Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304069743M
Compliance #: HL304069242C

Date Concluded: April 8, 2025

Name, Address, and County of Licensee Investigated:
Sunrise Village of Milaca
115 9th Street NW 107
Milaca, MN 56353
Mille Lacs County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Katherine Barnhardt RN, Special Investigator

Finding: Substantiated, facility and individual responsibility

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), facility unlicensed personnel, financially exploited resident 1#, resident #2, resident #3, and resident #4, when their narcotic medications were taken by the AP for her own use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation and neglect was substantiated. The AP and facility were responsible for financial exploitation and the facility was responsible for the neglect. At the time of the financial exploitation, the facility's licensed staff were aware the AP was the only unlicensed personnel that had access to alter the actual narcotic count on the computerized system. The facility system lacked consistent and strict narcotic monitoring and control measures to ensure the security of narcotics. The system failure allowed the AP to take narcotic medications from resident #1 and resident #3 for her own use. Resident #2 had no missing narcotics and resident #4's record did not include enough information to substantiate financial exploitation.

During the course of investigation, it was discovered neglect occurred when facility licensed staff failed to intervene when resident #2's prescribed medications were refused and not administered to resident #2 for 27 days. As a result, resident #2 was hospitalized for pulmonary edema.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and a pharmacy. The investigation included review of the resident record(s), hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed unlicensed staff pass medications.

FINANCIAL EXPLOITATION

Resident #1 resided in an assisted living facility. The resident's diagnoses included cerebral palsy (disorder that affects movement, muscle tone and posture) and chronic pain. The resident's service plan included assistance with activities of daily living and medication management. The resident's assessment indicated the resident was mildly cognitively impaired. The resident was prescribed oxycodone (opioid narcotic) 15 mg one tab orally every evening.

Resident #3 resided in an assisted living facility. The resident's diagnoses included Bell's palsy (facial muscle weakness), diabetes and bipolar disease. The resident's service plan included assistance with activities of daily living and medication management. The resident's assessment indicated he had a history of anxiety and pain. The resident was prescribed lorazepam (treat anxiety) 0.5 mg one tab by mouth every six hours as needed and oxycodone 5 mg one tab by mouth every four hours as needed for pain.

Resident #1's electronic medication administration records indicated the resident received oxycodone every evening until the last week of February 2025. Unlicensed staff had not administered the resident's oxycodone for 28 days because the 28-count package of narcotic medications went missing shortly after the pharmacy delivered the medication to the facility and were never located. The narcotic pain medication was unable to be refilled, and the resident went without the pain medication.

Resident #3's electronic medication administration record indicated the oxycodone inventory history log indicated twenty tabs of oxycodone were delivered to the facility and licensed staff added twenty to the resident's oxycodone count. The inventory log indicated over a period of three days after the oxycodone was delivered licensed staff adjusted the narcotic count four times leading to discrepancies in the narcotics remaining. Licensed staff adjusted the narcotic counts after phone call requests from the AP to the facility nurse when the AP reported narcotic administration discrepancies. The medication administration discrepancies were consistently made by the AP and not investigated by licensed staff.

Resident #3's lorazepam medication card was observed by the investigator to have an empty pill spot where a lorazepam tab had been removed and a marker was used to highlight the missing pill with a set of parentheses and a question mark. The facility had no evidence a licensed staff investigated the missing narcotic, and the narcotic inventory log contained discrepancies.

Pharmacy records indicated narcotic medications were delivered at various times during the month for resident #1 and resident #3. Pharmacy delivery records indicated the AP signed for receipt of narcotic deliveries seven out of nine deliveries during the period reviewed. Facility management signed for two of the deliveries during the period and handed the narcotic deliveries off to the AP to secure them in a locked medication cart. Pharmacy records indicated resident #1's oxycodone was delivered to the facility and signed for by facility management, however, the narcotic pack did not get put in the medication cart and was unaccounted for the following morning at shift change. Law enforcement was notified.

Law enforcement records indicated an officer visited the facility to speak with licensed staff. Law enforcement requested video footage and information about the missing narcotics, however, law enforcement stated the facility had not provided the requested information.

The facility's video indicated resident #1's missing 28-count oxycodone was not accounted for during the evening narcotic count completed by the AP and a second unlicensed staff at shift change. Video footage indicated one pack of narcotics was observed removed from the locked box and narcotic records indicated two should have been in the locked box. The AP and unlicensed staff observed in the video stated the count they completed did not include the 28 pack of oxycodone for resident #1 that was delivered, received and handed off to the AP earlier in the evening.

During an interview, the AP stated nine out of ten times she would sign for narcotics delivered to the facility, however, the 28-count package of missing oxycodone for resident #1 was delivered to the facility and signed for by management. The AP stated management handed the oxycodone card to her and she carried it from the office to the medication cart then placed it on top of the cart next to another pharmacy delivery that was sitting on top of the cart from an earlier delivery. The AP stated she had not had time to put delivered medications in the cart yet. The AP stated she must have gotten distracted and thought she placed both pharmacy bags in the medication cart but was unsure what happened to the narcotic medication. The AP stated she was made aware the narcotics were missing the next morning when the licensed staff notified her. The AP stated she had access to change the narcotic inventory in the computer system but would first notify licensed staff. The AP stated she had not had any previous allegations against her for missing narcotics.

A review of database information indicated the AP was affiliated with another facility that had filed two prior allegations on the AP for oxycodone diversion. Filed reports indicated oxycodone went missing during the AP's medication administration duties.

During an interview, facility management stated she had signed for resident #1's narcotic delivery and handed it to the AP to lock in the medication cart. Facility management stated she observed the AP walk to the end of the hall with the package until the AP was out of sight. Facility management stated she was made aware of the missing narcotics the next morning by licensed staff. Facility management stated a search was completed of the facility, the narcotics were not found, and she filed a report with law enforcement. Facility management stated law enforcement had not been to the facility to speak with staff about the missing narcotics, but video footage showed the shift change staff count one narcotic medication card and two should have been in the cart to count.

During an interview, unlicensed staff stated a narcotic counting process is completed at every shift change with two unlicensed staff. Unlicensed staff stated when the count is off, they are instructed to notify licensed staff and remain at the facility until the missing narcotics are located or the count is correctly reconciled by a licensed staff, however, that process had not been followed. Unlicensed staff stated when narcotics are delivered to the facility after normal hours, staff take a photo of the medication card and send a picture to licensed staff for the narcotic to be added to the count or place the pack in a locked box. Unlicensed staff stated the system manages the narcotic tally and there are no numbers entered by staff other than what was administered. Unlicensed staff stated "about two weekends ago" the narcotic count stayed incorrect all weekend and the count in the system did not match the narcotic pills in the medication cart. Unlicensed staff stated licensed staff were notified of the discrepancies and licensed staff directed unlicensed staff to count the narcotics with the discrepancies as is through the weekend until licensed staff were onsite on a Monday. Unlicensed staff stated during shift change narcotic count, on the day a 28-pack of oxycodone went missing, the AP told her a narcotic medication card was delivered to the facility that evening but had disappeared off the top of the medication cart.

During interview, licensed staff stated medication errors would be documented, and narcotic counts were reviewed every morning with random narcotic counts of the medication carts. Licensed staff stated the electronic system alerts unlicensed staff when the narcotic count was inaccurate, and staff were directed to notify licensed staff and remain onsite until the missing narcotic issue was resolved. Licensed staff stated the pharmacy had delivered a 28-count package of oxycodone for resident #1, management had signed for it and handed the medication card to the AP to put in the medication cart. Licensed staff stated she entered 28 into the electronic system based on a photo or phone call she received that evening. The next morning licensed staff stated she was alerted that the card of oxycodone was not in the medication cart and a search of the facility was initiated. Licensed staff stated she spoke with the AP and the AP had assisted in searching the facility for the missing oxycodone, but the medication was not found. Licensed staff notified law enforcement the following morning. Licensed staff stated there had been an incident on a recent weekend of inaccurate narcotic counts and she was notified by unlicensed staff. Licensed staff stated she had directed unlicensed staff to count the narcotics with the discrepancies until she returned to the facility

on Monday. Licensed staff stated the AP had accidently discovered she had the ability to alter the narcotic counts in the electronic system, however, licensed staff stated she had no cause to suspect the AP was involved with narcotic diversion. Licensed staff stated the unlicensed staff probably should not have access to alter narcotic counts and stated she would look at that.

NEGLECT

Resident #2 resided in an assisted living. The resident's diagnoses included Parkinson's disease (a progressive neurological movement disorder) congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The resident's service plan indicated the resident received services to include activities of daily living, daily weights for management of fluid buildup and medication management. The resident's assessment indicated the resident was socially active with other residents, a high fall risk and could be verbally abusive when upset.

Resident #2's electronic medication record indicated the resident was refusing medications the last two weeks of February 2025, except for a few that included the resident's Parkinson's medication and inhalers. The last week of February 2025, the resident was diagnosed with a respiratory infection and prescribed a steroid medication that he took. The first 16 days of March 2025 unlicensed staff documented the resident refused most medications daily that included diuretics (used to treat fluid retention) and blood pressure regulating medications. The second week of March the resident had teeth removed. The resident's electronic medication record indicated the resident was prescribed hydrocodone (opioid narcotic) for pain and unlicensed staff documented the resident had not refused any narcotic pain medication even as he refused most other medications.

The resident's physician ordered daily weights for monitoring and management of fluid retention medications. The orders included special instructions to report a weight gain over 3 pounds in a day or 5 pounds in a week. Orders provided included a separate diuretic to be administered if the resident's weight was recorded 5 pounds above baseline.

The resident's completed services record indicated licensed staff scheduled daily weights to be completed on Mondays, Wednesdays and Fridays and were not completed as scheduled.

The resident's progress notes indicated the resident was hospitalized for pulmonary edema (buildup of fluids in the lungs causing breathing difficulty), had not returned to baseline and had not returned to the facility a week after hospital admission.

During interview, licensed staff stated it was a "regular thing" for the resident to refuse medications when he was upset and unlicensed staff would not reapproach the resident because "if he's not taking them, he's not taking them". Licensed staff stated unlicensed staff were instructed to chart the medications refused and the medications were disposed of. Licensed staff stated notes were reviewed and she knew when resident's refused medications. Licensed staff stated she had sent the provider a fax notifying the provider of the medication

refusals; however, the provider had not responded. Licensed staff did not provide documentation of the provider notification. Licensed staff stated the facility's policies and procedures may have something in it about implementing interventions for unlicensed staff to try when a resident refused medication, but she had not had time to review them.

In conclusion, the Minnesota Department of Health determined neglect and financial exploitation was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority, a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

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

Action taken by facility:
The facility notified law enforcement and filed a report for the missing 28-count package of oxycodone for resident #1. The facility sent resident #2 to the emergency room for evaluation.
Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Mille Lacs County Attorney
Milaca City Attorney
Milaca City Police Department

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 03/17/2025

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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL304069743M/#HL304069242C On March 17, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 32 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL304069743M/#HL304069242C, tag identification 1750, 1760, 1820, 1920 and 2360.	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.	

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 03/17/2025

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
01750	Continued From page 1	01750		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prior to delegating nursing tasks, the unlicensed personnel (ULP) were trained in the proper methods to perform the task or procedure for each resident, and were able to demonstrate the ability to competently follow the procedure for one of one unlicensed personnel (ULP)-E. Additionally, the licensee failed to ensure the registered nurse (RN) included resident-specific instructions for the unlicensed staff to follow when administering as needed (PRN) medications for three of four residents (R2, R3, R4). This failure had the potential to cause harm to all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	01750		

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 03/17/2025

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
01750	Continued From page 2 has affected or has potential to affect a large portion or all of the residents). The findings include: MEDICATION ADMINISTRATION DELEGATION ULP-E started employment with the licensee on October 24, 2024, to provide direct care to licensee residents. Licensee's electronic medication administration record (EMAR)'s dated January though March 2025, indicated ULP-E had administered medications to resident's R1, R2, R3, R4, on the following dates: - January 1, 2, 9, 10, 14, 15, 16, 21, 22, 23, 24, 26, 28, 29, 2025. - February 4, 5, 6, 7, 11, 12, 13, 14, 18, 20, 21, 22, 23, 25, 26, 27, 28, 2025. - March 4, 5, 6, 7, 8, 9, 10, 13, 14, 2025. ULP-E's employee record lacked evidence ULP-E had been trained and demonstrated competency for the administration of oral medications. Medication administration records indicated ULP-E had administered muscle relaxers, heart regulators, diuretics and narcotic pain medications to the above noted residents. On March 20, 2025, at 8:35 a.m., ULP-E stated she started passing medications to licensee's residents not long after she was hired. ULP-E stated a night shift co-worker had abruptly ended employment and ULP-E was immediately moved into the med passer position. ULP-E stated it was planned for her to spend time training with licensee nurses, however, the licensee needed her to administer medications on the night shift before the training could be done. ULP-E stated	01750		

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 03/17/2025

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
01750	Continued From page 3 she had never met the licensee's current registered nurse (RN) and had learned medication administration from "experienced co-workers". On March 24, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated she had never met ULP-E, however she had spoke with ULP-E over the phone. CNS-B stated she thought all medication passers were signed off all medication competencies when she started employment and was unaware ULP-E was not competency tested for oral medication administration. CNS-B stated ULP-E was the only medication passer on the night shift when she was assigned to work. PRN MEDICATIONS R2 Review of R2's medical record indicated R2 admitted on June 20, 2024, under the licensee's assisted living license. On March 14, 2025, R2's physician orders included hydrocodone 5/325 milligram (mg) narcotic pain medication to be administered one tablet by mouth every 4-6 hours as needed. R2's electronic medication administration record (EMAR) dated March 2025, instructed ULP's to administer one tablet by mouth every 4-6 hours as needed for pain. R2's record lacked specific instructions for ULP's to know how often to administer the narcotic pain medication. R2's EMAR dated March 2025, indicated ULP's administered hydrocodone ten times on the following dates: - March 14, 15, 16, 17, 2025.	01750		

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 03/17/2025

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
01750	Continued From page 4 R3 Review of R3's medical record indicated R3 admitted on February 20, 2025, under the licensee's assisted living license. On March 7, 2025, R3's physician order included oxycodone 5 mg take 1-2 tabs by mouth every 4 hours if needed for pain. R3's EMAR dated March 2025, instructed ULP's to administer oxycodone 1-2 tabs by mouth every 4 hours if needed for pain. R3's record lacked specific instructions for ULP's to know how much oxycodone to administer and what conditions determined the amount to administer. R3's EMAR dated March 2025, indicated ULP's administered oxycodone on the following dates: - March 7, 8, 9, 10, 11, 12, 13, 14, 15, 2025. On March 20, 2025, at 8:35 a.m., ULP-E stated she did not think about asking R3's level of pain to determine how many tabs to administer to R3. R4 Review of R4's medical record indicated R4 admitted on June 4, 2018, under the licensee's assisted living license. On February 3, 2025, R4's physician ordered oxycodone 5 mg take one tablet by mouth every 4-6 hours as needed for severe pain. Take with food. May take half tab. R4's EMAR dated February 2025, instructed ULP's to administer oxycodone 5 mg take one tab by mouth every 4-6 hours as needed for severe pain. R4's record lacked specific instructions for ULP's to know how often to administer R4's	01750		

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 03/17/2025

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
01750	Continued From page 5 oxycodone based on the physicians severe pain parameter. R4's EMAR dated February 2025, indicated ULP's administered as needed oxycodone on the following dates: - February 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 2025. R4's EMAR dated February 2025, included two sets of active orders for acetaminophen extra strength (ES) 500 mg tablet, take 1-2 tablets by mouth every 6-8 hours. One set of instructions included instructions for ULP's to "give two tablets by mouth every 6 hours". The second set of instructions directed 1-2 tablets by mouth every 6-8 hours and indicated seven ULP's had signed off with initials that the range instructions were used to administer the medication. R4's EMAR dated February 2025, indicated ULP's administered as needed acetaminophen on the following dates: - February 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 2025. On March 24, 2025, at 11:00 a.m., CNS-B stated she was aware that ULP's were not allowed to determine medications administered with range instructions. CNS-B stated resident order's were sent to licensed staff including ranges and providers were notified that ULP's could not administer based on range orders, however, providers had not responded to the faxed notifications and "we never got other orders". Licensee's policy Medication & Treatment - Administration and Delegation dated August 1, 2024, indicated when unlicensed personnel were	01750		

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 03/17/2025

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
01750	Continued From page 6 delegated or assigned medication administration, the registered nurse would ensure the unlicensed personnel were instructed in the proper methods with respect to each resident to administer medication to, the unlicensed personnel had demonstrated the ability to competently follow the procedures and specified in writing, specific instructions for each resident and documented those instructions in the resident's record. Licensee's PRN Medications policy dated August 1, 2024, indicated only properly trained staff of licensee may provide PRN medication administration and the ULP must be trained and competency tested by a RN with the documentation on file. Additionally, PRN information must include right person, right medication, right time, right route, right dose, and right record. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	01750		
01760 SS=I	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet	01760		

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 03/17/2025

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
01760	Continued From page 7 the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure staff administered medications as ordered for three of four residents (R1, R2, R4). Additionally, the licensee failed to ensure staff followed up on administered as needed (PRN) medications for three of four residents (R2, R3, R4) with records reviewed. This practice had the ability to harm all residents prescribed medications. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 Review of R1 medical record indicated R1's diagnoses included cerebral palsy, cognitive impairment and cerebrovascular disease. R1's electronic medication administration record (EMAR) dated February 2025, indicated R1's physician ordered oxycodone 15 milligrams (mg) one tablet by mouth every evening for pain. R1's EMAR indicated oxycodone was scheduled at 7:00 p.m. daily.	01760		

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 03/17/2025

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
01760	Continued From page 8 R1's February 2025 EMAR showed staff did not administer R1's oxycodone doses as scheduled on the following dates: - February 22, 23, 24, 25, 26, 27, 28, 2025 - "no supply", "med is out" - March 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 2025. "no supply" R2 Review of R2's medical record indicated R2's diagnoses included Parkinson's disease, congestive heart disease and chronic obstructive pulmonary disease (COPD). R2's EMAR dated February 2025, indicated R2's physician ordered Carbidopa/L-Dopa (treatment for Parkinson's disease) 25-250 mg two tablets by mouth three times a day, Carvedilol (treatment for heart failure) 6.25 mg one tablet by mouth twice a day, cyclobenzaprine (muscle relaxer) 10 mg one tablet by mouth every night at bedtime for muscle spasms, Trazodone (anti-depressant) 50 mg two tablets by mouth every night at bedtime, Losartan (treat high blood pressure) 100 mg one tablet by mouth once daily, Simvastatin (treat high blood cholesterol) 40 mg one tablet by mouth once daily and Spironolactone (treat high blood pressure) 25 mg one tablet by mouth every morning. . R2's February and March 2025 EMAR, respectively, showed staff did not administer the following medications on the following dates: Carbidopa/L-Dopa - February 6, 7, 8, 9, 10, 2025. - March 4, 5, 14, 2025. Carvedilol - February 19, 20, 21, 22, 23, 25, 26, 27, 28, 2025.	01760		

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 03/17/2025

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
01760	Continued From page 9 - March 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 2025 Cyclobenzaprine - February 19, 20, 21, 22, 23, 25, 26, 27, 28, 2025. - March 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 2025. Trazodone - February 19, 20, 21, 22, 23, 25, 26, 27, 28, 2025. - March 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 2025 Losartan - February 19, 2025. - March 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 2025. Simvastatin - February 19, 2025. - March 1, 2, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 2025. Spironolactone - February 19, 2025. - March 2, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 2025. R2's record lacked documentation of refusal education by a registered nurse or a face-to-face medication assessment when R2 refused medications. R2's progress note dated March 17, 2025, indicated R2 was sent to the emergency room and hospitalized for pulmonary edema (a serious medical emergency of excess fluid buildup in the lungs causing impaired breathing). As of March 24, 2025, R2 remained hospitalized and had not	01760		

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 03/17/2025

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
01760	Continued From page 10 returned to baseline. R2's EMAR dated March 2025, indicated R2's physician orders included Hydrocodone/apap (opioid narcotic) 5/325 mg one tablet by mouth every 4-6 hours as needed for pain. R2's EMAR indicated staff administered but did not follow up on the effectiveness of the PRN medication on the following date and time: - Hydrocodone, March 16, 2025 R2's record lacked a physician's prescription for the hydrocodone 5/325 mg. R3 R3's medical record indicated R3's diagnoses included diabetes, bipolar and Bell's palsy. R3's EMAR dated February 2025, indicated staff did not follow up on the effectiveness of the Oxycodone or acetaminophen PRN medication on the following dates and times: - Acetaminophen, February 7, 2025. - Oxycodone, February 7, 2025. R3's EMAR dated March 2025, indicated R3's physician orders included Lorazepam (treatment for anxiety)0.5 mg one tab by mouth every 6 hours as needed for anxiety and Oxycodone (opioid narcotic) 5 mg one to two tabs by mouth every four hours if needed for pain. R3's EMAR indicated staff administered but did not follow up on the effectiveness of the PRN medication on the following dates and times: - Oxycodone, March 8, 2025 - Oxycodone, March 15, 2025 - Lorazepam March 15, 2025 On March 17, 2025, R3's 30-pack of lorazepam bubble pack was observed by the investigator to	01760		

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 03/17/2025

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
01760	Continued From page 11 have one tablet removed and unaccounted for with no initials, date or documentation in the electronic medication system. The bubble pack with the missing lorazepam was circled with a black marker and had a question mark written next to it. ULP-D stated she had no knowledge of where the tablet was or why the empty bubble was circled with a question mark. R4 R4's medical record indicated R4's diagnoses included diabetes, schizophrenia, heart failure and chronic obstructive pulmonary disease (COPD). R4's EMAR dated March 2025, indicated R4's physician orders included Fluticasone (used to treat asthma) 50 microgram (mcg)/ act nasal spray, one spray into each nostril every night at bedtime for nasal congestion. R4's February and March 2025 EMAR, respectively, showed staff did not administer the following medications on the following dates: Fluticasone 50 mcg/act - February 25, 26, 27, 28, 2025. "couldn't find", "can't find" - March 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 2025. "no supply" R4's EMAR dated February 2025, indicated R4's physician orders included Oxycodone 5 mg one tab by mouth every 4-6 hours as needed for severe pain and acetaminophen 325 mg take 2 tabs by mouth three times daily as needed for pain. On March 24, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated R1's oxycodone bubble pack had disappeared on February 24,	01760		

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 03/17/2025

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
01760	Continued From page 12 2025, and licensee was unable to locate the 28 count pack. CNS-B stated the licensee requested a pharmacy refill of the oxycodone medication, however, due to it's designation as a controlled substance, the medication was unable to be refilled until 28 days from delivery. CNS-B stated R2 would refuse medications based on his mood. CNS-B was unaware R2 had consistently refused medications for 27 consecutive days prior to hospitalization. CNS-B stated there were no special instructions or interventions for staff to attempt for medication administration. CNS-B was unaware of R3's missing oxycodone tablet. Licensee's Narcotic Log policy dated August 1, 2024, indicated the accuracy of the count will be documented by the electronic signature of the personnel in the electronic medical record, along with date and time the count is performed. The RN supervisor would verify the documentation in the electronic record including counts and records regularly. Licensee's Medication and Treatment Record - Documentation and Refusal policy dated August 1, 2024, indicated licensee would create and maintain a correct and accurate medication record for each resident receiving medication assistance or administration. Additionally, licensee would record a refusal for an assessment for medication management by the resident and the licensee must discuss with the resident the possible consequences of the resident's refusal and document the discussion in the resident's record. Licensee's PRN Medications policy dated August 1, 2024, indicated documentation in the resident's medication record was to include follow up communication with the resident.	01760		

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 03/17/2025

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
01760	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of four residents (R2) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During investigation entrance on March 17, 2025, at 10:24 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided medication management services, including storage of controlled substances.	01820		

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 03/17/2025

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
01820	Continued From page 14 On March 17, 2025, at 11:23 a.m., unlicensed personnel (ULP)-D conducted a review of controlled substance medications locked in a metal narcotic box in medication cart one with the investigator. ULP-D removed one bubble pack (cardboard medication organizer containing separate bubbles for medication by days/dates) at a time and verified the count. ULP-D removed R2's hydrocodone (opioid narcotic) 5/325 milligram (mg) from the bubble pack and the investigator observed initials and dates on the individual bubbles. R2's hydrocodone bubble pack count did not match the electronic recorded count and a discrepancy in the count was brought to the attention of the clinical nurse supervisor (CNS)-B. Review of R2's medical record indicated R2's diagnosis included Parkinson's disease and congestive heart failure (CHF). R2's Service agreement dated October 8, 2024, indicated R2 received services to include medication management. R2's electronic medication administration record (EMAR) dated March 2025, indicated unlicensed personnel (ULP)'s administered R2's hydrocodone 5/325 milligram (mg) one tab by mouth every 4-6 hours as needed for pain on the following dates: - March 14, 2025 at 5:02 p.m., 9:15 p.m. - March 15, 2025, at 1:05 a.m., 7:23 a.m., 2:02 p.m., 6:27 p.m. - March 16, 2025, at 12:10 a.m., 5:33 p.m., 9:44 p.m. R2's record contained annual prescriber orders dated June 20, 2024, however, the annual orders	01820		

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 03/17/2025

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
01820	Continued From page 15 did not include prescription orders for R2's hydrocodone narcotic medication. On March 17, 2024, at 12:27 p.m., , the investigator requested signed prescriber orders for R2's hydrocodone. CNS-B stated the facility did not have prescription orders for R2's hydrocodone on file because licensed practical nurse (LPN)-C dropped the original hard copy order off at the pharmacy for fill and licensed staff had not taken a copy of the prescription. CNS-B was unaware the licensee was required to have a copy of the prescription in R2's record. The licensee's Medication & Treatment - Administration & Delegation policy dated August 1, 2024, indicated prior to a ULP providing delegated medication administration the licensee would have a current prescriber's order on file. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01820		
01920 SS=I	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal	01920		

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 03/17/2025

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
01920	Continued From page 16 regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement procedures for loss and spillage of all controlled substances defined in Minnesota Rules part 6800.4220. This had the potential to affect and harm all 32 residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During investigation entrance on March 17, 2025, at 10:24 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided medication management services, including storage of controlled substances. On March 17, 2025, at 11:23 a.m., unlicensed personnel (ULP)-D conducted a review of controlled substance medications locked in a metal narcotic box on medication cart one with the investigator. ULP-D removed one bubble	01920		

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 03/17/2025

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
01920	Continued From page 17 pack (cardboard medication organizer containing separate bubbles for medication by days/dates) at a time and verified the count. ULP-D removed R2's hydrocodone 5/325 milligram (mg) bubble pack and the investigator observed initials and dates on the individual bubbles did not match the recorded electronic medication administration record (EMAR) for R2. ULP-D removed R3's Lorazepam 0.5 mg bubble pack and the investigator observed one bubble opened and the tablet missing. The empty bubble had a set of parenthesis and a question mark written on it in black marker. R2 R2's physician order dated March 14, 2025, ordered: hydrocodone 5/325 mg take one tab every 4-6 hours as needed. The physician's order lacked the route and licensed staff failed to request clarification from the provider. R3 R3's physician orders dated February 25, 2025, ordered: Lorazepam 0.5 mg take one tablet by mouth every 6 hours if needed for anxiety. On March 17, 2025, at 12:15 p.m., clinical nurse supervisor (CNS)-B stated she audited the narcotic medications daily, however, was unaware of the discrepancies and would look into the narcotic counts. CNS-B stated there were no medication error write ups or investigations about the discrepancies. Licensee's Narcotic Log policy dated August 1, 2024, indicated all controlled substances must be recorded in an individual's medication record for each resident in the narcotic log and in the electronic medical record. All controlled substances would be counted and recorded in the	01920		

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 03/17/2025

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
01920	Continued From page 18 electronic medical record at the end and beginning of each shift. The accuracy of the count would be documented by an electronic signature of the personnel in the electronic medical record, along with date and time the count is performed. The RN supervisor would verify the documentation in the electronic record including counts and records regularly. Licensee's Medications Loss or Spillage policy dated August 1, 2024, indicated when a loss or spillage occurred licensee would record and account for the loss or spillage of all medications. When a loss or spillage occurred a notation would be made in the resident's record explaining actions taken and must be signed by the person responsible for the loss or spillage. Additionally, the policy indicated a medication error report must be completed, staff would notify the registered nurse (RN), an RN would investigate the situation, the investigation would be documented in required records and any state or federal required action would be taken. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	01920		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure three of four residents	02360		

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 03/17/2025

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
02360	Continued From page 19 reviewed (R1, R2, and R3) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility and individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		