Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52344042M
Compliance #: H52344068C

Date Concluded: August 26, 2025

Name, Address, and County of Licensee Investigated:
Good Samaritan Society – Waconia &
Westview Acre
333 5th Street W.
Waconia, MN 55387
Carver County

Facility Type: Nursing Home

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The resident was neglected when alleged perpetrator, AP1, put the resident on a bed pan, left the facility, and did not alert other staff the resident was on the bedpan. The resident remained on the bedpan for 11.5 hours when AP2 failed to assist the resident with cares. The resident was found on the bedpan 11.5 hours later and sustained a suspected deep tissue injury.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the neglect. The resident was dependent on staff for repositioning, incontinence care, and toileting. AP1 and AP2 provided the resident cares according to the resident's plan of care that was in place at the time of the incident. Although the resident had a coccyx pressure ulcer prior to the incident, the facility failed to ensure ordered interventions to prevent new or worsening pressure ulcers were communicated for staff to implement. As a result, the residents specific needs regarding incontinence care/toileting, and repositioning was not

communicated to staff. The resident sustained a suspected deep tissue injury and developed new pressure ulcers as a result of the neglect.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), death record, hospital records, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator reviewed previous federal investigation documentation.

The resident resided in a skilled nursing facility rehabilitation unit with diagnoses including breast cancer, lung cancer (unspecified location), metabolic encephalopathy, lymphocytopenia, acute kidney failure, and hypertensive chronic kidney disease stage 3.

The resident's hospital discharge summary the day the resident was readmitted to the facility (11 days prior to the incident) included orders to reposition the resident every 2 hours from side to side and apply Meplex (a type of dressing) to the resident's coccyx, with instructions to assess the resident's skin underneath the dressing by peeling it back and checking the resident's skin for blanch ability every shift.

A physician's order summary report at the time of readmission included orders to avoid excess products over the resident's mattress or pressure relieving devices which could decrease the effectiveness, assess skin under prophylactic dressing every shift, change dressing every shift and PRN, and reposition the resident side to side when in bed every 2 hours.

The resident's readmission assessment completed 9 days prior to the incident indicated the resident had moderately impaired cognition and was incontinent. The assessment indicated the resident was totally dependent on staff for toileting and incontinence cares due to limited mobility and complex medical conditions. The assessment indicated the resident should be checked for incontinence and changed as needed. The assessment indicated the resident was at a moderate risk for pressure ulcers due to occasional skin moisture, limited sensory perception, and very limited ability to change her own body position. The assessment identified the resident was unable to make significant changes in her body position independently. The assessment indicated interventions for residents at a moderate risk for pressure ulcers included frequent turning with a planned schedule, pressure reducing surfaces, and management of moisture. The assessment indicated the resident had no pressure ulcers at the time of readmission to the facility.

The resident's treatment administration record (TAR) included orders on readmission to reposition the resident every 2 hours side to side. The TAR also included orders to apply Meplex to the resident's coccyx with instruction to assess skin for blanch ability underneath the dressing every shift and change as needed. The orders were signed off as completed by nursing staff each shift including the day of the incident.

The resident's plan of care at the time of the incident indicated the resident had a self-care deficit related to weakness following a urinary tract infection and recent cancer treatment. The plan of care indicated the resident had a potential for pressure ulcer development related to impaired mobility and incontinence.

Although the plan of care indicated the resident required assistance from 2 staff with repositioning side to side or moving up in bed, the facility failed to ensure the plan of care communicated the resident required repositioning while in bed every 2 hours for staff to implement prior to and at the time of the incident. Although the plan of care indicated staff should check/change and toilet the resident as needed (PRN) and anticipate the resident's toileting needs, the facility failed to direct staff on the frequency the resident should be checked for incontinence, changed, or toileted prior to and at the time of the incident.

The residents service delivery of care record and assigned task list (delegated care and services assigned to staff to complete) indicated repositioning every 2 hours was not implemented as a scheduled task until 3 days after the incident occurred.

The resident's progress notes from the time of readmission lacked documentation of ongoing skin assessment and monitoring of the resident's coccyx area for blanch ability as ordered. 2 days later facility nurses began documenting each day (for 7 days) that the resident had pressure ulcers on her coccyx that were cleaned, the dressing was changed, and the resident was repositioned every 2 hours. The only wound assessment completed prior to the incident, dated the day of the incident occurred, indicated the resident had a coccyx pressure ulcer stage 2 measuring 2.5 centimeters (cm) by 1 (cm). The assessment indicated repositioning/turning, and moisture incontinence protection were implemented, however there was no indication the resident's plan of care was updated to include scheduled repositioning every 2 hours while the resident was in bed. The day after the incident a progress note indicated the provider was contacted for a suspected deep tissue injury on the resident's buttocks and change in mental status. The progress notes indicated the resident's cognition continued to decline following the incident, and the resident was sent to the emergency department (ED) for evaluation.

Although the nurses progress notes indicated the resident had developed a coccyx pressure ulcer 9 days prior to the incident, the facility failed to complete initial and ongoing assessment and monitoring of the pressure ulcer. In addition, the facility failed to ensure interventions including every 2-hour repositioning were communicated to staff on the resident's plan of care and assigned task list to help prevent new or worsening pressure ulcers.

The ED/hospital record indicated the resident arrived for concerns of altered mental status. Emergency medical services (EMS) noted the resident was lethargic, less responsive, not opening her eyes, or following direction. The record indicated the resident had bilateral pulmonary embolism complicated by aspiration pneumonia. The physical exam identified the resident had a "coccyx bed sore", and a "large ring-shaped bed sore" noted on her backside/buttocks and lower extremities. Photograph images showed large, dark, ring-shaped

indentations into the resident's skin that appeared to be the same size and shape as a bed pan. A hospital wound care assessment indicated the resident had a deep tissue injury which appeared to have been caused by the resident being left on a bed pan or similar device. The assessment indicated the resident did not recall being left on the bed pan and complained of pain in the area during palpation of the injury. The assessment indicated the injury had evolved into a stage 2 pressure ulcer in areas of the ring at 3, 8, and 1 o'clock, with indurations (thickening hardening of the skin) noted on both sides of the injury. The assessment indicated deep tissue injuries can continue to progress even when the pressure is relieved because the damage had already been done. The assessment indicated the resident also had a partial thickness wound with hyperpigmentation and a scar on her coccyx present.

Facility investigation documentation indicated the day of the incident AP1 place the resident on the bedpan at 1:30 p.m. before the end of her shift, then forgot to return to remove the bed pan or report to oncoming staff the resident was on the bedpan. The investigation indicated AP2 had not checked the resident for incontinence during the evening shift because she thought the resident would verbalize her needs.

When interviewed and during email correspondence facility leadership indicated the order on the TAR for repositioning the resident every 2 hours was a "nurses only" order at the time of the incident because the resident did not have any active pressure ulcers. Leadership indicated the order was a preventative measure only, which was why it was not on the resident's plan of care, or task list prior to the incident. Leadership indicated the resident's provider had seen the resident on rounds and not identified any pressure ulcers prior to the incident. Leadership indicated she did not know why the nurses had documented the resident had coccyx pressure ulcers prior to the incident. Leadership indicated if the resident had coccyx pressure ulcers prior to the incident the nurses should have implemented weekly wound monitoring, and interventions to prevent new or worsening pressure ulcers including repositioning every 2 hours. Leadership indicated toileting, incontinence check/change, repositioning, and skin assessment were not provided as documented by staff the day of the incident or they would have noticed the resident was on the bed pan.

A review of the provider visit notes referred to by leadership from readmission to prior to the incident included a section for skin. However, the provider notes indicated the resident's skin was clean dry and intact "to exposed skin surfaces" only. There was no indication the provider completed a full body skin assessment to include the resident's coccyx area to identify if the resident had pressure ulcers prior to the incident.

When interviewed AP2 indicated she was not aware the resident needed repositioning or was on the bed pan the day of the incident. AP2 indicated the resident had no scheduled checks for incontinence, or toileting, and indicated the plan of care and assigned tasks did not indicate the resident needed to be repositioned every 2 hours. AP2 indicated she thought the resident would communicate her needs. AP2 indicated when she and the nurse boosted the resident up in bed one time during the evening shift, she had no indication the resident was on the bed pan.

AP2 indicated no repositioning, toileting, checks for incontinence, or brief changes were provided to the resident during the evening shift the day of the incident.

When interviewed the nurse working the evening shift the day of the incident indicated her understanding of the orders on the TAR for repositioning and skin assessment was that they (nurses) signed off the aides had completed the task. The nurse indicated she did not do any repositioning for the resident or check her skin because she had an aide (AP2). The nurse indicated repositioning should be communicated to the aides on the plan of care, and scheduled task list for staff to complete. The nurse indicated although she signed the TAR, she did not look at or assess the resident's coccyx or provide every 2-hour repositioning to the resident because she thought AP2 (a nursing assistant) had done it. The nurse indicated she assisted AP2 to boost the resident in bed one time during her shift, but she did not assist AP2 with any repositioning.

When interviewed one nurse stated the resident was dependent on staff for bed mobility and incontinence care, and unable to consistently make her needs known. The nurse indicated she had documented in progress notes she had cleaned the resident's pressure ulcers, applied a new dressing, and provided repositioning every 2 hours prior to the incident. The nurse indicated the resident had a stage 2 coccyx pressure ulcer present shortly after readmission to the facility and was still present at the time of the incident. The nurse indicated she thought the aides repositioned the resident every 2 hours, and indicated repositioning was a task delegated to the aides on the plan of care and assigned task list. The nurse indicated she signed off repositioning was provided, but did not herself provide any repositioning unless the aides asked for help. The nurse indicated the day of the incident if staff had checked, changed, or repositioned the resident they would have noticed the resident was on a bed pan.

When interviewed another nurse stated the resident did not consistently communicate her needs to staff and was totally dependent on staff to move in bed, check for incontinence, and toilet. The nurse indicated she also had documented repositioning was provided every 2 hours but indicated the aides were responsible for repositioning the resident and indicated she would help if they needed. The nurse stated the resident's coccyx was red on admission then became a stage 2 pressure ulcer prior to the incident. The nurse indicated if repositioning, toileting, and incontinence check/change were provided staff would have noticed the resident was on the bed pan.

When interviewed the resident's family member indicated the resident's change in cognition/ change of condition was identified by the facility timely the day after the incident occurred, and was not related to the resident being left on the bed pan which caused the deep tissue injury.

The resident's record of death indicated the resident died while in the hospital of natural causes related to acute on chronic respiratory failure, pneumonia, pulmonary embolism, and metabolic encephalopathy.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes, AP2. No, AP1 failed to respond to interview attempts including phone, email, and subpoena.

Action taken by facility:
The facility suspended the staff involved pending and investigation, transferred the resident to the ED, and provided education to staff.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

The purpose of this investigation was to determine individual or facility responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Carver County Attorney
Waconia City Attorney
Waconia Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/23/2025**

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
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: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H52344042M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for #H52344042M, tag identification 21850.	20000		

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

Minnesota State 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 **07/23/2025**

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

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20000	Continued from page 1 The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul .htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. 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.	20000		
21850	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 14 Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This LICENSURE REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		