Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL321837182M
Compliance #: HL321832201C

Date Concluded: March 31, 2025

Name, Address, and County of Licensee Investigated:
Sunrise View Assisted Living
603 Louisiana Avenue
Adrian, MN 56110
Nobles County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Substantiated, facility 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):
Failed to respond and monitor a known change in condition resulting in a 17-pound weight loss, multiple refusals of medications, skin changes, aggressive behaviors resulting in hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to notify the resident's primary provider of a change in condition, weight loss, and refusals of care, services, medications, food, and water. In addition, the facility failed to complete an assessment and/or implement interventions to address the resident's needs.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff and a physician. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares and staff interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, diabetes, and chronic kidney disease. The resident's service plan included assistance with ambulation, transfers, bathing, dressing, grooming, incontinent care, meal reminders and medication administration. The resident's assessment indicated the resident was cognitively impaired and was at risk for dehydration. Interventions included for staff to document the resident's intake. The assessment also indicated nursing would provide consistent follow-up of health concerns with the resident's primary care provider. Staff were directed to notify a supervisor if cares were not completed due to refusals.

The resident's medical record indicated that upon admission to the facility, the resident refused cares, meals, and medications daily. The facility nurse attempted to contact the resident's primary care provider (PCP) twice via fax regarding the resident's refusals, but no response was received, and the nurse did not attempt to call to update or follow-up with the resident's PCP on the refusals. A fax was returned to the facility that did not address the resident concerns but the nurse did not follow up with the fax.

Twenty-seven days after admission, the resident's family contacted the facility nurse with concerns that the resident appeared dehydrated and continued to refuse cares, medications, food, and reported he did not like the facility water. The nurse recommended the resident be sent to the local emergency room (ER). The resident returned from the ER with no new orders. The facility did not complete an assessment or implement interventions after the ER visit. The medical record did not include documentation of meals or fluid consumed per the resident's service plan.

Nine days later, the PCP saw the resident via video conference appointment and was alerted of the 17-pound weight loss. The PCP discontinued most medications and ordered two medications for anxiety and agitation. The facility did not contact the PCP with notification of continued refusals of cares, medication, and food.

Thirteen days later, the resident was hospitalized for dehydration, weight loss, and refusal of cares and services.

During an interview, an unlicensed staff member stated the resident refused care, medications, meals, water, bathing, and grooming daily. The staff stated there was no direction to contact the nurse with resident refusals, but the nurse was aware, and it was the responsibility of the nurse to update the PCP.

During an interview, the registered nurse (RN) stated she was only on site one or two days every other week and completed most of her work remotely including assessments. The RN stated since she was not onsite, she was at the mercy of what staff told her. The RN could not recall if she followed up with the resident's PCP after faxes were sent or if any interventions were added to the care plan.

During an interview, the resident's PCP stated she began providing care for the resident 36 days after his admission to the facility. The PCP stated she was not notified the resident continued to refuse medications, food, and services. The PCP stated she felt that the facility admitted difficult residents without proper training to care for those residents and that the RN should be onsite to ensure quality care was provided.

During an interview, the housing manger stated resident refusals could be seen on the dashboard remotely and the nurse was responsible to update the PCP. The housing manager also indicated that the nurse responsible for completing assessments and service plans and assessments should be on site.

During an interview, management staff stated based on notes and daily meetings, the resident refused to eat and drink but management did not personally witness the continued refusals. If a resident's PCP did not respond to faxes or communication, the nurse should have followed up daily. Management staff stated a change in condition assessment should have been completed if the resident required a change in services and that the assessment could be conducted via a phone system.

During an interview, the resident's family member stated the facility nurse should have been in constant communication with the resident's PCP. The family stated the facility should have told them about the repeated refusals and weight loss and that the resident was not appropriate for assisted living.

In conclusion, the Minnesota Department of Health determined neglect 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.

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, due to cognition.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Nobles County Attorney
Adrian City Attorney
Adrian Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32183	A. BUILDING: _____ B. WING _____	C 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VIEW ASSISTED LIVING	603 LOUISIANA AVENUE ADRIAN, MN 56110

(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: #HL321832201C/#HL321837182M On January 29, 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 27 residents receiving services under the Assisted Living with Dementia Care license. The following correction orders are issued for #HL321832201C/#HL321837182M, tag identification 1620, 2310, 2360.	0 000		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620		

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01620	Continued From page 1 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing, in-person, resident assessment and monitoring based on the change in the needs of the resident for two of two residents (R1, R2) reviewed. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	01620	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.	

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01620	Continued From page 2 R1 was admitted on September 24, 2024, to the locked memory care unit with diagnoses including dementia without behavioral disturbance, diabetes, and chronic kidney disease. R1's 14 day assessment was completed remotely dated October 7, 2024. R1 discharged to the hospital on November 13, 2024. R2 was admitted on February 27, 2023, with diagnoses including dementia, hypertension and dysphagia (difficulty swallowing). R2's 90 day assessment was completed remotely on November 8, 2024. On February 21, 2025, at 10:00 a.m., registered nurse (RN)-B stated she was the nurse for the facility from the end of August 2024 until November 15, 2024, but lived 3.5 to 4 hours away from the facility so the majority of her work was completed remotely. Throughout that time she was onsite for eight days. RN-B stated she completed assessments remotely and management was aware as there would be no other way for the assessments to be completed. On February 26, 2025, at 12:00 p.m., the housing manager (HM)-D stated all of the assessment needed to be completed in person and was not aware assessments were completed remotely. HM-D stated if there was something that needed to be done over the weekend the licensee would use emergency phones with a camera to a complete an assessment. On February 26, 2025, at 1:00 p.m., licensed	01620	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.	

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01620	Continued From page 3 assisted living director (LALDIR)-E stated the RN had to gather data onsite and the documentation of the assessment could be completed remotely. LALDIR-E stated that if an assessment needed to be completed on the weekends the assessment could be done via a video call. The licensee's Assessment, Monitoring, and Reassessment policy dated August 1, 2021, indicated resident reassessment and monitoring must be conducted not more than 14 calendars days after the initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changed in the needs of the resident and can not exceed 90 calendar days from the last day of the assessment. The assessments must be conducted in person, be in writing dated and signed by a registered nurse. Minnesota Assisted Living Statute 144G.70 Subd. 2 indicates that an assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01620		

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01620	Continued From page 4 days	01620		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure appropriate care and services were provided based on resident's needs and according to an up-to-date service plan and accepted health care standards for one of one (R1) resident when facility staff failed to notify R1's primary care physician after consistent refusals of medications, meals, water, and assistance with activities of daily living (ADLs). R1 lost 17 lbs (pounds) in less than 60 days and concerns with skin integrity upon hospitalization. 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 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: R1's emergency department note (ED) dated September 11, 2024, indicated a diagnosis of	02310		

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02310	Continued From page 5 moderate dementia without behavioral disturbance. The ED note indicated R1 was in need of a skilled nursing facility due to increasing weakness, frequent falls, and worsening dementia. The note indicated R1 would be eligible for nursing home level of care given the need for medical assistance with pills, behavioral assistance with his dementia, and functional assistance with ADLs. Following the hospitalization R1 admitted to the licensee's facility on September 24, 2024 R1's medical record indicated R1 admitted on September 24, 2024, to the locked memory care unit with diagnoses including dementia without behavioral disturbance, diabetes, and chronic kidney disease. R1's admission assessment dated September 24, 2024, indicated R1 was admitted due to increasing falls and dementia diagnosis and had seven falls in the last three weeks prior to admission. The assessment indicated R1 was at risk for dehydration and staff were to document percent consumed and report any concerns to nursing for follow up. The assessment also indicated nursing would provide consistent follow-up with all health care concerns or issues with the resident's primary care provider and family and maintain efficient communication with all appropriate health care personnel. R1's service plan dated September 24, 2024, indicated R1 required assistance with ambulation, bathing, dressing, grooming, incontinence care, meal reminders, transfer assistance and medication administration. R1's service plan did not include to document percentange of food and water consumed as indicated in the assessment.	02310		

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02310	Continued From page 6 R1's September 26, 2024, individual review indicated R1 was resistant toward bathing, refused anti-embolism stocking application, and incontinence briefs. R1's 14 day assessment (completed remotely) dated October 7, 2024, indicated R1 was resistive with cares and would change clothes, bathing, grooming, toileting, eating, and go to meals. Interventions included to approach calmly, explain what you are doing, leave in a safe position, and try again later, and use distraction. Staff were directed to notify the supervisor if cares were not completed due to R1's refusals. Skin appearance was documented as no open areas. R1's service plan was not updated to include behavior management or refusals. The service plan also did not include documentation of food and water consumed. R1's service delivery record dated October and November 2024 indicated R1 refused services and meals daily. R1's physician orders signed October 16, 2024 included: Amlodipine 10 mg daily hypertension (high blood pressure), Levothyroxine 75 micrograms (mcg) daily for hypothyroidism, Lisinopril 20 mg daily for hypertension, omeprazole 20 mg daily for gastroesophageal reflux disease (GERD), and temaxapam 7.5 mg as needed for insomnia. R1's medication administration record (MAR) dated October, 2024, indicated R1 refused medications 21 out of 31 days. R1's MAR dated November, 2024, indicated R1 refused medications 13 out of the 14 days of R1's stay at the facility.	02310		

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02310	Continued From page 7 R1's medical record indicated weights included: September 24, 2024: 201.4 lbs October 7, 2024: 197 lbs October 22, 2024: 184 lbs R1's medical record did not include interventions to attempt to prevent continued weight loss. R1's primary care provider (PCP) was not notified of the weight loss until October 31, 2024. R1's progress notes indicated: - September 26, 2024, at 9:34 a.m., a fax was sent to R1's primary care physician (PCP) to notify the PCP R1 refused all meals yesterday, has not slept, and refused assistance from staff. The registered nurse (RN) indicated there may be a need for a neurocognitive medication due to dementia diagnosis. The RN also requested an order for incontinence briefs and would await return communication for new orders. - September 30, 2024, at 4:11 p.m., documentation of R1's dementia history was received from another provider. No response to date regarding the previous fax that was sent on September 26, 2025, and would await return correspondence. - October 4, 2024, at 1:04 p.m., a response had not been received regarding resident concerns. A fax was re-sent to two providers. - October 8, 2024, R1 had not been changed in four days, and the resident's groin was red and raw and he refused cream. - October 14, 2024, a fax communication sent to another physician, regarding R1's refusals of	02310		

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02310	Continued From page 8 cares, medications and was concerned because he was beginning to have skin breakdown in the perineal area due to incontinence. - October 16, 2024, Communication received from PCP for incontinence briefs, no orders or directives regarding neurocognitive status or recent behaviors. - October 17, 2024, Phone call from R1's daughter informing them they were in the process of trying to get a local PCP. R1's daughter was updated on current status including frequent refusals of cares, medications, and meals and currently refusal to take milk of magnesia for having no bowel movement for several days. R1's daughter will notify the facility when R1 was cleared to be seen by a local PCP. - October 21, 2024, phone call from R1's daughter concerned that R1 appeared dehydrated, still resisting, cares, medications, food and doesn't like the water at the facility. The RN recommended R1 being sent to local ER. - October 21, 2024, the emergency department (ED) RN stated R1 refused all medications and treatments and would be returning to the facility with no orders. - October 24, 2024, a provider visit referral note indicated the resident had been resistant and refused most cares including activities of daily living (ADL), medications, and food and hydration. R1 was having frequent behaviors such as physical and verbal aggression. - October 30, 2024, staff were unable to take R1 to the scheduled appointment with a local physician but the resident refused, resisted and	02310		

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02310	Continued From page 9 was combative with staff attempting to transport him to the clinic. PCP arranged a video conference appointment and R1's daughter was present. New orders to discontinue Lisinopril, Amlodipine, donepezil, omeprazole and temazepam, start Seroquel 25 milligrams (mg) twice daily and Ativan 0.4 mg every four hours as needed for agitation. A follow up videoconferencing appointment was scheduled for November 1, 2024. - October 31, 2024, a provider visit referral note indicated the resident was recently started on donepezil, frequent behaviors including physical and verbal aggression, delusional thinking and paranoia. Will not take medication consistently as he stated staff are trying to poison him. R1's weight was down 17 pounds since admission and requested if Seroquel could be started. - November 12, 2024, daughter called and was concerned about R1's sore on his bottom and requested staff look at it. Unlicensed staff attempted to look at the area but R2 refused. - November 13, 2024, R1 was transferred to the emergency room for an assessment by the PCP due to skin issues and refusal of cares. R1 was admitted to the hospital. R1's medical record did not include updated interventions, consistent communication or follow-up with R1's PCP regarding R1's refusal of activities of daily living, medications, food, water, skin concerns, and weight loss. R1's last documented in person assessment was completed on September 24, 2024. On February 21, 2025, at 9:00 a.m., unlicensed personal (ULP)-A stated R1 was resistive to cares	02310		

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02310	Continued From page 10 from the time he moved in. R1 would refuse care, medications, meals, water, bathing, and grooming. ULP-A stated there was not direction to contact the RN with resident refusals but the RN was aware. On February 21, 2025, at 10:00 a.m., registered nurse (RN)-B stated she was the nurse during this time but lived 3.5 to 4 hours away from the facility so the majority of her work was completed remotely. RN-B stated she worked with the licensee for about three months and was on site eight days. RN-B stated she had never been trained or witnessed an admission assessment she, "just figured it out." RN-B stated since she was not onsite she was at the mercy of what staff would tell her. RN-B upon admission R1's PCP was from veteran affairs (VA) and the PCP would not respond to two faxes that were sent. RN-B did not recall if she every called the VA, but stated it usually would be a long process if you called the VA. RN-B stated R1 did refuse many services, including food, and medications but were taught that they could not force residents to do things. RN-B was aware R1 was not eating or drinking and was aware of R1's 17 pound weight loss. RN-B stated a change in condition assessment was not completed since R1 did not change. RN-B stated she was not sure what else could have been done. On February 21, 2025, at 1:00 p.m., medical doctor (MD)-C stated she was not notified R1 did not take medications that were ordered on October 30, 2024, nor was she updated regarding R1's continued refusals. MD-C stated the licensee admitted difficult residents without proper staff training to care for the residents. MD-C stated there needed to be a RN onsite to ensure quality care.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32183	A. BUILDING: _____ B. WING _____	C 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE VIEW ASSISTED LIVING	603 LOUISIANA AVENUE ADRIAN, MN 56110

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02310	Continued From page 11 On February 26, 2025, at 12:00 p.m., housing manager (HM-D) refusals could be seen on the dashboard remotely and was responsible to update the PCP. HM-D stated the RN was responsible for completing assessments and service plans and assessments should be completed on site. On February 26, 2025, at 1:00 p.m., licensed assisted living director in residence (LALDIR)-E stated based on the notes and daily meetings R1 refused to eat and drink. LALDIR-E stated if a PCP does not respond to faxes or communication the RN should have followed up daily. LALDIR-E stated a change in condition assessment should have been completed if the resident required a change in services and could be conducted via a phone system. On March 5, 2025, at 3:00 p.m., family member (FM)-F stated she only saw the RN onsite on R1's admission date. FM-F stated the RN should have been in constant contact with R1's PCP regarding refusals and should have let the family know assisted living was not appropriate for R1. The licensee's Assessment, Monitoring, and Reassessment policy dated August 1, 2021, did not include when a change of condition assessment was required or when notification to the resident's primary provider was indicated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02360	Continued From page 12	02360		
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 one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		