*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL240972961M
**Compliance #:** HL240971555C

**Date Concluded:** August 12, 2026

**Name, Address, and County of Licensee Investigated:**
KSMS Our House LLC
1401 15th Avenue Northwest
Austin MN, 55912
Mower County

**Facility Type:** Assisted Living Facility with Dementia Care (ALFDC)

**Evaluator's Name:** Kris Detsch, RN
Special Investigator

**Finding:** Not Substantiated

**Nature of Investigation:**
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

**Initial Investigation Allegation(s):**
The facility neglected the resident when they failed to provide care and services to him as his health declined. As a result, the resident was in unsanitary conditions and required hospitalization.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. Although the resident was soiled with incontinence (stool and urine), the resident had an acute (sudden) condition change. The facility called emergency services to bring the resident to the hospital. The resident continued to have incontinence while in the hospital. The resident had a urinary tract infection (UTI), but he also had a significant decline in his physical and cognitive (memory) abilities. The resident remained in the hospital for an extended time because he became no longer capable of making decisions for himself and required intervention from the legal system (court system) to determine who could help him make decisions for appropriate housing.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed staffing levels, documentation systems, and medication administration.

The resident resided in an assisted living facility. The resident did not live in the memory care unit and could come and go freely. The resident's diagnoses included dementia (memory loss), chronic (long term) pain, incontinence, and absence of his left upper limb (arm). The resident's service plan included assistance with showering/bathing, dressing, toileting, grooming, and behavior management. The resident's nursing assessment indicated he was alert and orientated, but made poor decisions. The resident's behavior included refusing assistance from staff.

Physician visit notes indicated a physician assessed the resident at the facility three weeks prior to this hospitalization. The physician visit notes indicated the resident was alert and orientated but had underlying memory impairment. The resident's health was stable.

Hospital records indicated the while in the emergency room the resident spoke in full sentences, and he did not appear "ill." The resident's lab results indicated he had a UTI and a physician admitted him to the hospital. Hospital records further indicated the resident's health declined. He fell while in the hospital and required a mechanical lift for mobility. The resident's incontinence continued and he developed wounds. The resident's memory declined drastically, and he was no longer able to make decisions for himself. The hospital had to petition the court (legal system) to determine who could make decisions for the resident. The resident remained in the hospital for the duration of this process.

During an interview, the nurse said a staff member went to her for help because they attempted to get the resident up out of bed so he could get toileted, washed, and dressed for the day. The resident would not stand up. The nurse said she went into the resident's room and saw the resident's legs were over the side of the bed and he was partially sitting up. The resident could not stand up, but he was conversational and together they made the decision for him to go to the hospital. The nurse said the staff member told her the resident refused care and help during the night. The nurse said she saw the resident the day before this. He independently obtained transportation and went to Walmart, however he had difficulty shopping and returned to the facility. The nurse said the resident had episodes of forgetfulness, but he wanted to be self-sufficient. The resident was often non-compliant with care and services. The nurse said she sent multiple referrals to other facilities to obtain different housing for the resident.

During an interview, the manager said the resident had alcohol seeking behavior and drank alcohol heavily. This impacted his behavior, and he was aggressive. The manager said the resident left the facility independently, on his own accord. The resident was "his own person"

and made his own decisions. The manager said the facility made multiple attempts to obtain an environment more suitable to meet his changing needs and the facility began the process of terminating his services. The manger said the resident remained at the hospital because his health declined and he was no longer able to move independently or make decisions about himself. The manager said the court system was involved to help make/appoint someone who could make appropriate decisions for the resident regarding his care and service requirements.

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

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

**Neglect: Minnesota Statutes, section 626.5572, subdivision 17**
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

**Vulnerable Adult interviewed**: No. Hospitalized.
**Family/Responsible Party interviewed**: No. Attempted.
**Alleged Perpetrator interviewed**: No. Not Applicable.

**Action taken by facility:**
Staff sent to resident to the hospital when he had a change in condition.

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24097 | A. BUILDING: _____ B. WING _____ | C 07/21/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 0 000 | Initial Comments<br><br>On July 21, 2026, the Minnesota Department of Health initiated an investigation of complaint HL240972783C/HL240973448M and HL240971555C/HL240972961M. No correction orders are issued. | 0 000 | | |