DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H53171882M
Compliance #: H53171781C

Date Concluded: July 29, 2025

Name, Address, and County of Licensee Investigated:
Good Samaritan Society Comforcare
1201 17th Street NE
Austin, MN 55912
Mower 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 by Alleged Perpetrators 1 and 2. Alleged perpetrator 1 (AP)1 failed to provide the correct diet, and AP2 failed to ensure the resident wore his dentures and was supervised when eating. The resident received a regular diet in error and was sent to the emergency department (ED) with low oxygen saturations and shortness of breath.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident's plan of care failed to direct staff to ensure the resident wore his dentures during oral intake to help reduce his risk of aspiration. The resident record directed the resident had a soft bite sized diet, with no bread, and staff supervision during oral intake. However, the facility failed to ensure the resident was supervised, and failed to ensure dietary orders were accurately followed and communicated for staff to implement. As a result, the resident received whole sausage patties and toast in error, causing the resident

to cough, vomit, and have low oxygen saturations. The resident was transferred to the emergency department (ED) and admitted to the hospital with aspiration pneumonia.

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), hospital records, facility internal investigation, facility incident reports, personnel files, related facility policy and procedures, and previous federal investigation documentation.

The International Dysphagia Diet Standardization Initiative (IDDSI) identified the dysphagia diet level 6 as soft bite sized foods. The IDDSI indicated bite sized meant pieces of food no bigger than 1.5 centimeters (cm) by 1.5 cm that are soft enough to be mashed with a fork. The IDDSI indicated the diet did not include regular dry bread due to the high risk for choking.

The resident resided in a skilled nursing facility with diagnoses including acute on chronic systolic and diastolic congestive heart failure, respiratory failure with hypoxemia (low oxygen), hemiplegia (paralysis on one side of the body), and dysphagia (difficulty swallowing).

A hospital discharge summary dated February 27 indicated the resident required supervision assistance during meal intake and a mechanically altered diet (a change in the texture of foods provided).

The resident's admission assessment indicated the resident was admitted from the hospital with orders for a mechanically altered diet.

A facility speech language pathology note indicated the resident was assessed to need his dentures during oral intake to reduce his risk of aspiration prior to admission to the facility.

The resident's plan of care at the time of the incident indicated the resident could feed himself but required line of sight supervision while eating. The dietary section of the care plan at the time of the incident indicated the resident had aspiration/choking precautions and required a dysphagia diet level 6 which included soft bite sized foods cut into small pieces with no coleslaw, bread, or straws. The plan of care indicated the resident should take small bites one at a time, eat slowly, and chew thoroughly with staff providing line-of-sight supervision. The plan of care failed to direct staff to ensure the resident wore his dentures during meals.

On March 3, a facility speech language pathology progress note/assessment summary indicated the resident required soft bite sized food with extra moisture and should have no bread at this time. A facility communication form from speech language pathology also included direction that the resident should not have bread.

The same day a dietary notification form indicated the resident should have dysphagia diet level 6 soft bite sized foods with extra moisture, and line of sight supervision while eating. The communication failed to specify the resident should not have bread.

A dietary progress note the same day included a nutritional status update that indicated the speech language pathologist started a trial of diet level 6, soft and bite sized foods with extra moisture and no bread. The note indicated the resident required line of site supervision and aspiration choking precautions including taking small bites one at a time, eating slowly, and chewing thoroughly.

A previous federal investigation documentation indicated while the federal investigator was onsite the resident's dietary tray card (used to ensure the correct diet of food is plated and delivered to the residents) dated March 4, through March 19, (the day of the incident) included orders for soft and bite sized foods but did not include direction the resident could not have bread, or needed supervision during oral intake. The tray card that was in place at the time of the incident was not able to be reviewed by this investigator.

The day of the incident a speech therapy note indicated the therapist entered the dining room toward the end of the meal and the resident had a sausage patty and a piece of toast that were half eaten. The note indicated the resident did not have his dentures, so the therapist left the resident to get them and when she returned the resident stated, "something was caught in his throat." The note indicated the therapist gave the resident a small sip of water and instructed the resident to swallow hard to try and clear the bolus of food, but the resident began coughing and appeared as if he was going to vomit. The therapist moved the resident to his room where the resident pointed to his throat and continued to cough up what he could, then vomited in a garbage can. The therapist notified nursing who assessed the resident and noted his oxygen saturations were in the 80's (a normal oxygen saturation is greater than 90%). The note indicated the resident complained of feeling lightheaded.

A facility incident report indicated when the therapist entered the dining room the resident was finishing his last bites of food but did not have dentures, so she went and got them. When the therapist returned the resident was coughing and reported feeling something was stuck in his throat. The therapist brought the resident to his room where he vomited a mixture of food, mucus, and saliva. The resident reported he choked on his food then complained of feeling short of breath with chest tightness/pain. The incident report indicated a nebulizer treatment and supplemental oxygen were provided and the provider was notified with orders to send the resident to the ED for evaluation.

A facility hospital transfer form indicated the resident's oxygen saturations were 90% following the nebulizer treatment while on 3 liters of oxygen via nasal canula. The resident's medication and treatment administration record indicated the resident did not normally utilize oxygen.

The resident's hospital record indicated the resident was admitted with aspiration pneumonia. The record identified although the resident was originally assessed to require thickened liquids, he did not have his dentures in during the initial swallow study, and this was believed to be the reason the resident aspirated on thin liquids. The note indicated the resident should utilize his dentures to help prevent aspiration.

The facility investigation identified the resident reported he choked on his food, felt like something was stuck in his throat, and felt short of breath. The investigation identified the resident was not provided line of sight supervision during the meal and was not wearing his dentures because the resident's plan of care did not indicate the resident needed dentures for meals at the time the incident occurred. The investigation identified the resident's tray failed to indicate the resident could not have bread. The investigation identified dietary staff lacked knowledge to perform their job duties correctly at the time the incident occurred. The investigation also identified staff were not aware the resident required line-of-sight supervision when eating meals despite it being on his plan of care. The investigation identified the restriction of no bread and line-of-sight supervision was not properly reflected on the resident's tray card for staff to implement until after the incident occurred.

When interviewed nursing leadership indicated the facility investigation identified the resident's need to wear dentures during meals was not on the plan of care or Kardex, and the diet card lacked information to provide supervision, and failed to include the restriction of no bread for staff to implement at the time the incident occurred. Nursing leadership indicated following the incident all resident's plan of care, Kardex, and tray cards were audited and updated as needed to ensure they contain all the necessary information needed for staff to implement. Nursing leadership stated education was provided to nursing and dietary staff on diets and supervision following the incident.

When interviewed AP2, a nursing assistant, stated the day of the incident was the first time she had assisted the resident to get up for the day and she was not aware with his routine. AP2 stated she referred to the resident's Kardex (an abbreviated plan of care) the day of the incident, but it did not indicate the resident required line of sight supervision when eating or that he required his dentures. AP2 indicated she was not aware the resident was at a risk for aspiration/choking at the time the incident occurred.

When interviewed AP1, a cook, stated prior to the incident she had not received adequate training on the different diet consistencies, and the resident's tray card failed to direct staff that the resident needed supervision and could not have bread. AP1 stated the resident did not have his dentures the day of the incident and aspirated because he was given bread in error. AP1 indicated since the incident staff received additional training on diets and diet consistencies they had not had prior to the incident and the process had changed to include communication with nursing to make sure orders and updates were not missed.

When interviewed, a lead cook confirmed the resident's tray card did not include instructions for no bread or line-of sight supervision at the time the incident occurred.

When interviewed a speech therapist stated the day of the incident no staff were present in the dining room to provide line-of sight supervision for the resident. The therapist stated the resident had a half a slice of toast and a sausage patty left that was not cut up into pieces when she arrived to work with the resident. The therapist stated the diet provided was not a dysphagia diet level 6 with soft bite sized foods, but a regular diet. The therapist noticed the resident did not have his dentures in his mouth and went to get them, when she returned (approximately 20 to 60 seconds later) the resident began coughing and reported feeling something was stuck in his throat. The therapist indicated she provided verbal cues for swallowing however the resident continued to cough and vomited thick mucus mixed with pieces of food. The resident reported feeling lightheaded, so she notified nursing to assess the resident.

When interviewed the dietary manager at the time of the incident stated he had updated the resident's plan of care and tray card with the new diet orders but must have missed adding no bread to the tray card. The dietary manager stated the sausage patty should have been cut into small pieces before serving to the resident to meet the resident's orders for soft and bite sized foods.

When interviewed the nurse who responded to the resident after the incident indicated the resident was given toast which was not acceptable. The nurse stated after the incident it was identified the resident was not wearing his dentures and the resident's care plan did not direct staff to make sure the resident wore his dentures during meals.

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: Yes

Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility suspended staff involved, investigated the incident, and reported the concern to the Minnesota Adult Abuse Reporting Center (MAARC). Following the incident the facility audited and updated all residents tray cards, care plans, and Kardex to ensure resident needs including dentures, supervision, and dietary needs were accurate and clearly communicated for staff to implement to ensure resident safety and prevent recurrence. The facility provided education to all staff on diets, diet consistencies, and line-of-sight supervision. In addition, the facility implemented communication logs and provided educational dietary resources in the dietary department and nursing stations for staff to access as needed.

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 facility and/ or individual 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
Mower County Attorney
Austin City Attorney
Austin Police Department

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 **05/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Comforcare	**1201 17TH STREET NE , AUSTIN, Minnesota, 55912**

(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 #H53171882M, 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 #H53171882M, tag identification 21850.	20000		

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/28/2025**

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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 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		