Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL240973448M
Compliance #: HL240972783C

Date Concluded: August 12, 2026

Name, Address, and County of Licensee Investigated:
KSMS Our House LLC
1313 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: 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 alleged perpetrator (AP) sexually abused resident #1 when the AP fondled resident #1's penis to "wake him up". The AP sexually abused resident #2 when the AP put their ungloved hand into resident #2's pants.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive for resident #1. The AP denied touching the resident and video footage from inside resident #1's room failed to capture the incident. Another unlicensed staff personnel (ULP) # 1 was with resident #1 and the AP at the time of the incident, but did not report the incident. Management became aware of the allegation from another employee, (ULP) #2, who was not a direct caregiver of the resident.

The Minnesota Department of Health determined abuse was not substantiated for resident #2. The AP denied touching the resident, but other staff saw the AP put her hand down the resident's pants to check if his brief (incontinent product) was wet. This occurred in an open

area with other residents present. Although this action was unprofessional, it did not meet the definition of sexual abuse. The facility retrained staff on reporting and treating residents with respect of privacy.

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

Resident #1 and resident #2 resided in an assisted living memory care unit.

Resident #1

Resident # 1's diagnoses included brain cancer. The resident's service plan included assistance with bathing, dressing, grooming, toileting, and medications. The resident's nursing assessment indicated he was unable to stand or walk and required a mechanical lift (Hoyer) and a wheelchair. The resident required two staff to move him. The resident had memory loss and could not talk clearly. The resident was incontinent (no control of bowel or bladder).

During an interview, a nurse said she was in the process of issuing disciplinary action of ULP #2 for an unrelated issue. ULP #2 became angry during this process and began to yell and cuss at her. ULP #2 said the facility had a staff member who touched residents inappropriately. The nurse said ULP #2 did not identify the staff member or the residents. The nurse said she was unsure how ULP #2 became aware of these incidences because no other staff reported any allegations. The nurse said the facility immediately started an investigation and interviewed all staff members. During this process, ULP #1 said she was with the AP in resident #1's bedroom because they needed to change his incontinent product and get him up for a meal. ULP #1 said the AP opened and pulled back resident #1's brief. The AP touched his penis to try to wake him up. ULP #1 said the AP told resident #1 she was only "teasing him." ULP #1 said the touch only lasted a couple of seconds. ULP #1 said during this action, the AP's position blocked the camera.

Law enforcement records indicated ULP #1 told them the AP lifted resident #1's "diaper" then used a "flicking" motion as she touched his penis. ULP #1 told them the incident last for about one or two seconds. Law enforcement records indicated resident #1's family viewed video footage around the time of the incident, and it showed the AP in the room with ULP #1, but the video footage only captured "clips," and did not show the incident. Law enforcement went to the AP's home and asked her what occurred. The AP denied touching resident #1 and told law enforcement resident #1 had a camera in his room. The AP told law enforcement ULP #1 borrowed money from her, and she had to pay her back. Law enforcement records indicated they did not pursue criminal charges in this case.

During an interview, a manager said ULP #1 told her she was going to inform them (management) of an incident regarding the AP and resident #1, but it “slipped her mind.” Also, ULP #1 said she did not understand the facility’s policy regarding vulnerable adults and the requirement to report these allegations/instances immediately.

Resident #2

Resident # 2’s diagnoses included memory loss and depression. The resident’s service plan included assistance with bathing, dressing, grooming, toileting, and medications. The resident’s nursing assessment indicated he walked independently, but required staff to staff oversight and re-direction because of his memory loss. The resident was incontinent.

During an interview, the nurse said during the investigation of resident #1, two other staff members said they saw the AP put her hand down resident #2’s pants to see if his brief was wet when he was in the hallway. The nurse said staff members indicated this occurred once. The nurse said the AP did not wear a glove, but it was not clear if she touched his skin, or the outer side of his brief. The nurse said staff members did not report any of these allegations prior to their investigation. The nurse said the AP denied all the allegations.

During an interview, the manager said ULP #1 said she saw the AP put her hands down resident #2’s pants to determine if he was wet, but ULP #1 was unsure if this was appropriate behavior. The manager said during the facility’s investigation, other staff also said they saw the AP put her hand down resident #2’s pants to check for incontinence, but none of the staff reported the incident to the manager until after this investigation started. The manager said the facility immediately suspended the AP and the AP is no longer employed at the facility. The manager said the facility provided re-education to all their staff members.

During an interview, ULP #2 said ULP #1 appeared “irritated” so she spoke to her. During their conversation, ULP #1 told her the AP put her hands down resident #2’s pants to check for incontinence. Sometime during this conversation, ULP #1 then told ULP #2 about the incident between resident #1 and the AP. ULP #2 said she was not present when those things occurred and was unsure if the events were accurate. ULP #2 said there were problems with “gossip” within the facility, and she did not know the “facts.” ULP #2 said she planned on telling management about what she heard but did not get the opportunity.

ULP #1 did not respond to requests for interview.

During an interview, the AP said she did not touch resident #1’s penis, or “grope” anyone’s private area. The AP said she assumed resident #1’s camera had a sound component which would have captured any conversations. The AP said ULP #1 helped her change resident #1 and get him up out of bed, but did not make any comments to her while they changed him, or for the duration of their shift about her alleged behavior. The AP said she borrowed money to ULP #1 just a few days before ULP #1’s allegation. The AP denied putting her hands down resident

#2’s pants to check for incontinence because his brief had a strip which turns “blue” when filled with urine.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive for resident #1 and not substantiated for resident #2.

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.

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

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No. Resident #1, unable. Resident # 2, deceased.
Family/Responsible Party interviewed: No, family for resident #1 and resident #2 declined.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Facility provided re-education to staff members.

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
0 000	Initial Comments 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		