STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. Building B. Wing	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, MN 55387

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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. 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 [DATE] 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 [DATE] 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 [DATE], 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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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 [DATE]), 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 1/4 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 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 1/2 hour (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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.