Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304061521M
Compliance #: HL304062422C

Date Concluded: April 11, 2025

Name, Address, and County of Licensee Investigated:
Sunrise Village of Milaca
115 9th Street NW
Milaca, MN 56353
Mille Lacs County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katherine Barnhardt 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 restrained and neglected the resident when facility staff failed to provide the resident with a call pendant to summon staff assistance.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility failed to provide a call pendant for the resident for a short period of time when the resident returned from a hospital stay, however, facility staff were working with outside agencies to attain a third call pendant and the resident's room was in an area that staff could see and hear the resident. The lack of a call pendant for a short period of time did not cause harm to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff and unlicensed staff. The investigator contacted a hospice agency. The investigation included review of the resident record(s), hospital records, hospice records,

pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed unlicensed staff provide incontinence cares and assist the resident to get ready for the day.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure (weakened heart condition causing fluid buildup) and chronic obstructive pulmonary disease (progressive lung disease causes chronic respiratory symptoms and airflow limitations). The resident's service plan included assistance with activities of daily living and medication administration. The resident's assessment indicated the resident was a high fall risk, interacted socially with other residents, was dependent on staff and had a history of destroying call pendants and television remotes when upset.

The resident's record indicated the resident would get upset with staff if he felt staff did not respond fast enough when the call pendant was activated. The resident's record indicated the resident had previously been provided two call pendants and the resident had a history of destroying them. The resident's record indicated the resident had destroyed his second call pendant before he was hospitalized for ten days.

The resident's progress notes indicated the resident was sent to the emergency room when he developed shortness of breath and elevated blood pressure. Progress notes indicated the resident was admitted to the hospital for ten days and returned to the facility with a decline in overall health and capabilities. Progress notes indicated the hospital physician ordered hospice support at discharge and a licensed hospice staff visited the resident the next day at the facility.

The resident's hospice records indicated the resident had reported morphine made him feel "loopy" and the resident had received several doses of morphine before a licensed hospice staff visited the resident. Licensed hospice staff noted the resident did not have a call pendant to summon facility staff and indicated the resident told licensed hospice staff he had not had a call pendant for weeks. Hospice records indicated the resident had been hospitalized for ten days prior to the licensed hospice staff visit and had not been at the facility. Hospice records indicated licensed hospice staff approached facility leadership and requested a call pendant for the resident, and a call pendant was provided.

During interview, licensed staff stated the resident had returned from the hospital and did not have a call pendant because he had lost one and destroyed one before his hospitalization and there was an issue about payment for a third call pendant. Licensed staff stated she was unsure how long the resident had gone without a call pendant, but the resident kept his door open, and he was able to summon assistance from staff when needed. Licensed staff stated facility staff were often near the resident's room and provided the resident what was requested or scheduled. Licensed staff stated the resident was provided a new call pendant.

During interview, facility leadership stated the resident would get upset and had destroyed or lost two call pendants prior to a hospitalization. Facility leadership stated the resident did not

have a call pendant when he returned from the hospital because the facility was in the process of determining how the third call pendant would be paid for. Facility leadership stated the resident's room was located where he was monitored closely by facility staff. Facility leadership stated the call pendant situation was reviewed with outside agencies involved with the resident's care and the facility had been told a call pendant had to be provided and the resident would be responsible for the cost. Facility leadership stated the resident had been provided a new call pendant.

During interview, the resident stated he had a working call pendant and had his favorite person helping him with cares.

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: Yes
Family/Responsible Party interviewed: N/A
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility provided the resident with a new call pendant.

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
	30406	A. BUILDING: _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VILLAGE OF MILACA	115 9TH STREET NW #120 MILACA, MN 56353

(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 April 8, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL304061521M/#HL304062422C. No correction orders are issued.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	