Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #:
HL369183704M, HL369183703M
Compliance #: HL369187151C, HL369187150C

Date Concluded: October 14, 2025

Name, Address, and County of Licensee Investigated:
Sunrise Assisted Living
15236 Geranium Circle Northwest
Ramsey, Minnesota 55303
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected resident 1, resident 2, and resident 3, when resident 3 kissed resident 1, and kissed resident 2 and touched her breasts.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. As soon as the facility became aware of resident 3's alleged behaviors toward residents 1 and 2, the facility investigated and implemented interventions to ensure safety and help prevent similar issues in the future.

The investigator conducted interviews with facility staff members, including administrative and nursing staff, and unlicensed staff. The investigator contacted case managers. The investigation included review of the residents' records, facility incident reports, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed

staff supervision of residents, as well as the proximity of resident 3's room to resident 1's and resident 2's.

Resident 1 resided in an assisted living facility. Resident 1's diagnoses included several mental health diagnoses. Resident 1's service plan included assistance with monitoring behaviors and medication administration. Resident 1's assessment identified resident 1 as independent with activities of daily living (ADLs).

Resident 2 resided in an assisted living facility. Resident 2's diagnoses included several mental health diagnoses. Resident 2's service plan included assistance with behavior monitoring and medication management. Resident 2's assessment identified resident 2 as independent with ADLs.

Resident 3 resided in an assisted living facility. Resident 3's diagnoses included several mental health diagnoses. Resident 3's service plan included assistance with managing behaviors and medication administration. Resident 3's assessment identified resident 3 as independent with ADLs.

An incident report indicated resident 3 touched resident 2's breasts without her permission. The report indicated the residents were given the opportunity to move to another location, but they declined. Resident 3 had been placed on one-to-one monitoring while in the facility, and the residents were reminded of the facility rules.

A second incident report written the same day indicated resident 1 reported resident 3 kissed her without consent while in resident 3's room.

During an interview, a nurse stated regarding the incident between resident 1 and resident 3, resident 1 had been low on money, so she went to resident 3's room to ask for a soda, and resident 3 kissed her. Resident 1 did not tell staff at the time because she felt like she did not need to tell anyone. The nurse reviewed camera footage and talked with staff. Staff told the nurse resident 1 never informed them of the incident. The nurse reminded resident 1 to call him if anything happened again. The nurse interviewed resident 3 who denied the incident. Regarding resident 2 and resident 3, the two residents had been interacting casually prior to the incident. At one point, resident 2 gave resident 3 a ride in her car. The nurse reminded resident 2 not to give rides to other residents. Then, the nurse received notice of the allegation about resident 3 touching resident 2's breasts. While interviewing resident 2 about the incident, she also informed the nurse he touched her leg at another time. The nurse also interviewed resident 3 who stated what happened between him and resident 3 had been mutual, but things did not work out. Resident 3 apologized to resident 2. Resident 3 worked almost every day outside the facility, but while at the facility, they initiated one-to-one staffing for monitoring resident 3 and watching the security cameras. Related to both incidents, the nurse re-trained staff of vulnerable adult abuse prevention and forms of abuse and educated all residents on where and how to report concerns. The nurse also reminded the residents of the house rules to

stay out of each other's rooms, and not to ask one another for items like soda and cigarettes or allow other residents in their vehicle. The nurse installed another camera in the garage.

During an interview, resident 1 stated the facility had not been aware of the incident when it happened. However, the staff started keeping a better eye on the residents since everything happened, and there have not been issues since.

During an interview, resident 2 stated she had been outside in the garage for a while with resident 3. After some time of talking with each other, resident 3 stopped using the punching bag, came over, and touched her breasts. Resident 2 had been embarrassed to tell anyone what happened, but when she told the nurse, he responded immediately to ensure her safety. The nurse had a conversation with resident 3 who did apologize. A couple months before the incident, resident 2 went for a drive, and resident 3 went with. Resident 3 put his hand on her inner thigh while talking with her. Resident 2 again felt embarrassed, so she did not tell anyone. Since the incident in the garage, nothing similar has happened, and any interactions with resident 3 were appropriate. Resident 2 stated she had been impressed with how the nurse responded to the incident. The nurse increased staffing, put a camera in the garage, and told her notify him immediately if anything else happened. Resident 2 stated she felt much safer with the interventions put in place.

During an interview, resident 3 stated the facility increased staffing after the allegations were made, but a lot of them were false, and that a couple of residents were trying to get him in trouble. Resident 3 says since everything happened, he began keeping to himself. The facility installed the camera in the garage, and someone always has eyes on them while outside of their rooms.

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: VA1: No, the family member declined to interview. VA2: No, VA2 is her own responsible party. VA3: No, VA3 is his own responsible party.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility spoke with each of the residents and investigated the concerns. The facility implemented one-to-one staffing whenever resident 3 was at the house and installed another security camera in the garage.

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

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
	36918	A. BUILDING: _____ B. WING _____	C 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING	15236 GERMANIUM CIRCLE RAMSEY, MN 55303

(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: HL369183704M/HL369187151C HL369183703M/HL369187150C On August 5, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 5 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL369183703M/HL369187150C, tag identification 0630. No correction order is issued for HL369183704M/HL369187151C.	0 000	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.	
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update the individual abuse prevention plan (IAPP) with individualized interventions for two of three residents (R2, R3), after R3 touched R2's breasts without her consent. 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2's diagnoses included depression, anxiety, and a history of sexual abuse. R2's service plan dated February 15, 2025, indicated R2 received	0 630	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	

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0 630	Continued From page 2 assistance with behavior monitoring and medication management. R2's care plan dated February 21, 2025, indicated R2 received safety checks every two hours during the night shift. R2's assessment dated June 6, 2025, identified R2 as oriented and independent with activities of daily living (ADLs). R3's diagnoses included a mood disorder impulsive disorder. R3's service plan dated June 19, 2024, R3 received assistance with managing behaviors and medication administration. R3's assessment dated July 6, 2025, identified R3 as oriented and independent with ADLs. An incident report dated June 10, 2025, indicated R2 reported R3 grabbed her breasts without her permission. The report indicated action taken by the licensee included offering one of the residents move to another location but both declined, the licensee R3 placed on 1:1 monitoring while at the facility, and both residents were reminded of the house rules. R2's IAPP dated February 21, 2025, and May 21, 2025, identified R2 as susceptible to abuse from another individual, including other vulnerable adults. The IAPP included an intervention of staff monitoring for signs or symptoms of abuse or neglect from others and reporting to the nurse. The licensee failed to update the IAPP after the incident. The IAPP did not include the incident or individualized interventions related to the incident between R2 and R3. R3's IAPP dated April 1, 2025, and July 1, 2025, identified R3 at as risk of abusing other vulnerable adults. The IAPP included an intervention that staff would monitor resident	0 630	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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0 630	Continued From page 3 behavior and intervene with any actions of abuse toward others. The IAPP failed to include the incident and individualized interventions related to R3's behaviors during the incident. During an interview August 28, 2025, at 10:02 a.m., registered nurse (RN)-A stated he completed the IAPPs upon admission, every 90 days, and as required if the resident had a change. RN-A stated he considered the resident's history, health and diagnoses, and he assessed the resident's susceptibility to abuse from others, as well as their susceptibility to abuse others. When RN-A learned about the incident between R2 and R3, RN-A began providing 1:1 staff whenever R3 was at the licensee, and he installed a camera in the garage where the incident took place. RN-A stated R2 and R3's IAPPs were updated after the incident. The licensee's policy titled Abuse Prevention Plan, undated, indicated the licensee would develop a statement of specific measures that would be taken to minimize the risk of abuse to the residents. The IAPP would identify areas of vulnerability and safety concerns. Interventions to address the areas of concern would be documented on the IAPP and included in the resident care plan. The policy did not identify how frequently and under what circumstances the IAPP would be updated. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		