Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL240973801M
Compliance #: HL240974247C

Date Concluded: October 1, 2024

Name, Address, and County of Licensee Investigated:
KSMS Our House LLC
1401 15th Ave NW 22
Austin, MN 55912-1911
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 facility failed to seek medical evaluation earlier for a change in condition including being unresponsive. The resident was hospitalized and found to be septic.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did become septic (a systemic infection), the facility had assessed the resident appropriately and sent her to the hospital. The medical record indicated the resident had been responsive earlier that same day. Additionally, the facility sent the resident to the hospital on multiple occasions and the resident had been on multiple courses of antibiotics for urinary tract infection in the weeks leading up to this event.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member and emergency responder staff. The investigation included review of the resident's assessment, plan of care, progress notes, hospital records, facility internal investigation, and related facility policies and procedures. Also, the investigator conducted an onsite visit to the facility and observed staff to resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included history of urinary tract infections, severe intellectual disabilities, multiple mental illness diagnoses, and dementia. The resident's service plan included assistance with toileting, showering, and medication administration. Service plan included interventions when resident displayed periods of refusals, behaviors, and outbursts.

The resident's assessment indicated the resident was alert, oriented to person but was forgetful, unable to provide accurate information consistently and had impaired decision-making. The resident was independent with ambulation and transfers. The resident's level of cognitive function and behaviors fluctuated. The resident's medical record indicated she had periods of crawling on the floor, lying on the floor in common areas, standing on tables, and refusing medications and cares.

One day the resident was transported to the emergency room due to a change in her level of consciousness. A concern arose that the resident had not been responsive for three days prior to hospitalization.

On the evening the facility sent the resident to the hospital, the resident's medical record indicated an unlicensed caregiver entered the resident's apartment to check on the resident and found the resident was not responding, her face was flush and reddened. The caregiver took the resident's temperature, called the on-call nurse, and was directed to call for emergency medical services. The same document indicated the resident had been sleeping throughout the day but had eaten, conversed with staff, and took her medications also.

The resident's progress notes indicated the evening staff discovered the resident's condition has changed and transferred to the hospital unresponsive. However, the same documents indicated staff members had been in the resident's room multiple times throughout the day, resident was verbal with staff directing staff to leave her room, and the resident refused to get out of bed.

In the weeks prior to this hospitalization, the resident's medical record also indicated the resident had multiple emergency department visits for urinary tract infections and uncontrolled behaviors.

A review of medical provider notes indicated the resident was noncompliant with prescribed medications, within the recent months had numerous recent visits to the emergency department for urinary tract infections, agitation, and escalated behaviors. The provider notes also indicated medication changes had also been attempted and the resident had been followed by her medical provider in person at least twice a month.

During an interview, an unlicensed caregiver stated the day prior to the incident the resident had been out of her room and watching TV in the back commons area. On the day of the incident the caregiver was working in the building when another caregiver came out of the resident's room and said the resident had a fever, so the on-call nurse was contacted who directed that emergency medical services be contacted. Caregiver #1 stated when emergency medical service arrived, she was in the resident's room but left the room as there was not enough space in the room. The caregiver stated she reentered the room when she heard an emergency medical service personnel verbally call out to come assist transfer the resident from her bed to a gurney.

During an interview manager #1, who was also a nurse, stated the resident was care planned as independent for transfers. Manager #1 stated staff are trained to use a mechanical Hoyer lift as needed for resident transfers. Management stated on the day emergency medical services were called the resident had been verbally responding throughout the day.

During an interview management #2 stated the resident had been sent to the emergency department five or six times in the past few months. Manager #2 stated the resident was responsive and alert and had last seen the resident alert prior to leaving the facility earlier that same day.

During an interview manager #3 stated towards the end of the residents stay at the facility the resident had been refusing medications.

During an interview, the nurse stated the resident had been having numerous urinary tract infections prior to this hospitalization and had been prescribed multiple courses of antibiotics. Nurse stated the resident was seen by her medical provider at least once every two weeks with several medication changes.

During an interview, a family member stated in the recent six months it seemed as if the resident's urinary tract infections never completely resolved. The family member stated the resident's behaviors had also increased when she had urinary tract infections. The family member stated the resident would often not allow staff to assist her with hygiene and toileting.

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 Page 3 of 3 (2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility:
Facility investigated the incident and collected interviews from staff who were scheduled that evening.

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 08/28/2024

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
0 000	Initial Comments On August 28, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL240974247C/#HL240973801M. No correction orders are issued.	0 000		