Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306306222M
Compliance #: HL306309131C

Date Concluded: February 21, 2025

Name, Address, and County of Licensee Investigated:
KSMS Our House LLC
204 14th Street NW
Austin, MN 55912
Mower County

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

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Inconclusive

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 the resident fell and laid on the floor for approximately one hour before receiving assistance.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to incomplete and conflicting accounts of the incident, it could not be determined if maltreatment occurred. There was not a preponderance of evidence that staff failed provide necessary cares or services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the case worker. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and major depressive disorder. The resident's service plan included assistance with medication management, dressing, grooming, and every 30 minute safety checks. The resident's assessment indicated the resident had impaired decision making and was forgetful.

Video footage showed the resident moving through the frame of the video. The video had an obstructed view, but outside of the video frame the resident was heard saying "owww, owww" with additional unintelligible speaking.

The medical record indicated facility staff documented the resident was sleeping in her bed when safety checks were completed.

A police report indicated police arrived at the facility with reports the resident was seen on video footage by the family laying on the floor in her apartment. The resident was in her apartment responsive on the floor. The resident had no obvious injuries, and the resident was transported to the hospital for evaluation.

Hospital records indicated the resident was on the floor for an unknown period of time and no injuries noted. The resident was treated for a bladder infection and was discharged to a new facility.

During an interview, facility staff stated she worked the night of the incident but left her shift early. A coworker had completed the safety checks and documented with her name.

During an interview, facility management stated the facility was not provided the video footage from the incident; however, through medical record review and interviews the staff completed the cares scheduled for the resident. After the incident the resident did not return to the facility.

During an interview, a family member stated she had several concerns with the care her mom received at the facility and had five cameras throughout the apartment. A family member stated the night of the incident the resident laid on the floor for almost two hours and was saturated in urine when arriving to the hospital. A family member stated the resident moved to a different facility and was doing well at the new facility.

Attempts made to interview facility staff working the night of the incident were not successful.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, resident no longer lived at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility investigated the incident when it occurred and provided education to facility staff.

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
	30630	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KSMS OUR HOUSE LLC	204 14TH ST 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
0 000	Initial Comments On January 22, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306309131C/#HL306306222M and #HL306309129C/HL306306221M. No correction orders are issued.	0 000		