Electronically Delivered

November 20, 2025

Licensee
KSMS Our House LLC
1313 15th Avenue Northwest
Austin, MN 55912

RE: Project Number(s) SL24097016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 6, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24097	A. BUILDING: _____ B. WING _____	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KSMS OUR HOUSE LLC	1313 15TH AVENUE NW AUSTIN, MN 55912

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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL24097016-0 On November 3, 2025, through November 6, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 50 residents; 43 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 4, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 485		

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0 485	Continued From page 4 affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On page four of the licensee's assisted living contract, Section II Services included: B. The community offers the meal plans as described on the schedule of fees. The licensee's Exhibit 1 Schedule of Fees (part of the assisted living contract) noted the following services, products and charges are in addition to the monthly fee: 3-meals per day plan; no meals per day plan. The licensee's schedule of fees for the meal plans lacked an option for residents to opt out of payment for one or two meals residents would not want. On November 6, 2025, at 1:52 p.m., registered nurse/licensed assisted living director (RN/LALD)-C stated the same assisted living contract was used for all residents and did not offer residents to opt out of one or two meals the resident would not want. On November 6, 2025, at 2:14 p.m., executive director (ED)-A stated she was aware it was in the contract and not allowed. ED-A further indicated being unable to make any changes to the contract without upper management involvement.	0 485		

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0 485	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a current two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of two employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 6 violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Facility TB Risk Assessment dated October 1, 2025, indicated the licensee was a "low risk." ULP-F had a hire date of February 4, 2025. ULP-F's record included a TB symptom screen dated February 4, 2025, and a negative QuantiFERON blood sample dated October 14, 2024. The record lacked evidence of TB testing upon hire or within 90 days prior to hire. On November 6, 2025, at 2:01 p.m., registered nurse/licensed assisted living director (RN/LALD)-C stated ULP-F's record did not include evidence TB testing had been completed upon hire or within 90 days of hire. RN/LALD-C stated she thought TB screening and testing could be done within 12 months of hire. "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The	0 660		

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0 660	Continued From page 7 second TST may be performed after the health care worker (HCW) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan dated October 27, 2025, included a hazard and vulnerability assessment and various policies/procedures. However, the plan lacked the following required content: Development of all policies/procedures for: -Roles under a waiver declared by secretary; On November 6, 2025, at 2:08 p.m., registered nurse/licensed assisted living director (RN/LALD)-C and executive director (ED)-A stated the emergency preparedness binder had been altered with changes in management. RN/LALD-C and ED-A indicated the licensee lacked the above requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680		

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0 680	Continued From page 9 (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). There are two buildings on this campus. Facility staff identified one building as "21" which housed assisted living residents. The other building was called "22" and housed assisted living with memory care residents. The findings include: BUILDING 21 During facility tour of building 21 on November 4, 2025, from 12:19 p.m. through 1:28 p.m., with assistant director (AD)-D and maintenance tech	0 775		

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0 775	Continued From page 10 (MT)-G, the surveyor observed a half high door at the top of the basement stairs. The door was equipped with a handle that required a key to unlock from both sides and these stairs were the only exit from the basement area. State Fire Code in Minnesota Rules, chapter 7511 requires exit doors be equipped with hardware that is operable from the egress side of the door without the use of keys or special knowledge. MT-G stated they had a lock and key company scheduled to replace all resident room locks so they would have them replace this handle as well. During same tour the surveyor observed a 45-minute fire rated door to the main floor laundry room that had the door closer removed. The second-floor laundry room door was equipped with a door closer, but the door did not latch properly. State Fire Code in Minnesota Rules, chapter 7511 requires fire rated doors be maintained to automatically close and latch as designed. During same tour the surveyor observed a table on the second-floor deck with a small ashtray on it. There was cigarette butts and ashes scattered around on and between the deck floorboards, including a large pile of cigarette butts on a floor mat with garbage and leaves right next to the building. State Fire Code in Minnesota Rules, chapter 7511 prohibits the discarding of cigarettes, ashes, or other burning objects on combustible surfaces. AD-D and MT-G verified the above findings while accompanying on the tour and stated they understood the requirements.	0 775		

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0 775	Continued From page 11 BUILDING 22 During facility tour of building 22 on November 4, 2025, from 1:32 p.m. through 1:54 p.m. with MT-G, licensed practical nurse/executive director (LPN/ED)-H, assistant director (AD)-I and assistant director (AD)-J the surveyor observed magnetic locks that required a code to unlock them at all exterior exit doors. MT-G stated that the locks were not capable of being deactivated by a signal or switch located in an approved location as required in State Fire Code in Minnesota Rules, chapter 7511. During same tour the surveyor observed yellowed smoke alarms in resident rooms three and six. MT-G stated that several other resident rooms had the same style smoke alarms. MT-G stated that they replace smoke alarms when the resident rooms are vacated and that the yellowed alarms may be original to the building and have not been replaced. State Fire Code in Minnesota Rules, chapter 7511 requires smoke alarms to be replaced when they fail to operate or when they exceed ten years from the date of manufacture. MT-G verified the above findings while accompanying on the tour and stated they understood the requirements.	0 775		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for	0 780		

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	24097	A. BUILDING: _____ B. WING _____	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KSMS OUR HOUSE LLC	1313 15TH AVENUE NW AUSTIN, MN 55912

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0 780	Continued From page 12 sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or	0 780		

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0 780	Continued From page 13 a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During facility tour of building 21 on November 4, 2025, from 12:19 p.m. through 1:28 p.m., the surveyor entered resident room 118 with assistant director (AD)-D and maintenance tech (MT)-G. MT-G tested the smoke alarm in the living room area. The surveyor observed that the smoke alarm inside the bedroom was not interconnected with the smoke alarm that was tested. During the tour the same condition was observed in resident room 207. MT-G removed the smoke alarm from the living room area in resident room 207 and stated that the wires were not properly connected. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. AD-D and MT-G verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 14 (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 15 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 4, 2025, at 2:38 p.m., assistant director (AD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN FOR BUILDING 21 The licensees FSEP titled, Our House Senior Living Fire Response Policy, undated, failed to include the following: The FSEP included standard employee procedures but lacked specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alert, Confine, and Extinguish or Evacuate) but the plan had not been updated to provide complete and specific actions for employees to take at this licensed facility. The plan included procedures for staff such as alerting other staff members via the communication system and placing a pillow or towel by the door of rooms that were evacuated. During interview at 2:59 p.m. AD-D stated that the facility did not have a communication system	0 810		

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0 810	Continued From page 16 and staff use ribbons to identify evacuated rooms and not pillows. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On November 4, 2025, at 2:59 p.m., AD-D stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	01060		

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01060	Continued From page 17 (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the	01060		

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01060	Continued From page 18 situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, osteoarthritis (joint pain, stiffness, and reduced mobility), high blood pressure, and atrial fibrillation (irregular heart rhythm). R1's after visit summary and discharge instructions dated October 28, 2025, indicated R1 was hospitalized on October 24, 2025, and discharged October 28, 2025, for acute kidney injury. R1's record lacked a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC the resident had been relocated and had not returned to the facility within four days. On November 6, 2025, at 1:56 p.m., registered	01060		

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01060	Continued From page 19 nurse/licensed assisted living director (RN/LALD)-C stated R1's record lacked a written notice related to R1's emergency relocation. In addition, R1's record lacked notification to the OOLTC that R1 had been relocated and had not returned to the facility within four days. RN/LALD-C stated this was missed because the licensee had a change in nurses. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01330		

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01330	Continued From page 20 review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care by one of two unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on May 7, 2019, to provide direct care services to the residents. On November 4, 2025, at 7:53 a.m., the surveyor observed ULP-E administering medications to R3, R7, and R6. ULP-E's employee record lacked evidence ULP-E had been trained and/or competency tested in the following: (1) training on the prevention of falls. On November 6, 2025, at 2:07 p.m., registered nurse/licensed assisted living director (RN/LALD)-C and executive director (ED)-A stated the licensee had changed training venues since ULP-E had been hired. RN/LALD-C and ED-A indicated ULP-E should have had all the required trainings and competencies, but they were unable to provide it. No further information was provided.	01330		

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01330	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01330		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system;	01790		

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01790	Continued From page 22 (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) trained and ensured competency for two of two employees (unlicensed personnel (ULP)-E, ULP-F) providing medications for residents with unplanned time away from home when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01790		

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01790	Continued From page 23 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings included: ULP-E was hired on May 7, 2019. ULP-F was hired on February 4, 2025. ULP-E and ULP-F's employee record lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home. On November 6, 2025, at 2:04 p.m., registered nurse/licensed assisted living director (RN/LALD)-C stated both ULP-E and ULP-F administered medications and would encounter times when they would need to get medications ready for a resident to take with them for unplanned time away. RN/LALD-C stated there was a form for this competency but was unable to locate it, indicating both ULP-E and ULP-F's employee records lacked the above required competency. The licensee's policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications had an opened date for one of one resident (R1) with insulin. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes. R1's Individual Service Plan (ISP) and Care Plan (identified as the service plan) dated effective June 9, 2025, indicated R1 received assistance with medication administration. R1's prescriber orders dated April 9, 2025, included orders for: - insulin aspart (fast-acting insulin) flexpen inject 7 units subcutaneously three times daily before	01890		

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01890	Continued From page 25 meals. On November 4, 2025, at 12:14 p.m., the surveyor observed unlicensed personnel (ULP)-L administer insulin aspart to R1. R1's insulin aspart pen was not dated when opened. ULP-L stated all insulin pens were to be dated when opened and stated this was not completed for R1's insulin pen. On November 5, 2025, at 11:33 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated staff are expected to date all insulin pens upon opening. The manufacturer's NovoLog (insulin aspart) FlexPen Instructions for Use revised February 2023, indicated: In-use pen: The NovoLog FlexPen you are using should be thrown away after 28 days, even if it still has insulin left in it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures	01960		

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	24097	A. BUILDING: _____ B. WING _____	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KSMS OUR HOUSE LLC	1313 15TH AVENUE NW AUSTIN, MN 55912

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01960	Continued From page 26 that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes, osteoarthritis (joint pain, stiffness, and reduced mboility), high blood pressure, and atrial fibrillation (irregular heart rhythm). R1's Individual Service Plan (ISP) and Care Plan (identified as the service plan) dated effective June 9, 2025, indicated R1 received assistance with thrombo-embolic deterrent (TED)stockings (compression socks to prevent blood clots and swelling in the legs) twice daily. R1's prescriber orders dated July 24, 2025, included an order for compression stockings on in AM and off in PM. On November 3, 2025, at 12:30 p.m., November	01960		

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01960	Continued From page 27 4, 2025, at 1:52 p.m., and November 5, 2025, at 9:53 a.m. the surveyor observed R1 sitting in the 2nd floor sunroom wearing purple grippy socks and shoes. R1 was not wearing compression stockings. R1 stated she is supposed to wear TED socks, but staff have not been putting them on. On November 5, 2025, at 11:20 a.m., unlicensed personnel (ULP)-L stated she could not find R1's TED socks to apply. At this same time, ULP-M interjected R1 did not wear compression stockings and hadn't for a "long time". R1's Service Checkoff List dated November 1, 2025, through November 5, 2025, included staff initials that compression stockings had been applied or removed on the following dates: November 1, 2025, both AM and PM shift; November 2, 2025, both AM and PM shift; November 3, 2025, both AM and PM shift; November 4, 2025, both AM and PM shift; November 5, 2025, both AM and PM shift; On November 6, 2025, at 1:44 p.m., registered nurse/licensed assisted living director (RN/LALD)-C stated she was not aware staff were not applying the compression stockings to R1 and indicated staff should not document the task as completed if they are not applying the stockings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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02040	Continued From page 28 An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On November 4, 2025, at 1:55 p.m., the surveyor	02040		

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02040	Continued From page 29 requested from licensed practical nurse/executive director (LPN/ED)-H and assistant director (AD)-I documents on the hazard vulnerability assessment for the physical environment of the facility. During an interview on November 4, 2025, at 2:25 p.m., LPN/ED-H and AD-I verified that the licensee was not able to provide documentation of a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. LPN/ED-H and AD-I stated they were not aware of this requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility	02240		

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02240	Continued From page 30 Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written acknowledgement of receipt of the current assisted living bill of rights was obtained for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	02240		

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02240	Continued From page 31 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted for services on July 3, 2012. R1's diagnoses included diabetes, osteoarthritis (joint pain, stiffness, and reduced mobility), high blood pressure, and atrial fibrillation (irregular heart rhythm). R1's Individual Service Plan (ISP) and Care Plan (identified as the service plan) dated effective June 9, 2025, indicated R1 received assistance with dressing, grooming, toileting, bathing, blood sugar checks, medication administration, thrombo-embolic deterrent (TED) stockings (compression socks to prevent blood clots and swelling in the legs) twice daily, light housekeeping, and laundry. R1's Assisted Living Contract was signed on February 22, 2024. R2 R2 was admitted for services on January 22, 2022. R2's diagnoses included dementia, hypertension, and anxiety. R2's service plan dated effective September 2, 2025, indicated R2 received assistance with dressing, grooming, bathing, toileting, safety checks, behaviors, compression stockings,	02240		

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02240	Continued From page 32 medication administration, laundry, and light housekeeping. R2's assisted living contract was signed February 20, 2024. R3 R3 was admitted for services on February 5, 2025. R3's diagnoses included Alzheimer's disease and delirium (confused thinking and lack of awareness of someone's surroundings). R3's service plan dated effective June 13, 2025, indicated R3 received assistance with bathing, toileting, behaviors, medication administration, laundry, and light housekeeping. R1, R2, and R3's record lacked written acknowledgement that they received the current Minnesota Bill of Rights for Assisted Living Residents, as required. On November 6, 2025, at 2:14 p.m., registered nurse/licensed assisted living director (RN/LALD)-C stated the Bill of Rights had been provided on admission and had a signature sheet indicating that. RN/LALD-C was unable to provide paperwork acknowledging the receipt. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services	02320		

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02320	Continued From page 33 (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to policy and accepted standards of practice by one of one unlicensed personnel (ULP-F) observed during insulin administration. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes. R1's Individual Service Plan (ISP) and Care Plan (identified as the service plan) dated effective June 9, 2025, indicated R1 received services including medication administration. R1's prescriber orders dated April 9, 2025, included orders for: - insulin aspart (fast-acting insulin) flexpen inject	02320		

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02320	Continued From page 34 7 units subcutaneously three times daily before meals. On November 4, 2025, at 12:14 p.m., the surveyor observed ULP-F administer insulin aspart to R1. ULP-F removed the cap from R1's insulin aspart and applied a new needle. ULP-F did not use an alcohol prep pad to cleanse the port of the pen before applying the needle. ULP-F did a 2-unit air shot to prime the pen, then dialed the insulin to the prescribed amount, used an alcohol pad to cleanse R1's abdomen and injected the insulin and immediately removed the insulin pen from R1's abdomen. Immediately following the observation, the surveyor asked ULP-F if she ever utilized alcohol to cleanse the port of the insulin pen prior to applying the needle, and also about leaving the needle in place for at least six seconds after injecting the insulin. ULP-F stated she should have cleansed the insulin pen prior to applying the needle but was not aware she should hold the needle in place for at least six seconds indicating she had not been trained to do that. On November 5, 2025, at 11:35 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated staff are trained to use an alcohol wipe to insulin pen hub before applying the new needle and should inject and leave needle in place for at least five seconds. The manufacturer's NovoLog (insulin aspart) FlexPen Instructions for Use revised February 2023, indicated: Preparing you NovoLog FlexPen A. Pull off the pen cap, wipe the rubber stopper with an alcohol swab. B. Removed the protective tab from a disposable	02320		

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02320	Continued From page 35 needle, screw the needle tightly onto your FlexPen. Giving the injection I. Insert the needle into your skin. Inject the dose by pressing the push-button all the way in until the 0 lines up with the pointer. J. Keep the needle in the skin for at least 6 seconds and keep the push-button pressed all the way in until the needle has been pulled out from the skin. This will make sure that the full dose has been given. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

KSMS OUR HOUSE LLC
1313 15TH AVENUE NW
Austin, MN 55912
Mower County
Parcel:

Phone:
Jhorgeshimer@ourhouses1.com

License Info

License: HFID 24097
Jennifer Dingley-Horgedhimer
Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1038251117
Inspection Type: Full - Single
Date: 11/4/2025 Time: 9:22:42 AM
Duration: 60 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT:
NO ONE ON STAFF HAS THE CFPM CARD.
Comply By: 1/30/2026 Originally Issued On: 11/4/2025

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Rochester District Office inspection report number F1038251117 from 11/4/2025

Jennifer Dingley-Horgeshimer
Kitchen Manager

Rob Davis,
Public Health Sanitarian 2
rob.davis@state.mn.us