Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL369188622M
Compliance #: HL369181660C

Date Concluded: May 28, 2026

Name, Address, and County of Licensee Investigated:
Sunrise Assisted Living
15236 Germanium Circle NW
Ramsey, MN 55303
Anoka County
HFID: 36918

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, 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 Allegations:
Allegation 1: The facility neglected Resident 1 and Resident 2 when they got into a physical altercation resulting in an emergency room visit for both residents.

Allegation 2: The facility neglected Resident 2 when he obtained a knife and subsequently displayed it in a threatening manner resulting in police involvement.

Investigative Findings and Conclusion:
Allegation 1: The Minnesota Department of Health determined neglect was not substantiated. Resident 1 thought Resident 2 was harming his own cat and confronted Resident 2 physically and a scuffle ensued. The facility could not have reasonably anticipated this event. Two staff members were present and separated from each other. Both residents were medically evaluated in the emergency room and returned to the facility afterward.

Allegation 2: The Minnesota Department of Health determined neglect was inconclusive. Resident 2 had knives in his possession and was showing them to the nurse and a community support person. Resident 2 stated later it was not his intent to threaten anyone.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case workers and a physician. 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 two recent visits to the facility.

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. The resident's assessment indicated resident 1 was independent with activities of daily living (ADLs) and decision making.

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 and decision making.

Allegation #1
A concern arose when Resident 2's cat got caught in the door. Resident 1 heard the cat cry out and thought Resident 2 was hurting the cat. Resident 2 confronted Resident 1 and a scuffle ensured. Resident 2 reacted and got Resident 1 to the ground with an arm around Resident 1's throat in a choking manner. Resident 1 was sent to the emergency room for evaluation.

An emergency room note indicated Resident 1 was evaluated for an assault. Resident 1 had minor neck abrasions, but further exams found there were no airway injury or acute trauma. The resident discharged back to the facility the same day.

Allegation #2
A second concern on a different occasion when Resident 2 displayed and waved around a knife. Both a facility staff member and a community support person for Resident 1, who was visiting the facility, were present. For safety concerns and not knowing what Resident 2 was going to do with the knife the community support person called 911. Police arrived but said they could not enforce the facility's Weapons Prohibition Policy.

An incident which occurred approximately a month prior, involved a knife also. Resident 1 approached Resident 2 with a blade after comments were made back and forth. Resident 2 had a tool with a knife, which he was going to use to defend himself. Caregivers intervened and separated the two residents. Resident 1 went to her room, however proceeded to self-injure

herself via cutting herself and required medical care. The incident note indicated residents were verbally reminded not to have any potentially harmful tools or items like knives.

Interviews
During an interview, the nurse stated she was not present when the incident over the cat in the doorway occurred. Staff reported to her Resident 1 put her arms around Resident 2 and they ended up on the floor with Resident 2 holding down Resident 1. She stated when Resident 2 perceived something threatening, he would react. The nurse was present during the second knife incident. She stated the police came, and she told them it was a misunderstanding, and the community support person became uncomfortable when Resident 2 displayed his knives.

During an interview, Resident 1 stated it took two staff persons to get Resident 2 off her back during the choking incident. Resident 1 stated resident 2 antagonized her. Additionally, Resident 1 said Resident 2 had a collection of knives he liked to show off.

During interview, Resident 2 stated he opened his door and closed it to go to kitchen and did not realize the cat ran out. The cat squealed which triggered Resident 1 to think he was hurting the cat. He stated he backed up to let cat back in his room and Resident 1 jumped on his back. This was the second time she had done this. He said he undid her arms and got her on the ground. He said he tried to handle it nicely and contained her to tire her out. He stated he did not try to choke Resident 1. The police came on another day, and he was arrested for the incident. Regarding the knives, Resident 2 stated he had two military knives which were just for display and/or emergency purposes.

During interview, the director stated he knew Resident 2 had a folding knife for his personal safety and told him not to have it out. The director stated he put a ‘No knives allowed’ sign on the door. The director stated Resident 2 could escalate quickly.

The facility’s Weapons Prohibition Policy indicated that weapons, which included knives (not intended for food preparation) were prohibited.

Conclusion(s)

Allegation #1: The Minnesota Department of Health determined neglect was not substantiated.

Allegation #2: The Minnesota Department of Health determined neglect was inconclusive.

Allegation #1: “Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Allegation #2: Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Residents represent themselves.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Allegation #1: The decision was made to discharge Resident 2 after the incident where Resident 2 put Resident 1 in a choke hold.

Allegation #2: None. Although no harm occurred, the facility had a Weapons Prohibition Policy in place, however it was not fully implemented. See below for information regarding actions taken by the Minnesota Department of Health.

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
Ramsey Police Department
Board of Executives for Long Term Services and Supports

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: #HL369181660C/HL369188622M 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 #HL369181660C/HL369188622M, tag identification 0500.	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.	
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to	0 500		

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0 500	Continued From page 2 practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure facility policies and procedures in place were implemented when R2, who had a history of impulsive behaviors, was allowed to have knives out in the common area. This had the potential to affect all five residents, staff and visitors. 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 widespread scope (when problems are pervasive or represent a systematic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1's Face sheet indicated she was admitted with diagnoses which included major depressive disorder, post-traumatic stress disorder (PTSD), and borderline personality disorder. R1's Signed service plan dated February 15, 2026, indicated services that included monitoring assessments, behavior monitoring, assistance	0 500		

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0 500	Continued From page 3 with redirection and safety checks. R2 R2's Signed service plan dated June 19, 2024, indicated services whic included comprehensive and monitoring assessments, managing behaviors, and medication management. R2's Assessment dated October 1, 2025, indicated R2's diagnoses included mood disorder, anxiety disorder, and impulse disorder. An event report dated November 27, 2025, indicated an event when R1 had an issue with R2 smiling at her and came up the stairs with a blade advancing toward R2. R2, in return, took out a tool that had a knife. Staff were able to separate the two residents. R2 handed the knife to the staff while R1 went to her room and cut herself around the face. On April 16, 2026, at 10:40 a.m., manager (M)-A stated he knew that R2 had a folding knife for his personal safety and told him not to have it out. M-A stated he put a 'No knives allowed' sign on the door. M-A stated R2 could go from "zero to ten'"in a minute. On April 23, 2026, at 8:03 a.m., community support person (CSP)-C stated one day (following the November incident) R2 was showing off the knife. R2 was sitting in the chair, pulled the cover off the knife and showed it off to CSP-C and registered nurse (RN)-B to get a reaction or something. Then R2 stood up and came toward us, and that is when CSP-C went into R1's room and locked the door and called police. CSP-C stated M-A said there were to be no weapons in the home.	0 500		

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0 500	Continued From page 4 On April 29, 2026, at 9:58 a.m., RN-B stated R1 had a folding knife with a nail cutter on it, "like a big one." RN-A stated she was present during the second knife incident. She stated that police came and she told them it was a misunderstanding and that the visitor became uncomfortable when R2 showed off his knives. RN-A stated when R2 perceived something threatening, he would react, referencing a different incident where R1 confronted R2 with a blade. As for R1, RN-A stated the facility does safety checks in her room (for blades) when she is present. The licensee's Weapons Prohibition Policy dated June 1, 2025, indicated that weapons, that included knives (not intended for food preparation) were prohibited. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 500		