B stated she may have seen R2 in the hallway however, was not sure because she did not know what he looked like. RN-B confirmed increased safety checks had not been implemented on R2 prio to his elopement. RN-B confirmed she had not placed a wanderguard on R2 because she did not know where they were kept and that placing a wanderguard on a resident was the nurse manager's responsibility. RN-B identified she was notified at approximately 4:15 p.m. on 7/19/25, that R2 was not in his room and searched the facility. When they were unable to find R2, she notified the DON, administrator, family, and police at approximately 5:00 p.m. R2 was located by the police across the street from the AL in the parking lot and returned to the facility at 5:30 p.m. During an interview on 7/24/25 at 11:10 a.m., nursing assistant (NA)-A indicated she worked the day of R2's admission and knew he was at risk for elopement because he went down the elevator in his wheelchair independently. NA-A confirmed a wanderguard had not been placed on R2 and that increased safety checks had not been implemented. NA-A stated NAs did not know how to apply wanderguards however, received education after R2's elopement.	F0689		

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F0689 SS = SQC-J	Continued from page 5 During an interview on 7/24/25 at 11:25 a.m., NA-B indicated she was working on 7/19/25, had not been informed R2 was an elopement risk when she received report. NA-B noted R2 had some of his personal items outside his room as if he were packing to leave and another resident told her that R2 was going to leave. NA-B checked on R2 at 4:15 p.m., and noted he was not in his room. NA-B notified the nurse, and they began to search for him and stated they did not know what he looked like at that time. Facility policy titled, Elopements dated 4/7/25, defined elopement as a resident who needed supervision left the premises or a safe area without authorization and/or any necessary supervision to do so. The policy indicated the skilled nursing facility (SNF) would be responsible for maintaining a system that clearly defined the mechanisms and procedures for monitoring residents at risk for elopement. These include identifying, evaluating, and analyzing environmental hazards and risks; and implementing, monitoring, and modifying interventions as needed. All SNF residents would be assessed for risk of elopement through pre-admission and/or admission process and as needed. Each SNF location would put measures in place to minimize the risk of elopement that are individualized to resident needs and identified on the care plan. The past-noncompliance immediate jeopardy began on 7/18/25, and was removed on 7/19/25, when the facility implemented a systemic plan to ensure all residents were safe. The following actions were implemented prior on 7/19/25; R2 had a wanderguard immediately placed on his wrist when he returned; all residents were re-assessed for elopement risk; all door access points and exit doors were checked for functionality; implemented 15-minute checks on all residents at risk for elopement until the door access points were fully functional on 7/21/25; re-education all nursing staff on wanderguard policies and procedures to include step-by-step instructions for placement and set-up; all elopement risks photos were update and distributed throughout the facility; and missing person drills were conducted.	F0689		

Minnesota State Department of Health

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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 7/23/25 to 7/24/25, a complaint 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 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.	20000		

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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
20000	Continued from page 1 The following complaints were reviewed: H52349388C (MN2560500) and H52349990C (MN2566880) with a licensing order issued at 0830. 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 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		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to	20830		

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remain in bed.

This LICENSURE REQUIREMENT is NOT MET as evidenced by:

Based on observation, interview, and document review, the facility failed to maintain resident supervision and safety to prevent accidents for 1 of 1 resident (R2) who was at a high risk for elopement, left the facility unsupervised, and was found across the street in another assisted living (AL) parking lot.

Findings include:

R2's Admission Record identified R2 was admitted to the facility on 7/18/25 at 2:15 p.m. The Minimum Data Set (MDS) was not completed yet due to R2's recent admission date of 7/18/25.

R2's Diagnoses List identified diagnoses of Alzheimer's disease and dementia.

R2's Brief Interview for Mental Status dated 7/18/25, indicated R2 had severe cognitive impairment.

R2's admission elopement assessment dated 7/18/25 at 8:00 p.m., identified R2 was at high risk for elopement related to R2's recent admission, caregiver change, disorientation to place, increased confusion and forgetfulness, recent room change, not understanding what is being said, inability to communicate needs, advanced dementia, wandering, and loss of self-control. In addition, the assessment identified diagnoses of Alzheimer's disease, dementia, and anxiety disorder and were risk factors for elopement. Interventions identified were to attempt non-pharmacological interventions and minimize potential of resident behavior problems by modifying environmental factors and daily routine.

R2's Fall Risk Assessment dated 7/18/25, indicated R2 was at a high risk for falls related to one or more falls in past three months, medications, severely impaired cognitive status, restlessness, delirium, confusion, poor memory, history of depression, disorientation, difficulty following instructions, restlessness, and poor sleep pattern.

R1's Care plan initiated 7/18/25, did not identify R2

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as an elopement risk or identify safety interventions to prevent or mitigate the risk of elopement until after R2's elopement on 7/19/25. R2's care plan did not identify the risk for falls or fall interventions until 7/19/25.

R2's Admission progress note on 7/18/25 at 2:15 p.m., identified R2 was admitted following hospitalization for mental status changes, left sided weakness, confusion, impaired speech, nasal fracture, periorbital (around the eyes) bruising due to a fall.

R2's facility Progress Notes dated 7/18/25 at 11:17 p.m., identified R2 required assist of one staff with all cares and standby assist with a walker. The progress note indicated R2 was a high fall risk due to cognitive issues, a high risk of elopement, and needed to be monitored at all times.

R2's Health Status progress note on 7/19/25 at 11:16 p.m., noted R2 eloped from the facility at 4:10-4:15 p.m. when staff noticed he was no longer in his room. Police officer found R2 wandering across the street at another AL facility. After the elopement, staff placed a wanderguard on R2 and implemented frequent checks.

During observation on 7/23/25 at 12:20 p.m., R2 was seated at a table in the common area with his spouse. Wanderguard noted on his wrist.

During an interview on 7/23/25 at 2:25 p.m., registered nurse (RN)-A identified she was the nurse that admitted R2 to the facility on a Friday afternoon (7/18/25). RN-A indicated on 7/18/25, R2 followed his wife down the facility elevators to the first floor exit doors. Staff responded and brought him back to the third floor and determined he was at high risk for elopement at that time. RN-A stated she did not apply a wanderguard because she did not know where the wanderguard bracelets were kept or how to activate them. RN-A further indicated the nurse managers usually applied them and stated she informed nurse manager (NM)-A that R2 was at risk for elopement and needed a wanderguard however, understood that NM-A had to leave and would apply one the next Monday (7/21/25), when she returned. RN-A indicated she wrote a progress note and passed the information to the next shift. RN-A confirmed a waderguard had not been placed on R2 on 7/18/25.

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During an interview on 7/23/25 at 2:50 p.m., RN-C indicated the nurse managers applied the wanderguard and he had not been trained on activating the wanderguard until after R2 eloped from the facility on 7/19/25.

During an interview on 7/23/25 at 4:00 p.m., the director of nursing (DON) stated she was notified by phone on 7/19/25, about R2's elopement when staff were unable to locate R2 in the facility. The police found him in the parking lot across the street from the facility at approximately 5:25 p.m. The DON stated a dietary aide saw R2 get on the elevator on 7/19/25, however, thought he was a visitor. R2 was identified as an elopement risk upon admission (7/18/25), however, RN-A misinterpreted what NM-A said and did not place a wanderguard on R2 or inform NM-A that she was not aware of the policy and procedure on wanderguard application and activation. In addition, 15-minute checks were not implemented.

During an observation of the route on 7/23/25 at 4:15 p.m., the DON stated the camera footage identified the route R2 had taken and the timeline of events on 7/19/25. R2 entered the third-floor elevators at approximated 4:10-4:15 p.m.; exited the elevators on first floor to the facility lobby, bypassed the main entrance and continued down the hallway to the attached assisted living (AL) hallway; exited the main entrance of the AL; entered the AL parking lot; crossed the approximate ¼ block long parking lot; crossed a busy street shared with a medical center and had a blind curve a short distance away. R2 was found by police in the parking lot of the AL across the street at approximately 5:20 – 5:25 p.m.

During an interview on 7/23/25 at 4:50 p.m., NM-A indicated RN-A notified her on 7/18/25, that R2 was actively exit seeking and needed a wanderguard. RN-A asked NM-A to apply one and NM-A stated she had to leave and offered to come back if needed. NM-A stated she was not aware RN-A did not know how to apply the wanderguard nor did RN-A ask NM-A to return and apply one. NM-A assumed RN-A had applied a wanderguard to R2 on 7/18/25, and was notified by the DON on 7/19/25, that R2 had eloped from the facility and did not have a wanderguard on. NM-A indicated a wanderguard was immediately placed on R2 when he returned to the facility on 7/19/25. NM-A stated that wanderguard policies, procedures, and instructions were not part of

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20830	Continued from page 5 the nurse's orientation however, it had been added after R2's elopement. During an interview on 7/24/25 at 9:47 a.m., dietary aide (DA)-A stated she was working the evening of 7/19/25, when she noticed a unknown man (later identified as R2) "waddling" down the hallway to the elevator without a walker or wheelchair. DA-A indicated she thought it was a visitor so did not think more about it until she overheard the nursing staff at approximately 4:20 p.m. saying that R2 was missing. DA-A stated she did not know that there was a new resident in the facility until that time. During an interview on 7/24/25 at 10:16 a.m., RN-B identified she was working on 7/19/25, when R2 eloped. RN-B indicated she was informed by RN-A that R2 had wandered off third floor for ½ hour the day prior (7/18/25), had not placed a wanderguard on R2 because NM-A would place the wanderguard on Monday (7/21/25). RN-B stated she may have seen R2 in the hallway however, was not sure because she did not know what he looked like. RN-B confirmed increased safety checks had not been implemented on R2 prio to his elopement. RN-B confirmed she had not placed a wanderguard on R2 because she did not know where they were kept and that placing a wanderguard on a resident was the nurse manager's responsibility. RN-B identified she was notified at approximately 4:15 p.m. on 7/19/25, that R2 was not in his room and searched the facility. When they were unable to find R2, she notified the DON, administrator, family, and police at approximately 5:00 p.m. R2 was located by the police across the street from the AL in the parking lot and returned to the facility at 5:30 p.m. During an interview on 7/24/25 at 11:10 a.m., nursing assistant (NA)-A indicated she worked the day of R2's admission and knew he was at risk for elopement because he went down the elevator in his wheelchair independently. NA-A confirmed a wanderguard had not been placed on R2 and that increased safety checks had not been implemented. NA-A stated NAs did not know how to apply wanderguards however, received education after R2's elopement. During an interview on 7/24/25 at 11:25 a.m., NA-B indicated she was working on 7/19/25, had not been informed R2 was an elopement risk when she received report. NA-B noted R2 had some of his personal items	20830		

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20830	Continued from page 6 outside his room as if he were packing to leave and another resident told her that R2 was going to leave. NA-B checked on R2 at 4:15 p.m., and noted he was not in his room. NA-B notified the nurse, and they began to search for him and stated they did not know what he looked like at that time. Facility policy titled, Elopements dated 4/7/25, defined elopement as a resident who needed supervision left the premises or a safe area without authorization and/or any necessary supervision to do so. The policy indicated the skilled nursing facility (SNF) would be responsible for maintaining a system that clearly defined the mechanisms and procedures for monitoring residents at risk for elopement. These include identifying, evaluating, and analyzing environmental hazards and risks; and implementing, monitoring, and modifying interventions as needed. All SNF residents would be assessed for risk of elopement through pre-admission and/or admission process and as needed. Each SNF location would put measures in place to minimize the risk of elopement that are individualized to resident needs and identified on the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to elopement and managing residents at risk for elopement. The DON or designee could re-educate all staff on policies and procedures, changes to care plans, and the results of assessments for those identified at risk. The DON or designee could develop a system for evaluating and monitoring consistent implementation of policies and procedures and audit to prevent potential elopement. The results of those measurable audits should be routinely brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		