Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL240976084M
Compliance #: HL240971451C

Date Concluded: January 22, 2024

Name, Address, and County of Licensee Investigated:
KSMS Our House LLC
1401 15th Ave NW
Austin, MN
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 client when she did not follow the resident's plan of care resulting in the resident falling and fracturing her hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did fall and break her hip when she got up on her own, the facility did have reasonable interventions in place to prevent falls. Additionally, the facility responded appropriately in providing cares after the fall occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's representative. The investigation included review of facility medical records, staff training and education, and facility policies and procedures. The investigator conducted an onsite visit, toured the facility, and observed staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's Disease, osteoporosis, anxiety, insomnia, fall history, restlessness, and generalized muscle weakness. The resident's service plan indicated assistance of one person with transfers, walking, and toileting. The resident's assessment indicated she was alert and oriented to self and required redirection from caregivers.

The facility investigation summary indicated the resident was walking in the dining room when she attempted to sit on her walker, which did not have a seat, and fell onto the floor with caregivers present and watching.

During an interview, the unlicensed caregiver who was working with the resident the day of the incident stated she was assisting the resident to find a location in the dining room to sit down. Once the resident appeared content, the caregiver walked to the opposite side of the dining room to speak to her co-workers about another work-related concern. The caregiver stated as she turned around to walk back, she witnessed the resident falling to the floor. The caregiver stated facility protocol was followed with a set of vital signs (blood pressure, pulse, respiration, and temperature) obtained. The resident denied of pain at the time, and two caregivers assisted resident up off the floor and into a chair. The caregiver stated each resident has a plan of care which can be found in the medication room and listed on the computer and that caregivers document in the resident's record when assigned tasks are completed.

During an interview, the nurse stated the resident has a history being impulsive and unaware of her safety. Later during the same day of the incident, the unlicensed caregivers requested assistance when the resident complained of pain, and she noticed one of the resident's legs was shorter than the other leg, which was concerning for an injury, so the resident was sent to the hospital emergently. At the hospital, the resident was diagnosed with a right hip fracture and hospitalized. The nurse stated the resident was reassessed after she returned, and her care plan was updated.

During an interview, the power of attorney for the resident stated the care the facility provides is good. She stated staff attempts interventions when the resident is restless which include facility activities, visual checks by leaving the resident's door open when she was in her room, and staff providing time visiting when resident when she is restless. Prior to her admission to the facility the resident had experienced falls at her home with multiple broken bones. The power attorney stated the resident is very fragile.

During investigative interviews, multiple unlicensed caregivers stated the resident was a one person assist with cares and this was communicated to the staff through their electronic computer system and will flag the staff with a message if a change has been made to a care plan. Caregivers stated she was a one person assist with cares including stand by assistance with transfers and ambulation. If caregivers were to see her walking or transferring on her own, they were to intervene and assist the resident. Caregivers stated the resident's cognitive status fluctuated as does the residents activity level.

During an interview, facility nurses stated the resident was at high risk for falls. The resident's care plan reflected the care the staff were to provide which included interventions staff were to provide during periods of restlessness or agitation.

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: not a reliable reporter
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
No action taken.

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 12/06/2023

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 December 6, 2023,, the Minnesota Department of Health initiated an investigation of complaint #HL240971451C/HL240976084M. No correction orders are issued	0 000		