Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL369188322M
Compliance #: HL369189783C

Date Concluded: May 26, 2026

Name, Address, and County of Licensee Investigated:
Sunrise Assisted Living
15236 Germanium Cir NW
Ramsey, MN 55303-5163
Anoka County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Julie Serbus, 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 and Resident #2 when it did not provide supervision and interventions to address each resident's behaviors. Resident #1 became upset and engaged in self-harm.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The facility addressed the residents' behaviors through facility assessments and put in place interventions to minimize risk of harm before incidents occurred. The facility could not have reasonably anticipated this specific incident under investigation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted crisis respite support and family members. The investigation included review of multiple resident records, hospital records, facility incident reports, staff schedules, law enforcement reports, related facility policy and procedures. Also, the investigator observed staff supervision of residents and general activities at a recent visit to the facility.

Resident #1 resided in an assisted living facility. Resident #1's diagnoses included several mental health diagnoses including self-injurious behaviors. Resident 1's service plan included assistance with monitoring behaviors and medication administration. The residents' assessment indicated Resident #1 was independent with all activities of daily living (ADLs). The resident's assessment indicated Resident #1 had documented history of verbal outburst towards Resident #2 which had at times triggered self-injurious behaviors.

Resident #1's abuse prevention plan indicated Resident #1 was susceptible to verbal and physical abuse and history of self-harm using sharp objects. The caregivers were directed to perform a comprehensive search of the room for sharp objects and, if found, were to store them securely.

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 monitoring behaviors and medication set up. The resident's assessment indicated Resident #2 was independent with all ADLs.

Resident #2's abuse prevention plan indicated current diagnosis significantly impaired his ability to control his impulses, especially when he encountered unpleasant situation involving another resident. He was at risk of harming others and continued to be reminded acts of violence towards other residents in the house were unacceptable.

Both residents were their own guardians.

One afternoon a verbal altercation occurred between Resident #2 and a third resident residing at the facility. Law enforcement was called and instructed both parties were instructed to avoid each other for the remainder of the day.

However, a concern arose after law enforcement left the facility between Resident #1, who was not directly involved in the initial verbal altercation, and Resident #2. Resident #1 started questioning staff member(s) regarding why Resident #2 was allowed certain privileges such as playing video games within the nursing cubical and/or with a loud volume while other residents were trying to sleep. This was followed by a verbal confrontation between Resident #1 and Resident #2.

Resident #1 became upset and pulled out an X-ACto blade (sharp razor-like blade) and approached the area towards Resident #2 who pulled out his folding knife and opened the blade. Before the two residents reached each other, the facility nurse intervened. Resident #1 left the area, went to her room, locked the door, and shortly came out with cuts on her face and bleeding.

Resident #1 left the facility. Resident 1's community support person was at the facility when the incident took place. Both the facility nurse and community support person proceeded to follow Resident #1 down the street. Police arrived on scene and Resident #1 was transported to the emergency department for medical attention and later returned to the facility.

During an interview, multiple unlicensed caregivers stated when disagreements occur between residents, they are trained to de-escalate the situation by listening, using a calm voice, removing the resident from the situation, if possible, try to figure out a solution, or call 911 when necessary. There are two staff in the facility on each shift. Caregivers stated Resident #2 has a pocketknife with keys on it and Resident #1 had concealed X-ACto blades. Caregivers stated even though they attempt to collect the blades from Resident #1, she had the right to leave the facility independently and drove her own car.

During an interview, the facility nurse stated she was present during Resident #1 and Resident #2's altercation. Resident #1 felt Resident #2 was verbally antagonizing her. The nurse stated she was able to get between the two residents to keep them apart. Resident #1 immediately went into her room and cut herself as a coping mechanism. The nurse and the community support person followed Resident #1 out of facility. The nurse stated 911 had already been called and law enforcement approached Resident #1 away from the facility. Law enforcement was able to calm down Resident #1, retrieve the blade, and then an ambulance transported Resident #1 to the emergency department for treatment.

During an interview, the community support person stated she received a panic call from Resident #1 and went to the facility. The community support person stated Resident #1 was questioning why Resident #2 was allowed in areas including the space for the nurse to work.

During an interview, resident #1 stated she had not slept much the night before due to Resident #2 being loud and staff not intervening to turn the noise down. Resident #1 stated she felt Resident #2 had verbally attacked her throughout this day with statements or words to upset her.

During an interview, Resident #2 stated he was reacting to the situation of Resident #1. Resident #1 was located in the entry way of the house and Resident #2 stated he was on the second level playing games when Resident #1 ran up the stairs to where he was. However staff intervened by blocking her as she had a blade in her hand.

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, Resident #1, Resident #2, Resident #3
Family/Responsible Party interviewed: Yes, Resident #1
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: The facility called 911 and law enforcement were involved.

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 04/29/2026

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: #HL369189783C/#HL369188322M On April 16, 2026 through April 29, 2026, 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 5 residents receiving services under the provider's Assisted Living license. The following correction order is issued for ##HL369189783C/#HL369188322M, tag identification 1640.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised and accurate to reflect the current services provided for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01640		

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01640	Continued From page 2 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: R1 R1's Face sheet indicated admitted on February 21, 2025, with diagnoses that included major depressive disorder, post-traumatic stress disorder (PTSD), and borderline personality disorder. R1's signed service plan dated February 15, 2026, with fees per hour/visit listed. The service plan indicated R1 received services to include comprehensive and monitoring assessments, assistance with bathing cleanup after shower, assist with folding and keeping[sic] away laundry, arranging grooming items, appointment assistance, meal assistance, medication management, medication administration, transportation, light and heavy housekeeping, personal laundry, laundry linen change, vitals, monthly weights, nail care, daily treatment/wound care, behavior monitoring, assist to redirect and safety checks. R1's service plan indicated a payer source was private pay. R1's Assessment dated March 30, 2026, indicated R1 was independent with all Activities of Daily Living (ADL's). However, required assistance with laundry, housekeeping, meal preparation, and medication management.	01640		

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01640	Continued From page 3 On April 29, 2026, at 11:35 a.m., R1 stated that she has her own vehicle, and the facility does not provide transportation services at this time. R1 also stated that they used to wash her bedding but have not for several months. R1 also stated that her treatments consisted of skin ointment that she applies herself. R1 denied receiving daily vital signs, weekly nail care and she prepares a lot of her own meals in the microwave. She verified she is on a Community Access for Disability Inclusion (CADI) waiver and did not know about any private pay source. On April 29, 2026, at 11:20 a.m., registered nurse (RN)-A stated she agreed the service plan and the services scheduled do not match and stated the transportation charges should not be on there. On April 29, 2026, at 12:20 p.m., surveyors observed R1's bedroom. R1 had no bed linens on her mattress. R2 R2's Face sheet did not include a date of admission or current diagnoses. R2's Signed service plan dated June 19, 2024, with fees per hour/visit listed. The service plan indicated R2 received services to include comprehensive and monitoring assessments, assistance with bathing, grooming, oral care, dressing, shopping, assist making appointments, light and heavy housekeeping, meal prep, manage behaviors, medication management, medication administration, delegated blood sugar checks, transportation, personal laundry, laundry linen change, vitals, and weights. R2's service plan indicated a payer source was waiver. R2's Assessment dated October 1, 2025,	01640		

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01640	Continued From page 4 indicated R2's diagnoses included mood disorder, anxiety disorder, and impulse disorder. The assessment indicated R2 self-administered his own medications and was independent with all Activities of Daily Living (ADLs), grooming and oral hygiene. On April 29, 2026, at 11:20 a.m., RN-A stated services for R2 included meal preparation, transportation, laundry, deep and light room cleaning. R2 self-administered his own medications but she did medication setup. She stated R2 was independent with all ADLs and finances. The licensee's specific Service Plan policy was requested but not received. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01640		