

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Jackson		STREET ADDRESS, CITY, STATE, ZIP CODE 601 West Jackson Jackson, MN 56143	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure infection control measures were followed during observation of 1 of 1 meal services. This had the potential to effect all 36 residents in the facility. Findings include: Observation on 7/29/26 at 11:29 a.m. as cook-A completed preparation of the noon meal consisting of chicken with mushroom gravy, noodles, and broccoli. Cook-A was placing the food items onto the steam table when she turned and went to the cabinet, opened the door, removed a saltshaker, and shook salt into her bare hand. After filling the palm of her hand with salt she returned to the stove, where she dumped the salt from her hand into the cooking noodles. When questioned as to her action, she replied she had measured the salt to add to the noodles. She then asked if this was a problem as that was how she always did it. Cook-A then set the pot into the sink and prepared a fresh pot of noodles which were placed onto the steam table. As she was pouring the noodles into the steamtable pan several noodles landed on the counter Infront of the pan. Cook-A used her bare hand and tossed the noodles from the counter back into the pan of noodles in the steamtable. Observation on 7/29/26 at 11:42 a.m. as cook-A washed her hands, returned to the counter across from the steamtable, where she picked up a tray containing 2 paper meal slips, picked up the slips and identified the resident meals, turned back to the steamtable, picked up 2 plates, and began placing food items onto the plates. She used a large, slotted spoon to scoop noodles onto the plates, then placed the slotted spoon on the side of the steamtable, went around the steamtable to a drawer which she opened with her bare hand, removed a green handle scoop spoon and returned to plating the meal. As she was scooping noodles onto the plate, several noodles were hanging off the side of the plate, and she used her bare hand to scoop them back onto the plate. Cook-A placed the filled plates onto the tray and pushed them into the window for staff to serve to residents in the dining room. Cook-A continued the same process of serving several plates and again used her bare hand to scoop noodles hanging off the side of the plate back onto the plate being served. Observation on 7/29/26 at 11:52 a.m. as cook-A left the steamtable, walked into the dining room where she went to trays set-up on a cart, and identified as room trays. She returned to the steamtable with no hand hygiene and continued to plate meals, covered with a lid, and after stacking 4 covered plates, she took them into the dining room and placed them onto the trays designated as room trays. Cook-A then returned to the kitchen, took a cloth from the bucket of sanitizer solution in the sink and began wiping down the counter and cart that had contained the pudding served for dessert. Interview on 7/29/26 at 12:05 p.m. with cook-A reported she had always measured seasonings using her hand and was not aware there was a problem doing it that way. When asked about serving of the noodles and handling them with her bare hands, reported she did not realize she had done that and reported she should have, tossed the noodles that landed on the counter Infront of the steam pan, and used the scoop to (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and document review the facility failed to identify when an employee would be able to return to work (RTW) for 3 of 3 sampled staff (nursing assistant (NA)-A, NA-F, and licensed practical nurse (LPN)-A) identified with potential norovirus symptoms. This had the potential to affect all 36 residents residing at the facility. Findings include: Review of the 2024-2025 Norovirus Information for Long-term Care Facilities, located at, https://www.health.state.mn.us/diseases/foodborne/outbreak/facility/lcfnorovirus.pdf, identified Norovirus is transmitted through a fecal (stool)-oral route with symptoms of diarrhea, vomiting, nausea, abdominal pain, low grade fever, headache, and or body aches. Individuals generally become ill 12-48 hours after exposure (swallowing Norovirus). Infected individuals shed the virus in their stool and contaminate food, surfaces, and objects and can be shed in the stool for several weeks after recovery. Products used to clean Norovirus must say they are effective against Norovirus. Hand sanitizer does not work to kill the virus. Individuals should wash their hands for 20 seconds with soap and water. Individual cases of Norovirus are not reportable to the State, however, possible outbreaks or multiple cases with Norovirus-like symptoms must be reported. Documentation of possible outbreaks was to include: Use the RESIDENT ILLNESS LOG and STAFF ILLNESS LOG to document illnesses among staff and residents/patients: Contact managers of each unit, etc. as necessary to gather illness information. Send both ILLNESS LOGS back to MDH within 2 business days of reporting the suspected outbreak. Epidemiology staff will use this to assess A) which pathogen is causing the outbreak, B) the likely route of transmission, and C) whether additional prevention measures are needed. Gather additional information List activities, events, etc., held during the week prior to the first illness (especially if food was served). Determine when and where there were any vomiting incidents or diarrheal accidents in the facility. If requested by MDH, provide a dietary menu (breakfast, lunch, and dinner). If requested by MDH, provide names and phone numbers for staff and/or residents (in rare cases, MDH may want to conduct interviews). Collect a stool sample from three (3) residents and/or staff and send to MDH Laboratory for analysis (MDH will provide specimen collection kits; the testing is free of charge). If stools from residents or staff were sent to a clinical laboratory, notify MDH of any results. Send both completed ILLNESS LOGS back to MDH between 1 and 2 weeks after the last illness. IMPLEMENT OUTBREAK CONTROL MEASURES: Monitor for resident illness (record on RESIDENT ILLNESS LOG) and when possible, isolate residents while they are ill and for 72 hours after symptoms have stopped. Consider halting new admissions until the outbreak has ended. Exclude actively ill residents from games/activities where touching common items occurs (e.g., checkers, cards). Monitor for staff illness (record on STAFF ILLNESS LOG) and restrict ill staff/volunteers from patient care and food handling duties until 72 hours after their vomiting/diarrhea has ended. Review of the current, undated Centers for Disease Control (CDC) Norovirus guidelines, located at https://www.cdc.gov/norovirus/index.html, identified Norovirus is a very contagious virus that causes vomiting and diarrhea. It is sometimes called the stomach flu or the stomach bug. However, norovirus illness is not related to the flu. The flu is caused by the influenza virus. Norovirus causes acute gastroenteritis, an inflammation of the stomach or intestines. Most people with norovirus illness get better within 1 to 3 days; but they can still spread the virus for a few days after. Most common symptoms: Diarrhea, vomiting, nausea, stomach pain. Other symptoms: Fever, headache, and body aches. Food workers should stay home when sick and for at least 48 hours after symptoms stop. This also applies to sick workers in schools, daycares, healthcare facilities, and other places where they may expose people to norovirus. Review of Employee Illness Tracking log included a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	section to log the employee's name, the unit they worked on, the date of the call in, the illness symptoms, the onset date, prevention measures (work restriction, COVID testing, etc.) and the return-to-work date. Review of the April, May, and June 2026 Employee Illness Tracking logs identified the following:NA-A called in on 4/2/26, with symptoms of diarrhea, the onset was 4/2/26 and noted in the prevention measures section of the form identified removed from work. The return-to-work date was left blank. Review of NA-A time punch for that week identified NA-A returned to work on 4/4/26.NA-F had called in on 4/7/26 and 4/8/26, with symptoms of fever and diarrhea, the onset was 4/7/26 and noted in the prevention measures section of the form identified removed from work. The return-to-work date was left blank. Review of NA-F time punch for that week identified NA-F returned to work on 4/9/26.LPN-A had called in on 6/18/26, with symptoms of vomiting and diarrhea, the onset was 6/18/26 and noted in the prevention measures section of the form identified removed from work. The return-to-work date identified LPN-A return to work on 6/19/26. During interview on 7/30/26 at 4:00 p.m., with registered nurse (RN)-C who was the infection preventionist, agreed that the Employee Illness forms for April and May 2026, were not filled out thoroughly and lacked identification of a return to work. She stated she did not track when employees returned to work very well. The June 2026 Employee Illness form was completed thoroughly and identified the return-to-work date. RN-C confirmed that NA-A, NA-F, and LPN-A had returned to work too soon according the MDH Norovirus employee return to work guidance for potential norovirus however, she did not believe that any of the employees were suspicious of having norovirus. Interview on 7/30/26 at 11:30 a.m., with the regional clinical services director identified the facility should be documenting and filling out the employee illness form thoroughly. She agreed the facility should establish a baseline to know when to implement more stringent precautions to follow for staff to return to work depending on their symptoms. Review of 9/23/25, Employee Health Conditions Reporting and Managing, Infection Control policy identified Employees providing direct care with symptoms of infection will consult with their supervisor to evaluate their condition. A decision as to whether the staff may return to work or be restricted would be determined. Employees were to promptly report symptoms of viruses, respiratory infections, diarrhea, communicable diseases, fever, or open wounds. For symptoms of gastrointestinal illness such as vomiting or diarrhea the employee would be referred to their supervisor or the infection preventionist before the employee would be permitted to perform food handling or resident care duties. Certain Federal, state, and local regulations may require certain communicable illness to be reported and certain procedures or restrictions to be followed.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and document review the facility failed to follow facility policy to identify allegations of verbal abuse and threats of involuntary seclusion reported through grievances, that were made about 2 staff (registered nurse (RN)-A) and licensed practical nurse (LPN)-A) involving 6 of 40 residents (R27, R30, R43, R13, R44 and R100). In addition, the facility also failed to perform timely and thorough investigations, report allegations to the SA, and immediately suspend RN-A and LPN-A per policy pending the investigations. Findings include: Review of the grievances submitted from 2025 and 2026 grievances identified the following grievances: On 8/19/25, a grievance was filed regarding R100 by the former director of nursing (DON)-A. R100 reported LPN-A was rude to R100 on or about 8/5/25. R100 was very agitated when he was discussing his concerns to the reporter and could not describe anything specific that LPN-A said, however felt it was much more her tone and how she said things to him. R100 reported LPN-A was like Sergeant Slaughter (a professional wrestler who dressed as a military drill sergeant and known to be very harsh in behavior) and was very stern. do as I say person. She just wasn't talking nice to me. An interview occurred with an unknown party (U)-A. R100 had called her because he was upset. He was upset about the chair and that he could not get a sleeping pill. R100 reported this place is terrible. U-A could not calm R100 down because he was so upset. U-A also called to speak with LPN-A. LPN-A explained R100 shouldn't be getting up on his own and that staff would assist him. LPN-A also reported to U-A that the facility couldn't start a sleeping pill without doing a sleep study. U-A reported she became upset with LPN-A when LPN-A had asked her if R100 had ever been married. U-A stated no. LPN-A said well he must not be able to handle women well. well, you know how these old farmers are. There was no more information provided from the interview. LPN-A was then interviewed and remarked she had asked U-A if R100 had ever been married and stated she had commented well, maybe he just doesn't take direction well from women. The reported explained comments like that came across as unprofessional and should be avoided in the future. LPN-A admitted it wasn't the best word choice but had not intended to be disrespectful or rude. LPN-A was told to reflect on this situation and choose her words more carefully in the future. The resolution was education had been given to LPN-A ensuring professional conversation was maintained when communicating with residents. The DON signed off on the report on 8/19/25, however, the administrator had not signed off the report until 3/5/26. No other residents and/or representatives were interviewed, nor were any other staff members interviewed. There was also no follow up noted to determine if R100 was asked if they felt safe or if there had been any effects on R100's psychosocial or physical status with lack of a potential sleep aide that may have been able to be offered, or if R100 had any psychosocial outcome such as increased behaviors, or further instances from LPN-A with other comments etc. No other staff or residents were identified to have been interviewed to determine if similar incidents had occurred with other residents. On 11/10/25, registered nurse (RN)-B made a grievance report on behalf of R30 to DON-A, (2 days later) that on 11/8/26. R30 had reported that she heard RN-A yelling loudly at R44. RN-A then entered R30's room and told R30 I don't care if he is your friend. I don't like him; he's not a good patient. The facility interviewed RN-B and she reported the order of events were that R30 had told her RN-A was yelling so loud that the building could hear. R30 did not know specifically what RN-A had said to R44. R30 had also reported that RN-A entered her room and stated I don't care if he's your friend. I don't like him he's not a good patient. R30 also told several people she hoped RN-A did not treat them like that. DON-A directed RN-B to speak to R44 to see if he felt safe and ask how staff treated him. RN-B followed up with DON that R44 responded he felt safe and (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated, I don't like being here but they're all treating me good. An interview with RN-A identified she denied yelling at R44. She reported she was just reminding him that he needed to ask for help. R44 was saying he was being imprisoned and kept getting up on his own. He also threatened to pull the fire alarm. RN-A reported R44 was basically a 1:1 due to behaviors and continual attempts to transfer. R30 was interviewed and stated she had no concerns about how RN-A treated her. DON-A had a conversation with RN-A to which RN-A denied yelling at R44 and only tried to redirect him. There was no mention the facility asked RN-A if she had spoken to R30 as noted above in the grievance as no other areas of the concern were documented. There was also no mention the facility identified the yelling would be considered an allegation of verbal abuse and should have been reported to the State agency (SA) and administrator immediately on 11/8/26, vs 2 days later on 11/10/26, and re-educated staff to what verbal abuse was, or ensured staff were timely reporting to the administrator and SA. There was also no mention the facility had interviewed other residents and/or their representatives other than R30 and R44, if they interviewed other staff, or had placed RN-A on suspension pending an investigation. The administrator signed off on the report on 11/10/25. On 11/17/25, R27 reported a concern to the administrator about RN-A was treating her. R27 reported RN-A had told her she was going in a time-out. R27 asked why and RN-A told her because you don't know what you are doing. R27 stated this made her feel inadequate. It was also noted the incident occurred on 11/15/25 or 11/16/25. The investigation identified an interview was conducted with nursing assistant (NA)-A who stated I just want to start with and say that the day I worked with RN-A and NA-C on north, was one of the best days I worked on north. Things went smoothly. When asked about general concerns regarding RN-A, NA-A stated, she is assertive and bossy and gave a random example of a resident (R43) who would go into their room in a wheelchair and staff may say to RN-A oh they just went to their room, and she will drag them back out. NA-A reported RN-A made R43 very upset that day (unknown date), and he was snappy because of how RN-A treated him and he is never that way. R43 normally would go into his room, and staff just paid attention to him if he tried to get up to go to the bathroom. NA-A further reported RN-A was also noted to be standing in front of his room blocking him from entering and said, You can't go in. staff will help you. NA-A felt RN-A's approach was the issue as she is assertive and bossy with the residents. RN-A was interviewed and a summary of the complaints was read to her. In the summary, it was noted R27 voiced to her family member about RN-A not allowing her into her room. RN-A denied that she yelled at residents. RN-A admitted she did block R43 from going into his room as she did not want him to fall self-transferring. When asked why she did not go with R43 to assist him with a transfer verse blocking him, she reported she was worn out. RN-A reported she does not intend to yell at residents. She acknowledged she may raise her voice, but that was so they could hear her. The DON directed RN-A to reflect on her tone, volume of voice, body language, and word choice. She needed to soften her tone and approach. RN-A was tearful reporting that she had been trying hard to change her approach since the last conversation. Attached to the grievance was an email that had been sent to the administrator and DON on 11/16/21 at 11:03 a.m., (the sender of the email had been redacted). The email identified there were a few complaints/concerns regarding RN-A over the weekend (unknown if that was 11/15/25 or 11/16/25 weekend or prior). The email identified on Thursday (presumably 11/13/25) RN-A had very much upset R13 and had her all worked up as RN-A yelled at her for hollering out. Nurse aide (NA)-B had to console R13 as she kept saying she yelled at me. The unknown author of the email identified being told by multiple people that RN-A hollered at certain residents as they attempted to self-transfer. RN-A would get mad at the residents and scold them for self-transferring. The unknown author identified that NA-A reported RN-A would not let certain residents go back into their room as RN-A (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview and document review the facility failed to identify allegations of verbal abuse and threats of involuntary seclusion reported through grievances, that were made about 2 staff (registered nurse (RN)-A) and licensed practical nurse (LPN)-A) involving 6 of 40 residents (R27, R30, R43, R13, R44 and R100). In addition, the facility also failed to perform timely and thorough investigations and immediately suspend RN-A and LPN-A pending the investigations. Findings include: Review of the grievances submitted from 2025 and 2026 grievances identified the following grievances: On 8/19/25, a grievance was filed regarding R100 by the former director of nursing (DON)-A. R100 reported LPN-A was rude to R100 on or about 8/5/25. R100 was very agitated when he was discussing his concerns to the reporter and could not describe anything specific that LPN-A said, however felt it was much more her tone and how she said things to him. R100 reported LPN-A was like Sergeant Slaughter (a professional wrestler who dressed as a military drill sergeant and known to be very harsh in behavior) and was very stern. do as I say person. She just wasn't talking nice to me. An interview occurred with an unknown party (U)-A. R100 had called her because he was upset. He was upset about the chair and that he could not get a sleeping pill. R100 reported this place is terrible. U-A could not calm R100 down because he was so upset. U-A also called to speak with LPN-A. LPN-A explained R100 shouldn't be getting up on his own and that staff would assist him. LPN-A also reported to U-A that the facility couldn't start a sleeping pill without doing a sleep study. U-A reported she became upset with LPN-A when LPN-A had asked her if R100 had ever been married. U-A stated no. LPN-A said well he must not be able to handle women well. well, you know how these old farmers are. There was no more information provided from the interview. LPN-A was then interviewed and remarked she had asked U-A if R100 had ever been married and stated she had commented well, maybe he just doesn't take direction well from women. The reporter explained comments like that came across as unprofessional and should be avoided in the future. LPN-A admitted it wasn't the best word choice but had not intended to be disrespectful or rude. LPN-A was told to reflect on this situation and choose her words more carefully in the future. The resolution was education had been given to LPN-A ensuring professional conversation was maintained when communicating with residents. The DON signed off on the report on 8/19/25, however, the administrator had not signed off the report until 3/5/26. No other residents and/or representatives were interviewed, nor were any other staff members interviewed. There was also no follow up noted to determine if R100 was asked if they felt safe or if there had been any effects on R100's psychosocial or physical status with lack of a potential sleep aide that may have been able to be offered, or if R100 had any psychosocial outcome such as increased behaviors, or further instances from LPN-A with other comments etc. No other staff or residents were identified to have been interviewed to determine if similar incidents had occurred with other residents. On 11/10/25, registered nurse (RN)-B made a grievance report on behalf of R30 to DON-A, (2 days later) that on 11/8/26. R30 had reported that she heard RN-A yelling loudly at R44. RN-A then entered R30's room and told R30 I don't care if he is your friend. I don't like him; he's not a good patient. The facility interviewed RN-B and she reported the order of events were that R30 had told her RN-A was yelling so loud that the building could hear. R30 did not know specifically what RN-A had said to R44. R30 had also reported that RN-A entered her room and stated I don't care if he's your friend. I don't like him he's not a good patient. R30 also told several people she hoped RN-A did not treat them like that. DON-A directed RN-B to speak to R44 to see if he felt safe and ask how staff treated him. RN-B followed up with DON that R44 responded he felt safe and stated, I don't like being here but they're all treating me good. An interview with RN-A identified she (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	denied yelling at R44. She reported she was just reminding him that he needed to ask for help. R44 was saying he was being imprisoned and kept getting up on his own. He also threatened to pull the fire alarm. RN-A reported R44 was basically a 1:1 due to behaviors and continual attempts to transfer. R30 was interviewed and stated she had no concerns about how RN-A treated her. DON-A had a conversation with RN-A to which RN-A denied yelling at R44 and only tried to redirect him. There was no mention the facility asked RN-A if she had spoken to R30 as noted above in the grievance as no other areas of the concern were documented. There was also no mention the facility identified the yelling would be considered an allegation of verbal abuse and should have been reported to the State agency (SA) and administrator immediately on 11/8/26, vs 2 days later on 11/10/26, and re-educated staff to what verbal abuse was, or ensured staff were timely reporting to the administrator and SA. There was also no mention the facility had interviewed other residents and/or their representatives other than R30 and R44, if they interviewed other staff, or had placed RN-A on suspension pending an investigation. The administrator signed off on the report on 11/10/25. On 11/17/25, R27 reported a concern to the administrator about RN-A was treating her. R27 reported RN-A had told her she was going in a time-out. R27 asked why and RN-A told her, because you don't know what you are doing. R27 stated this made her feel inadequate. It was also noted the incident occurred on 11/15/25 or 11/16/25. The investigation identified an interview was conducted with nursing assistant (NA)-A who stated I just want to start with and say that the day I worked with RN-A and NA-C on north, was one of the best days I worked on north. Things went smoothly. When asked about general concerns regarding RN-A, NA-A stated, she is assertive and bossy and gave a random example of a resident (R43) who would go into their room in a wheelchair and staff may say to RN-A oh they just went to their room, and she will drag them back out. NA-A reported RN-A made R43 very upset that day (unknown date), and he was snappy because of how RN-A treated him and he is never that way. R43 normally would go into his room, and staff just paid attention to him if he tried to get up to go to the bathroom. NA-A further reported RN-A was also noted to be standing in front of his room blocking him from entering and said, You can't go in. staff will help you. NA-A felt RN-A's approach was the issue as she is assertive and bossy with the residents. RN-A was interviewed and a summary of the complaints was read to her. In the summary, it was noted R27 voiced to her family member about RN-A not allowing her into her room. RN-A denied that she yelled at residents. RN-A admitted she did block R43 from going into his room as she did not want him to fall self-transferring. When asked why she did not go with R43 to assist him with a transfer verse blocking him, she reported she was worn out. RN-A reported she does not intend to yell at residents. She acknowledged she may raise her voice, but that was so they could hear her. The DON directed RN-A to reflect on her tone, volume of voice, body language, and word choice. She needed to soften her tone and approach. RN-A was tearful reporting that she had been trying hard to change her approach since the last conversation. Attached to the grievance was an email that had been sent to the administrator and DON on 11/16/21 at 11:03 a.m., (the sender of the email had been redacted). The email identified there were a few complaints/concerns regarding RN-A over the weekend (unknown if that was 11/15/25 or 11/16/25 weekend or prior). The email identified on Thursday (presumably 11/13/25) RN-A had very much upset R13 and had her all worked up as RN-A yelled at her for hollering out. Nurse aide (NA)-B had to console R13 as she kept saying she yelled at me. The unknown author of the email identified being told by multiple people that RN-A hollered at certain residents as they attempted to self-transfer. RN-A would get mad at the residents and scold them for self-transferring. The unknown author identified that NA-A reported RN-A would not let certain residents go back into their room as RN-A stated, they can't be in their rooms in a wheelchair and stating you can't be in here standing in front (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of R43's door scolding him and not letting R27 go back to her room and jumping down [R44's] throat when he self-transferred. The unknown author identified R27 was the most upset about this and refused to go to supper because she would get yelled at. R44 stated he was sick of that big lady hollering at him and apparently R43 was very upset on the day [shift] also. The unknown author reported they had heard on multiple cases of RN-A hollering or scolding residents and that was not ok, and the residents deserved better than this. 3 residents were interviewed along with R27. R27 had complaints of treatment and reported RN-A kept saying to her you're just going to timeout and kept putting her in a timeout. When R27 asked why, RN-A told R27, you don't know what you are doing. The questions about staff talking respectfully to others and if she felt safe here were blank. The question about who to report to R27 had reported she would talk with her daughter. The other 3 residents felt like they were treated respectfully and had no concerns. None of the interviews were dated when they occurred or identified who asked the questions. The resolution section and follow-up comments on the grievance report were left blank. There was no indication the administrator or DON acted per the facility policy on the alleged allegations of verbal abuse and involuntary, that a formal investigation occurred, nor mention that RN-A had been suspended while the facility investigated the recurring concerns, staff re-educated about reporting or if the facility identified potential burnout by RN-A's comments. The administrator signed off the report on 3/5/26. Interview on 7/29/26 at 3:26 p.m. with regional clinical service director identified the grievance forms were missing information including a thorough investigation of each grievance with follow up to the concerned party. She agreed that the facility should have acted upon that email and the grievances (allegations of verbal abuse and involuntary seclusion) should have resulted in the suspension of RN-A and the administration should have immediately started an investigation. She revealed in all the grievances reviewed from November and December 2025, there seemed to be a pattern of only interviewing the parties identified in the concern and agreed that further interviews should have been completed to ensure a thorough investigation had occurred. She further agreed that the resolution and follow-up with the party concerned was lacking in most of the reviewed grievances and should have been completed per facility policy to ensure a satisfactory resolution. Her expectation was that the facility would brainstorm to ensure all grievances were handled and resolved appropriately. She made no mention the grievances were allegations of verbal abuse and involuntary seclusion and should have been reported to the SA immediately. Interview on 7/30/26 at 8:07 a.m., with the administrator identified he felt the facility did start an investigation. The DON-A was to complete the investigation and that was why he had not participated in it. He reached out to DON-A who reported the concern. DON-A did educate RN-A but did not document that education. The facility completed interviews with residents last night (7/29/26) (nine after the incidents) and suspended RN-A while a new investigation was being conducted. He stated there was no verbal abuse identified and the situation had been handled as R27 had no concerns and there had been no lasting effect, and no signs of psychosocial distress. The administrator declined to answer if RN-A should have been suspended when the incidents occurred for R30 and R44 in order to potentially prevent further incidents with R27 and other residents. Review of the 4/7/25, Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy and Rehab policy identified the policy was created to ensure employees were knowledgeable regarding the reporting and investigative process of abuse and neglect allegations, and ensure an effective system was in place that prevented mistreatment, neglect and abuse. It was also designed to ensure a complete review by the investigative team was completed to identify allegations of abuse and neglect were promptly reported and investigated. Allegations involving mistreatment, neglect, or abuse were to be reported immediately to the administrator in order to intervene and protect (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents. With an allegation of employee to resident abuse, the employee was to be removed from providing direct care to all residents. And be placed on suspension pending the results of the investigation. Allegations were to be reported immediately but no later than 2 hours after the allegation was made. Allegations that did not involve abuse and had no serious bodily injury were to be reported no later than 24 hours after the allegation was made. The investigation team (social worker (SW), DON and administrator) were to review all events no later than the next working day following the event. The facility was to ensure someone was assigned to complete the investigation and the SW or designee was to notify the SA. The investigation was to include interviewing employees, residents and/or witnesses to the event, but made no mention of interviewing others not directly involved but who may have knowledge about other pertinent facts or data of incidents. The SW or designee was to report results of all investigations to the SA within 5 working days of the event.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and document review the facility failed to report allegations of verbal abuse and threats of involuntary seclusion, related to 2 of 2 staff (registered nurse (RN)-A) and licensed practical nurse (LPN)-A) to the State Agency. Findings include: Review of the grievances submitted from 2025 and 2026 grievances identified the following grievances: On 8/19/25, a grievance was filed regarding R100 by the former director of nursing (DON)-A. R100 reported LPN-A was rude to R100 on or about 8/5/25. R100 was very agitated when he was discussing his concerns to the reporter and could not describe anything specific that LPN-A said, however felt it was much more her tone and how she said things to him. R100 reported LPN-A was like Sergeant Slaughter (a professional wrestler who dressed as a military drill sergeant and known to be very harsh in behavior) and was very stern. do as I say person. She just wasn't talking nice to me. An interview occurred with an unknown party (U)-A. R100 had called her because he was upset. He was upset about the chair and that he could not get a sleeping pill. R100 reported this place is terrible. U-A could not calm R100 down because he was so upset. U-A also called to speak with LPN-A. LPN-A explained R100 shouldn't be getting up on his own and that staff would assist him. LPN-A also reported to U-A that the facility couldn't start a sleeping pill without doing a sleep study. U-A reported she became upset with LPN-A when LPN-A had asked her if R100 had ever been married. U-A stated no. LPN-A said well he must not be able to handle women well. well, you know how these old farmers are. There was no more information provided from the interview. LPN-A was then interviewed and remarked she had asked U-A if R100 had ever been married and stated she had commented well, maybe he just doesn't take direction well from women. The reported explained comments like that came across as unprofessional and should be avoided in the future. LPN-A admitted it wasn't the best word choice but had not intended to be disrespectful or rude. LPN-A was told to reflect on this situation and choose her words more carefully in the future. The resolution was education had been given to LPN-A ensuring professional conversation was maintained when communicating with residents. The DON signed off on the report on 8/19/25, however, the administrator had not signed off the report until 3/5/26. No report was made to the SA. On 11/10/25, registered nurse (RN)-B made a grievance report on behalf of R30 to DON-A, (2 days later) that on 11/8/26. R30 had reported that she heard RN-A yelling loudly at R44. RN-A then entered R30's room and told R30 I don't care if he is your friend. I don't like him; he's not a good patient. The facility interviewed RN-B and she reported the order of events were that R30 had told her RN-A was yelling so loud that the building could hear. R30 did not know specifically what RN-A had said to R44. R30 had also reported that RN-A entered her room and stated I don't care if he's your friend. I don't like him he's not a good patient. R30 also told several people she hoped RN-A did not treat them like that. DON-A directed RN-B to speak to R44 to see if he felt safe and ask how staff treated him. RN-B followed up with DON that R44 responded he felt safe and stated, I don't like being here but they're all treating me good. An interview with RN-A identified she denied yelling at R44. She reported she was just reminding him that he needed to ask for help. R44 was saying he was being imprisoned and kept getting up on his own. He also threatened to pull the fire alarm. RN-A reported R44 was basically a 1:1 due to behaviors and continual attempts to transfer. R30 was interviewed and stated she had no concerns about how RN-A treated her. DON-A had a conversation with RN-A to which RN-A denied yelling at R44 and only tried to redirect him. There was no mention the identified the yelling would be considered an allegation of verbal abuse and should have been reported to the State agency (SA) and administrator immediately on 11/8/26. The (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administrator signed off on the report on 11/10/25. On 11/17/25, R27 reported a concern to the administrator about RN-A was treating her. R27 reported RN-A had told her she was going in a time-out. R27 asked why and RN-A told her because you don't know what you are doing. R27 stated this made her feel inadequate. It was also noted the incident occurred on 11/15/25 or 11/16/25. The investigation identified an interview was conducted with nursing assistant (NA)-A who stated I just want to start with and say that the day I worked with RN-A and NA-C on north, was one of the best days I worked on north. Things went smoothly. When asked about general concerns regarding RN-A, NA-A stated, she is assertive and bossy and gave a random example of a resident (R43) who would go into their room in a wheelchair and staff may say to RN-A oh they just went to their room, and she will drag them back out. NA-A reported RN-A made R43 very upset that day (unknown date), and he was snappy because of how RN-A treated him and he is never that way. R43 normally would go into his room, and staff just paid attention to him if he tried to get up to go to the bathroom. NA-A further reported RN-A was also noted to be standing in front of his room blocking him from entering and said, You can't go in. staff will help you. NA-A felt RN-A's approach was the issue as she is assertive and bossy with the residents. RN-A was interviewed and a summary of the complaints was read to her. In the summary, it was noted R27 voiced to her family member about RN-A not allowing her into her room. RN-A denied that she yelled at residents. RN-A admitted she did block R43 from going into his room as she did not want him to fall self-transferring. When asked why she did not go with R43 to assist him with a transfer verse blocking him, she reported she was worn out. RN-A reported she does not intend to yell at residents. She acknowledged she may raise her voice, but that was so they could hear her. The DON directed RN-A to reflect on her tone, volume of voice, body language, and word choice. She needed to soften her tone and approach. RN-A was tearful reporting that she had been trying hard to change her approach since the last conversation. Attached to the grievance was an email that had been sent to the administrator and DON on 11/16/21 at 11:03 a.m., (the sender of the email had been redacted). The email identified there were a few complaints/concerns regarding RN-A over the weekend (unknown if that was 11/15/25 or 11/16/25 weekend or prior). The email identified on Thursday (presumably 11/13/25) RN-A had very much upset R13 and had her all worked up as RN-A yelled at her for hollering out. Nurse aide (NA)-B had to console R13 as she kept saying she yelled at me. The unknown author of the email identified being told by multiple people that RN-A hollered at certain residents as they attempted to self-transfer. RN-A would get mad at the residents and scold them for self-transferring. The unknown author identified that NA-A reported RN-A would not let certain residents go back into their room as RN-A stated, they can't be in their rooms in a wheelchair and stating you can't be in here standing in front of R43's door scolding him and not letting R27 go back to her room and jumping down [R44's] throat when he self-transferred. The unknown author identified R27 was the most upset about this and refused to go to supper because she would get yelled at. R44 stated he was sick of that big lady hollering at him and apparently R43 was very upset on the day [shift] also. The unknown author reported they had heard on multiple cases of RN-A hollering or scolding residents and that was not ok, and the residents deserved better than this. 3 residents were interviewed along with R27. R27 had complaints of treatment and reported RN-A kept saying to her you're just going to timeout and kept putting her in a timeout. When R27 asked why, RN-A told R27, you don't know what you are doing. The questions about staff talking respectfully to others and if she felt safe here were blank. The question about who to report to R27 had reported she would talk with her daughter. The other 3 residents felt like they were treated respectfully and had no concerns. None of the interviews were dated when they occurred or identified who asked the questions. The resolution section and follow-up comments on the grievance report were left blank. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The administrator signed off the report on 3/5/26. There was no indication the administrator or DON acted per the facility policy on the alleged allegations of verbal abuse and involuntary and reported the allegations to the SA. Interview on 7/29/26 at 3:26 p.m. with regional clinical service director identified the grievance forms were missing information including a thorough investigation of each grievance with follow up to the concerned party. She agreed that the facility should have acted upon that email and the grievances (allegations of verbal abuse and involuntary seclusion) should have resulted in the suspension of RN-A and the administration should have immediately started an investigation. She revealed in all the grievances reviewed from November and December 2025, there seemed to be a pattern of only interviewing the parties identified in the concern and agreed that further interviews should have been completed to ensure a thorough investigation had occurred. She further agreed that the resolution and follow-up with the party concerned was lacking in most of the reviewed grievances and should have been completed per facility policy to ensure a satisfactory resolution. Her expectation was that the facility would brainstorm to ensure all grievances were handled and resolved appropriately. She made no mention the grievances were allegations of verbal abuse and involuntary seclusion and should have been reported to the SA immediately. Interview on 7/30/26 at 8:07 a.m., with the administrator identified he felt the facility did start an investigation. The DON-A was to complete the investigation and that was why he had not participated in it. He reached out to DON-A who reported the concern. DON-A did educate RN-A but did not document that education. The facility completed interviews with residents last night (7/29/26) (nine after the incidents) and suspended RN-A while a new investigation was being conducted. He stated there was no verbal abuse identified and the situation had been handled as R27 had no concerns and there had been no lasting effect, and no signs of psychosocial distress. The administrator declined to answer if RN-A should have been suspended when the incidents occurred for R30 and R44 in order to potentially prevent further incidents with R27 and other residents. Review of the 4/7/25, Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy and Rehab policy identified the policy was created to ensure employees were knowledgeable regarding the reporting and investigative process of abuse and neglect allegations, and ensure an effective system was in place that prevented mistreatment, neglect and abuse. It was also designed to ensure a complete review by the investigative team was completed to identify allegations of abuse and neglect were promptly reported and investigated. Allegations involving mistreatment, neglect, or abuse were to be reported immediately to the administrator in order to intervene and protect residents. With an allegation of employee to resident abuse, the employee was to be removed from providing direct care to all residents. And be placed on suspension pending the results of the investigation. Allegations were to be reported immediately but no later than 2 hours after the allegation was made. Allegations that did not involve abuse and had no serious bodily injury were to be reported no later than 24 hours after the allegation was made. The investigation team (social worker (SW), DON and administrator) were to review all events no later than the next working day following the event. The facility was to ensure someone was assigned to complete the investigation and the SW or designee was to notify the SA. The investigation was to include interviewing employees, residents and/or witnesses to the event, but made no mention of interviewing others not directly involved but who may have knowledge about other pertinent facts or data of incidents. The SW or designee was to report results of all investigations to the SA within 5 working days of the event.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and document review, the facility failed to notify the designated State Mental Health Authority (SMHA) for 1 of 1 sampled resident (R8) who had a mental illness diagnosis not identified on the Pre admission Screen (PAS). Findings include: R8's 5/23/26, accepted quarterly Minimum Data Set (MDS) assessment identified her cognition was intact and she did not display any behaviors during the assessment period. R8 had a diagnosis of bipolar disorder (a mental health condition characterized by significant mood swings). R8's Pre admission Screen (PAS) level I completed on 10/09/2020, indicated R8 did not have a diagnosis of bipolar disorder or other mental illness, and a level II assessment was not required. R8's 7/29/26, diagnosis report identified R8 had diagnosis of bipolar disorder added on 4/29/21. R8's medical record lacked evidence R8 was referred to the SMHA after the identification of the bipolar disorder diagnosis. Interview on 7/29/26 at 1:38 p.m., with social service designee (SSD) identified she had not been reviewing the PAS to ensure a level II screening was completed if needed. She confirmed she had not notified the county for a level II however, R8 was being seen by psychiatry. She reported she had never done a level II referral to the local authority and had always just gone by what the PAS indicated. Interview on 7/30/26 at 11:30 a.m., with regional clinical service director identified the facility should be reviewing the PAS for accuracy and should follow up with the mental health authority if a mental illness was identified as a diagnosis and not identified on the PAS for a level II screening. Review of the 12/29/25, Pre-admission Screening and Resident Review (PASARR) policy identified residents would be screened for mental illness prior to admission. The PASARR was a level I screening and completed prior to admission to identify mental illness or related condition who then would need a level II screening and determination prior to admission. These screenings ensure that a resident who has a mental health disorder or related condition will be offered the most appropriate setting and services to meet their needs. A positive level I screening requires a level II screening by a state designated authority. The policy identified that the level I screening would be reviewed by the admissions coordinator, social services, or designated individual to determine whether a level II screening was required.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 1 of 1 resident was discharged home with non-controlled medications. Findings include: R39's accepted 5/8/26, accepted Minimum Data Set (MDS) assessment identified he was re-admitted to the facility the beginning of April 2026 for rehabilitation following a surgical procedure, and discharged [DATE]. R39 had diagnoses of a wedge compression fracture of (spinal fracture where the front of a vertebra collapses while the back stays intact), pulmonary fibrosis (lung disease that occurs when lung tissue becomes damaged and scarred making it harder for the lungs to work properly) heart disease, high blood pressure, Barrett's esophagus (damage to windpipe caused by acid reflux) ventricular tachycardia and supraventricular tachycardia (potentially life threatening arrhythmias that can lead to cardiac arrest), pneumonia, and pulmonary embolism (blood clot in lungs (PE)). R39's Medication Administration Record (MAR), in effect at the time of discharge on [DATE], identified R39 was receiving: Diltiazem (anti-arrhythmic medication to stabilize heart rate) extended release, 120 milligrams (mg) daily. Lidocaine patch 4% (used for pain control), to be applied topically to the lower back related to his wedge fracture, 1 x per day. Pantoprazole (prescription antacid) 20 mg daily for Barrett's esophagus treatment. Apixaban (blood thinner) 5 mg twice daily (BID) for diagnosis of PE. Mupirocin 2 % (antibiotic ointment) to be applied under his nose every 12 hours. Trolamine Salicylate 10% (pain cream). R39's discharge notes identified R39 was only sent home with his mupirocin ointment and the trolamine ointment. All other current prescriptions were sent to the local pharmacy for new prescriptions. Email correspondence on 7/30/26 at 8:16 a.m., with the MDS nurse (MDS-A) identified they had not sent R39's other medications home with him upon his discharge, just what was indicated in the discharge notes. There was no mention if this was the usual facility practice when asked. Follow-up email from MDS-A on 7/13/26 at 10:39 a.m., identified she spoke with the discharge nurse who relayed staff may send any bottled medications that are ordered, and they are discharging home on. That may include OTC medication, lotions, creams and we would document what was sent with the resident in the note if that was the scenario. Review of the 8/29/26, Medication: Disposition (Disposal) policy identified there was no mention of direction for staff, when a non-controlled medication was in effect at the time of discharge, that the remainder was to be sent with the resident upon discharge or at minimum. The policy only directed staff for the disposal of any medication was to be carried out under local, state and federal guidelines or in consultation of the pharmacist in the appropriate disposal procedure. Documentation was to include the resident's name, medication name, prescription number (as applicable), quantity, date of disposition and the staff member involved, consultant or other applicable individuals.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Jackson		STREET ADDRESS, CITY, STATE, ZIP CODE 601 West Jackson Jackson, MN 56143	
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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure the binding arbitration agreement was fully explained in a manner they or their representatives understood, including their right to not sign the agreement, for 3 of 4 residents (R31, R6, R40) reviewed for arbitration. Findings include: Review of the undated facility resident listing report identified R31, R6, and R40's Arbitration Agreement Response was yes. R31's comprehensive Minimum Data Set (MDS) assessment accepted on 7/31/26, identified she admitted to the facility on [DATE], and her cognition was moderately impaired. Review of R31's medical record identified that her resident representative/family member (FM)-A signed a Resolution of Legal Disputes/Arbitration Agreement on 7/15/26. Interview on 7/28/26 at 3:00 p.m., with FM-A identified she did not know what arbitration was. She did not recall the facility explaining it to her and did not recall signing an agreement. FM-A picked up a folder and said this is everything they gave me on admission day, the folder did not contain a copy of the arbitration agreement. FM-A identified she would like a copy of the agreement so she could review it before the 30 days were up. R6's comprehensive MDS accepted on 6/26/26, identified she was admitted on [DATE] and her cognition was intact. Review of R6's medical record identified her representative/family member had signed an arbitration agreement on the day of admission 6/11/26. Interview on 7/29/26 at 4:30 p.m., with FM-B identified she was not sure if they explained arbitration to her. She was not aware that she agreed not to use courts if they had a dispute. She identified the day of the admission as a hectic day and she had to sign a lot of papers. She was not sure that she would have agreed to the arbitration if she would have understood what it was. She further identified that she was very overwhelmed that day and she made that known to the facility. R40's Entry MDS identified she was admitted on [DATE]. Review of R40's medical record identified she had signed an arbitration agreement on the day of admission 7/21/26. Interview on 7/29/26 at 11:01 a.m., with R40 identified she was not aware of what arbitration was, she did not recall being given an explanation of what arbitration was and did not recall signing an Arbitration Agreement. She reviewed her folder that had been provided by the facility with her admission paperwork and said she did not receive a copy of the agreement. Interview on 7/28/26 at 2:23 p.m., with the social service designee (SSD) identified, sometimes she went through the paperwork quickly because the resident and/or representative didn't want to hear all the details of the admission paperwork. She asked them if there was a legal dispute would they be willing to work with an unrelated arbitrator to resolve a legal dispute, if they answered no, then she said if there was a legal dispute they could obtain council and the facility would obtain council and they would go through the court system. She identified that she did not go into detail and did not provide a copy of anything unless they asked for it. Interview on 7/29/26 at 11:03 a.m., with the administrator identified he had received training upon hire that they were to tell residents that arbitration meant working with a third party that did not represent the facility or the resident and avoided going to court. He was not sure if they were required to give the resident and/or the resident representative a copy of the agreement. The administrator said it could not be proven that the resident and/or representative did not receive a copy because they could have taken it home and that it was a [NAME] point. They did not have the residents or representatives explain their understanding of the agreement prior to having them sign it. A policy was requested but nothing was provided by the end of the survey period.		

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview and document review the facility failed to ensure 1 of 8 sampled staff (nurse aide (NA)-E) reviewed for annual required Alzheimer's Disease and Related Disorders training had been completed. Findings include: Review on 8/30/26 of the requested annual Alzheimer's and dementia training for 8 sampled staff identified nursing assistant (NA)-E failed to complete the required annual training. Interview on 8/30/26 at 1:30 p.m., with the administrator identified NA-E had failed to complete the annual training. They typically assign the training in their online training program; however, he had not realized NA-A had failed to complete his required training. A policy was requested but nothing was provided by the end of the survey period.		