

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306306443M
Compliance #: HL306305128C

Date Concluded: November 17, 2025

Name, Address, and County of Licensee

Investigated:

KSMS Our House
204 14th Street NW
Austin, MN 55912
Mower County

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

Evaluator's Name: Julie Serbus, 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 the resident fell while taking a shower resulting in a fracture of her right arm.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. While it was true the resident experienced a fall, she was not taking a shower at the time of the fall but was attempting to use the bathroom when she lost her footing and fell partially into the shower located in front of the toilet. Facility staff present at the time of the fall had followed the service plan.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident record(s), hospital records, facility internal investigation, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident's bathroom where the fall had occurred.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and was enrolled in hospice. The resident's service plan included one staff assistance with showering, scheduled toileting, and dressing. The resident's assessment indicated the resident was independent with all transfers and mobility. The resident did not use a walker or cane but did have a wheelchair family used for long outings out of the facility if needed. The resident did not have a history of falls but exhibited impaired cognition which may increase the risk of falls.

The resident medical record indicated the resident was with a caregiver when she entered the bathroom in her apartment, lost her footing, and fell landing on the bathroom floor with her upper body in the shower. The resident was in pain and was sent the emergency department.

The resident's discharge emergency department record indicated the resident was evaluated and diagnosed with a displaced fracture of the right proximal humerus (long bone in the arm that runs from shoulder to the elbow). The same document indicated the resident was treated with splint and a sling and returned to the facility the same day.

During an interview, an unlicensed caregiver stated resident had been walking with the resident back to her room to use the bathroom. The caregiver stated the resident did not use an assisted device to walk but instead put her hand out to be held and seems to feel more comfortable holding onto someone's hand. Upon entering the bathroom, the resident lost her footing and began to fall. The caregiver attempted to break the fall but could not and the resident landed with her upper body in the shower, which was in front of the toilet. The caregiver stated she used the call light to call another caregiver to help as the resident was in pain. After reaching out to the resident's contacts, the resident transferred to the emergency department. The caregiver stated the resident was wearing proper footwear (tennis shoes) at the time of the fall. She noticed a few droplets of water between the sink and toilet area but no significant amount or puddle.

During an interview, a nurse stated the resident was care planned for independent with walking, but caregivers were aware the resident would either raise her hand or use the call light and ask for someone to hold her hand while she walked. The nurse stated the morning of the fall the resident asked to use the bathroom and when walking back to her room resident had reported to staff, she was feeling kind of wobbly. The nurse stated when hospice aid gives weekly shower, they are very good at ensuring bathroom is cleaned up and bathroom floor is dry. the resident's clothes were reported wet after she fell, and this was due to the floor of the shower being wet however the resident was not taking a shower at the time of the fall nor was the actual bathroom floor wet.

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

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

“Neglect” means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No; deceased.

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: NA

Action taken by facility: No action required.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30630	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/22/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER KSMS OUR HOUSE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>On October 22, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306305128C/#HL306306443M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____