Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54558362M
Compliance #: H54558623C

Date Concluded: March 31, 2026

Name, Address, and County of Licensee Investigated:
Good Samaritan Society Jackson
Address: 601 West Street
Jackson, MN 56143
Jackson County

Facility Type: Nursing Home

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

Finding: Not Substantiated

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 the AP failed to provide mildly thickened dietary liquids as ordered and gave the resident regular thin liquids. The resident aspirated causing respiratory distress and was transferred to the emergency department (ED).

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. Although the AP gave the resident thin liquids in error, the resident had no symptoms of respiratory distress or concerns of aspiration until several days later. In addition, the resident record indicated the resident had recurring issues with coughing during fluid/meal intake and medication administration related to dysphagia (difficulty swallowing) despite having pureed food and thickened liquids. The AP's error was an isolated one and not part of a pattern nor could the respiratory distress occurring days later be necessarily attributed to this error.

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

The resident resided in a skilled nursing facility with diagnoses including aftercare following joint replacement, dementia, pneumonia, stroke, and dysphagia.

A concern arose when the AP gave the resident thin liquids, which was not consistent with the resident's dietary orders.

The resident's medical record included a video fluoroscopic swallow study approximately two weeks prior to the incident which indicated the resident had laryngeal aspiration. The record indicated the resident was to have pureed foods and mildly thickened liquids.

The resident's assessment and care plan indicated the resident was severely cognitively impaired. The assessment and plan of care indicated the resident had swallowing problems with coughing/choking during meal intake and when swallowing medications requiring a mechanically altered diet of pureed foods and mildly thickened liquids with no straws.

A dietary communication note indicated the resident's dietary change for pureed foods and mildly thickened liquids with no straws was communicated for staff to implement.

A facility incident report indicated the resident was observed drinking thin liquids which staff replaced with mildly thickened liquids. The incident report indicated the resident's lung sounds and vitals were checked with no concerns noted following the incident.

The resident's progress notes indicated the resident had recurring problems with coughing and choking during meals prior to and following the dietary changes despite the intervention of pureed foods and mildly thickened liquids with no straw.

Three days after the incident the resident record indicated the resident had respiratory distress and was transferred to the emergency department (ED) for evaluation and treatment.

The ED and hospital records indicated the resident was admitted for aspiration pneumonia and treated with antibiotics and fluids. The record indicated the resident continued to have recurring aspiration events despite being on a pureed diet with thickened liquids and was transferred to another hospital for further evaluation of his swallowing issues. The record indicated another swallow study identified the resident had pharyngeal dysphagia and recommended alternate feeding methods for the resident. The record indicated a nasal gastric feeding tube was trialed which the resident did not tolerate and was discontinued. The record

indicated the family declined more invasive interventions like surgical placement of a feeding tube and the resident was transitioned to hospice for end of life comfort care.

When interviewed facility staff stated the resident had ongoing issues with coughing during meals despite having a pureed diet and thickened liquids.

When interviewed the AP denied any wrongdoing and indicated although she made an error it was corrected, and the resident seemed fine.

When interviewed, the resident's family member indicated the resident was declining and had disease progression causing his swallowing issues which continued despite having thickened liquids. The family did not feel the isolated error by the AP caused the resident's aspiration pneumonia but indicated it was caused by a chronic recurring issue. The family stated facility staff were kind and attentive to the resident's needs and they had no concerns.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means: An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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

Action taken by facility: The facility reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC), investigated the incident, re-educated staff, and audited to ensure compliance.

Action taken by the Minnesota Department of Health: No further action taken at this time

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/10/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Jackson	**601 WEST JACKSON , JACKSON, Minnesota, 56143**

(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 H54558362M , in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you	20000		

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

Minnesota State Department of Health

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20000	Continued from page 1 acknowledge receipt of the electronic documents.	20000		