Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304063163M
Compliance #: HL304062141C

Date Concluded: July 21, 2026

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Ann Boutwell, RN
Special Investigator

Finding: Inconclusive

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) neglected the resident when she did not receive her oxycodone tablet (narcotic pain medication used for pain) resulting in the resident having unrelieved pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident was given the wrong medication, the investigation did not identify a specific person as the alleged perpetrator. The resident was given a second dose to manage her pain.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker. The investigation included review of the resident record(s), facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included chronic pain and fistula of the intestine (an abnormal opening connecting parts of the intestines to each other). The resident's service plan included assistance with medication management and mood monitoring. The resident's assessment indicated resident was a standby assist for showers, otherwise was independent. The resident received home care services for wound care.

The medication error report indicated an incorrect dose of pain medication, and suspected drug diversion.

The investigative report indicated the resident requested as needed pain medication. The AP brought the resident pain medication. The resident questioned the AP if it was the correct medication as the tablet had no markings and stated she should have received two 5 milligram (mg) tablets to complete the dose of 10 mg. The AP confirmed in the electronic health record and with the licensed staff and brought a second tablet to equal the correct dosage. The report indicated the electronic medication administration record and medication count were both correct. Cameras were reviewed and indicated the AP removed medications out of a medication blister pack and into a medication cup, went up the stairway (the stairway to the second floor was a blind spot), and the AP was seen going into the resident's apartment with the medication cup.

The medical record indicated the resident received the as needed pain medication as prescribed and indicated the effectiveness as some relief.

During an interview, the licensed staff member stated the resident requested pain medication. The resident texted the licensed staff member while receiving her pain medication and informed her the AP administered a tablet with no identifiers and only received one tablet instead of two tablets. The resident informed the licensed staff member she had called the pharmacy and the pharmacist stated there should be markings on the tablet. The licensed staff member called and spoke with AP and clarified the resident should have received two tablets for the correct dose. The AP stated she gave one tablet and would give another tablet. The licensed staff member stated she did not observe the tablet in question, or the narcotic bubble pack from which the tablet was removed.

During an interview, the resident stated she did not ask for pain medication, however, the AP brought one pain medication tablet along with an anti-anxiety medication she requested. The resident questioned the AP as she did not think the one tablet given was her pain medication and should have had two tablets for the proper medication dose. The resident stated it looked like a vitamin D tablet, but the AP was adamant it was the correct tablet. The resident stated she took a picture of the tablet and called the pharmacy. The resident stated she threw the questionable tablet away in her garbage. The AP did clarify and brought the second tablet (to complete the dose) in which she stated was her pain medication. The resident stated she does have some memory problems due to surgeries but thinks she took the second tablet. The

resident stated she was having pain in the evening, while the incident was later morning. The resident stated she was happy with the care received at the facility, however, stated sometimes they don't order her pain medication, and she may run out.

During an interview, the licensed home agency staff stated three days later while visiting the resident for a home care visit, the resident informed her an unlicensed staff member brought her a pain medication tablet over the weekend that did not have markings and questioned if it was correct medication. The licensed home agency staff did not know if the resident received other pain medications during that time. She stated the resident complained of having pain over the weekend and had chronic pain.

The AP declined to interview.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

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: No, resident independent.
Alleged Perpetrator interviewed: No, refused interview.

Action taken by facility:
The facility investigated the incident when it occurred, provided education and retraining to staff and terminated the AP.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	30406	A. BUILDING: _____ B. WING _____	C 06/09/2026

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 On June 9, 2026, the Minnesota Department of Health intiated an investigation of complaints #HL304063163M/HL304062141C. No correction orders are issued.	0 000		