DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 10, 2022

Administrator
Sunlight Senior Living
400 Western Avenue
Saint Paul, MN 55103

RE: Project Number(s) SL30672015

Dear Administrator:

On May 3, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the February 10, 2022, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-508-2791 Fax: 651-215-9697

PMB

Electronically Delivered

March 3, 2022

Administrator
Sunlight Senior Living
400 Western Avenue
Saint Paul, MN 55103

RE: Project Number(s) SL30672015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on February 10, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jessica.Chenze@state.mn.us
Phone: 651-508-2791| Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30672	A. BUILDING: _____ B. WING _____	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNLIGHT SENIOR LIVING	400 WESTERN AVENUE SAINT PAUL, MN 55103

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30672015 On, February 7, 2022, through February 10, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 50 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 430 SS=B	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist of disclosure was provided to two of four residents (R1, R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), 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 and R3's records lacked a uniform checklist disclosure of services to include:	0 430		

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0 430	Continued From page 2 - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of all services offered under the contract. R1 On February 8, 2022, at approximately at 8:42 a.m., the surveyor observed unlicensed personnel (ULP)-D administer oral medications to R1. R1's Service Plan dated January 21, 2021, indicated services included medication administration, assistance with bathing, grooming, dressing, laundry and housekeeping. On February 9, 2022, at approximately 1:00 p.m., owner(O)-G stated the licensee emailed a copy of the uniform checklist disclosure to R1's representative. O-G confirmed R1's recod lacked documentation of the email. R3 On February 8, 2022, at approximately 8:30 a.m., the surveyor observed ULP-F administer oral medications to R3. On February 9, 2022, at approximately 1:00 p.m., O-G confirmed R3's record lacked documentation to indicate the licensee provided a copy of the uniform checklist disclosure to R3. The licensee's 1.04 Uniform disclosure of Assisted Living Services and Amenities	0 430		

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0 430	Continued From page 3 (UDALSA) policy dated August 1, 2021, indicated the facility would obtain written acknowledgement from the resident or resident representative that Sunlight Senior Living provided the UDALSA or document the reason why an acknowledgement was not obtained. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 450 SS=B	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the assisted living bill of rights to two of four residents (R1 and R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 450		

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0 450	Continued From page 4 affect health or safety), 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 and R3's records lacked evidence the residents received Assisted Living Bill of Rights dated May 16, 2021. R1 On February 8, 2022, at approximately 8:42 a.m., the surveyor observed unlicensed personnel (ULP)-D administer oral medications to R1. R1's record lacked evidence R1 received the Assisted Living Bill of Rights dated May 16, 2021. On February 9, 2022, at approximately 1:00 p.m., owner (O)-G confirmed R1's record lacked evidence R1 received the Assisted Living Bill of Rights dated May 16, 2021. O-G stated she thought the licensee emailed the Assisted Living Bill of Rights to R1's guardian, but was unable to confirm the email was sent. R3 R3's record lacked evidence R3 received the Assisted Living Bill of Rights dated May 16, 2021. On February 9, 2022, at approximately 1:00 p.m., O-G confirmed R3's record lacked evidence R3 had received the Assisted Living Bill of Rights dated May 16, 2021. The licensee's 2.05 Bill of Rights policy dated August 1, 2021, indicated each resident will be provided the Assisted Living Bill of Rights.	0 450		

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0 450	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by:	0 470		

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0 470	Continued From page 6 Based on observation, interview and record review, the licensee failed to post the daily work schedule as required, potentially affecting all fifty (50) residents in the assisted living facility, staff and any visitors of the licensee. 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 of the residents). The findings include: On February 7, 2022, at approximately 12:00 p.m., during the tour of the facility, the surveyor noted the daily work schedule was posted in the PCA (personal care attendant) office. Owner (O)-G confirmed only staff have access to the PCA office. The licensee's 4.01 Staffing and Schedule policy dated August 1, 2021, indicated the daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		

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0 480	Continued From page 7	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all fifty (50) residents. 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:	0 480		

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0 480	Continued From page 8 Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 7, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. This had the potential to affect all fifty (50) 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 510		

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0 510	Continued From page 9 or has the potential to affect a large portion or all of the residents). The findings include: REUSABLE MEDICAL EQUIPMENT On February 7, 2021, at approximately 11:00 a.m., the surveyor observed a table by the main entrance of the assisted living building with a thermometer, a bottle of hand sanitizer and Covid-19 screening logs for visitors and staff. There were no supplies on the table to clean the thermometer after each use. The licensed assisted living director (LALD)-A confirmed at that time, there were no supplies on the table to clean the thermometer after each use. INFECTION CONTROL/HAND HYGIENE DURING CARES On February 8, 2022, at approximately 7:27 a.m., the surveyor observed unlicensed personnel (ULP)-E enter R2's room with gloved hands. ULP-E removed R2's wet adult brief, provide peri (perineal) care and applied a new adult brief. With the same gloved hands, ULP-E assisted R2 to put on clean pants. Again, with the same gloved hands, ULP-E left R2's room to obtain a bottle of lotion. While ULP-E was on her way back to R2's room, ULP-E walked through the common area and touched R9's shoulder. ULP-E re-entered R2's room, applied lotion to R2's feet and provided the rest of R2's morning cares. ULP-E confirmed she did not change gloves after providing peri care to R2. On February 8, 2022, at approximately 10:00 a.m., owner (O)-G and LALD-A stated ULP-E should have changed her gloves after providing	0 510		

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0 510	Continued From page 10 peri care to R2, before going on to providing additional cares. Policies and procedures were requested but were not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee,	0 650		

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(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
0 650	Continued From page 11 volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained all the required content for one of three employees (unlicensed personnel (ULP)-F) with records 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, but was not likely to cause 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: ULP-F had a hire date of September 24, 2021. On February 8, 2021, at approximately 8:30 a.m., the surveyor observed ULP-F providing medication administration to R3. ULP-F's employee record lacked evidence of training in administering medications and treatments. On February 9, 2022, at approximately 2:00 p.m., owner (O)-G indicated the licensee had provided training in administration of medications and treatments to ULP-F but confirmed the documentation of that training was missing from ULP-F's employee record. O-G stated that	0 650		

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	30672	A. BUILDING: _____ B. WING _____	02/10/2022

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0 650	Continued From page 12 registered nurse (RN)-H sent a statement to O-G via email, dated February 9, 2022, confirming that ULP-F had been trained and competency tested on all routes of medication administration and blood glucose testing on September 26, 2021. O-G provided a copy of this email to the surveyor, but this email did not include initials of RN-H and ULP-F. The license's 6.14 Delegation of Assisted Living Services policy, dated August 1, 2021, indicated unlicensed personnel must be trained and demonstrate competency in the required areas. The licensee's 4.05 Employee Record policy, dated August 1, 2021, indicated employee records for each person will include: records of all training and in-service education required and/or provided including record of competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees,	0 660		

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0 660	Continued From page 13 contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). In addition, the licensee failed to ensure history and symptom screenings and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for three of three unlicensed personnel (ULP-D, ULP-E, and ULP-F) with employee records 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 of the residents). The findings include: ULP-D, ULP-E, and ULP-F's employee records lacked evidence a history and symptom screening and screening for active TB were completed. The licensee's TB Risk Assessment dated January 31, 2022, indicated the licensee was a low risk for TB.	0 660		

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0 660	Continued From page 14 ULP-D started employment on August 16, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On February 8, 2022, at approximately 8:12 a.m., the surveyor observed ULP-D administer morning medications to several residents. ULP-E had a hire date of September 27, 2021, to provide direct service to residents. On February 8, 2022, at approximately 7:06 a.m., the surveyor observed ULP-E to provide direct care services to R2. ULP-F ULP-F had a hire date of September 24, 2021, to provide direct service to residents. On February 8, 2022, at approximately 8:30 a.m., the surveyor observed ULP-F provide medication services to R3. On February 7, 2022, at approximately 11:00 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated they had identified that several employees had not completed the history and symptom screen and screening for active TB. LALD-A confirmed ULP-D, ULP-E and ULP-F had not completed the history and symptom screen and screening for active TB. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2022, indicated staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients.	0 660		

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0 660	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 680		

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0 680	Continued From page 16 review, the licensee failed to post emergency exit diagrams in the required areas. This had the potential to affect fifty (50) residents receiving assisted living services, 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 systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 7, 2022, at approximately 12:00 p.m., during the tour of the facility, the surveyor observed emergency exit diagrams posted by the main entrance and outside of the nurse's office. Owner(O)-G confirmed emergency exit diagrams were not post in each of the hallways. The licensee's Evacuation Plan policy dated August 1, 2022, does not address the posting of emergency exit diagrams. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 17 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. 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 of the residents). The findings include: On February 10, 2022, between the hours of 9:10 a.m. to 11:30 a.m., survey staff toured the facility with the licensed assited living director (LALD)-A and the maintenance director (M)-C. The LALD-A dismissed herself at approximately 9:40 a.m. and rejoined the tour again at approximately from 10:00 a.m. to 10:47 a.m. During the tour, survey staff observed portable fire extinguishers located throughout the facility including the main level, the kitchen and the lower level were all tagged showing the required annual service date of 11/2021, but all lacked records to show the	0 790		

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0 790	Continued From page 18 required monthly visual inspections to date. At approximately 11:00 a.m., survey staff staff explainted that the monthly visual inspection of each extinguisher was necessary to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and no obvious physical damage or condition to the extinguisher to prevent their operation when needed. If extinguishers were comprised or questionable, the licensee will need to get them to a vendor for servicing such as recharging or maintenance. The M-C and LALD-A verified the findings during the tour. On February 10, 2022, at approximately 1:00 p.m., the M-C, and the LALD-A acknowledged the above findings at the exit interview as the LALD-A asked for clarification to ensure monthly quick visual inspections can be performed by their employees. Survey staff explained that was allowed (per the national standard governing portable fire extinguishers). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff. 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 of the residents). The findings include: On February 10, 2022, between the hours of 9:10 a.m. to 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A and the director of maintenance (M)-C. The LALD-A dismissed herself at approximately 9:40 a.m. and rejoined the tour again from approximately 10:00 a.m. to 10:47 a.m. During the tour, the following findings were observed: - Plumbing traps of the plumbing fixtures were completely dried out in unoccupied resident rooms, 168, 186, 166, M97, and M106; the flushing rim sink in the laundry room, and the plumbing fixtures in the two restrooms in the basement level. Dried-out plumbing traps create unsafe and health risks to residents and employees over time by allowing sewer gas to enter the building environment and must be maintained on a regular basis. -The ceiling light covers for the therapy tub room had a large number of dead flies and needed to be investigated and be cleaned.	0 800		

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0 800	Continued From page 20 -The wood handrail across from rooms M114 and M116 was loose and needed to be secured. In addition, the edge of a handrail near resident room 127 was missing a corner cover piece exposing a sharp pin from the corner and posed a safety concern for the residents. -The vinyl tile behind the toilet of a resident bathroom in room 148 was peeling. -The door to resident room 166 to the corridor did not latch when closed. Door hardware needs to be repaired or replaced. -The exhaust fans in resident bathrooms M106, M110, and M116 were heavily layered with dust and must be cleaned. -The fire door from the basement to the exit stairway serving the main floor was wedged open comprising the safe means of egress. In addition, the wall near one of the steps of the stairway had a 4 inch by 4 inch opening in the concrete wall. Both findings comprised the means of egress for residents and staff exiting from the kitchen area and the main floor. On February 10, 2022, at approximately 1:15 p.m., the M-C, and the LALD-A acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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0 810	Continued From page 21 rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, and the minimum required training of staff and residents on fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents receiving assisted living care.	0 810		

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0 810	Continued From page 22 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 of the residents). The findings include: On February 10, 2022, at approximately 11:30 a.m., survey staff received and reviewed the facility fire safety and evacuation plan and related documentation for review. FIRE SAFETY AND EVACUATION PLAN -The building layout plan posted throughout the facility lacked the number identification of sleeping rooms. In addition, building layout plans were not legible to read for responders or emergency personnel. -The documentation lacked procedures for employee actions to be taken in the event of a fire or similar emergency including resident movement, evacuation, and relocation, including unique resident-specific situations during an evacuation. Unique situations may be residents who are deaf or hard of hearing, wheelchair-bound, on walkers, bedridden, cognitive deficit, and needing assistance during an evacuation and must be addressed in the policy documentation. -The documentation lacked fire protection procedures for residents. TRAINING - The policy documentation lacked the content in their policy to cover employee training on the facility fire safety and evacuation plan for both upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 23 -No policy documentation was provided to show training of residents that can self assist in their evacuation during the proper actions to be taken in the event of a fire including movement, evacuation, or relocation. If relevant, the policy should incorporate and address all assisted living residents and any memory care residents to be capable of self-assist based on their individualized service plan assessment based on evaluating their physical and cognitive limitations if relevant. EVACUATION DRILLS - The facility documented schedule and policy did show evacuation drills that must be performed by their employees twice per year per shift, with at least one evacuation drill every other month. However, record review showed insufficient numbers of evacuation drills performed to date by employees. The last documented fire drill performed was on November 11, 2021, at 2:30 p.m. On February 10, 2022, at approximately 1:15 p.m., the director of maintenance-C, and the licensed assisted living director-A acknowledged the above findings at the exit interview No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written	0 900		

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0 900	Continued From page 24 contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute an assisted living contract to include all required content for three of four residents (R1, R3 and R4) receiving	0 900		

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0 900	Continued From page 25 assisted living services. 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: R1 R1's records lacked a written contract with the following required content: (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30672	A. BUILDING: _____ B. WING _____	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNLIGHT SENIOR LIVING	400 WESTERN AVENUE SAINT PAUL, MN 55103

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0 900	Continued From page 26 opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. On February 8, 2022, at approximately 8:42 a.m., the surveyor observed unlicensed personnel (ULP)-D administering oral medications to R1. R1's Service Plan dated January 21, 2021, indicated services included medication administration and assistance with bathing, housekeeping, and laundry. On February 9, 2022, at approximately 1:00 p.m., owner (O)-G stated the licensee emailed a copy of the assisted living agreement to R1's representative. O-G confirmed R1's record lacked documentation to indicate the email was sent. R3 R3's records lacked a written contract with the following required content: (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 900	Continued From page 27 (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. R3's Service Plan dated May 6, 2021, indicated services included medication administration and assistance with bathing, housekeeping, and laundry. On February 8, 2022, at approximately 8:30 a.m., the surveyor observed ULP-F administering oral medications to R3. R4 R4's records lacked a written contract with the following required content: (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable.	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 900	Continued From page 28 (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. R4's Service Plan dated January 3, 2022, indicated services included medication administration and assistance with bathing, housekeeping, and laundry. On February 9, 2022, at approximately 1:00 p.m., O-G confirmed that the licensee had not completed a signed assisted living contract for R3 and R4. The licensee's 1.05 Signing and Assisted Living Contract policy dated August 1, 2022, indicated when a prospective resident decides to move into [facility name] a signed Assisted Living contract is received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 900		

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0 900	Continued From page 29 (21) days	0 900		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity	0 950		

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0 950	Continued From page 30 to identify a designated representative in writing for three of three residents (R2, R3 and R4) with records 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, 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 systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's service plan dated November 21, 2021, indicated R2 received services to include medication administration, assistance with, bathing, dressing, grooming, mobility, toileting, housekeeping and laundry. R2's Assisted Living Contract dated July 28, 2021, included the Designated Representative form, which was blank. R3 R3's service plan dated May 6, 2021, indicated R3 received services to include medication services, assistance with bathing, dressing, grooming, mobility, toileting, housekeeping and laundry. R3's undated Assisted Living Contract included the Designated Representative form, which was blank. R4 R4's service plan dated December 30, 2021, indicated R4 received services to include medication administration, assistance with	0 950		

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0 950	Continued From page 31 bathing, dressing, grooming, mobility, toileting, housekeeping and laundry. R4's undated Assisted Living Contract included the Designated Representative form, which was blank. On February 8, 2022, at approximately, 1:00 p.m., O-G confirmed the licensee had not provided R2, R3 and R4 the opportunity to identify a designated representative. The licensee's 1.05 Signing and Assisted Living Contract policy dated August 1, 2022, indicated fill in all the blanks of the contract and provide the prospective resident and/or responsible person a copy of the appropriate assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01370 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including:	01370		

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01370	Continued From page 32 (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for two of three employees (unlicensed personnel (ULP)-E and ULP-F) with records 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, but was not likely to	01370		

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01370	Continued From page 33	01370		

cause 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:
ULP-E
ULP-E was hired on September 27, 2021, to provide direct care under the assisted living with dementia care license.

On February 8, 2022, at approximately 7:15 a.m., the surveyor observed ULP-E assisting R2 with bathing, dressing, grooming and transferring.

ULP-E's employee record lacked evidence they had received the following training:
- documentation requirements for all services provided;
- reports of changes in the resident's condition to the supervisor designated by the facility;
- maintenance of a clean and safe environment;
-appropriate and safe techniques in personal hygiene and grooming, including:
(i) hair care and bathing;
(ii) care of teeth, gums, and oral prosthetic devices;
(iii) care and use of hearing aids; and
(iv) dressing and assisting with toileting;
- training on the prevention of falls;
- standby assistance techniques and how to perform them;
- medication, exercise, and treatment reminders;
- communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;
- awareness of confidentiality and privacy;
- understanding appropriate boundaries between staff and residents and the resident's family; and

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01370	Continued From page 34 - awareness of commonly used health technology equipment and assistive devices. On February 9, 2022, at approximately 11:20 a.m., owner(O)-G stated she could not find documentation to indicated ULP-E had completed the training as indicated above. ULP-F ULP-F was hired on September 24, 2021, to provide direct care under the assisted living with dementia care license. On February 8, 2022, at approximately 8:30 a.m., the surveyor observed ULP-F assisting R3 with medication administration. ULP-F's employee record lacked evidence ULP-F received the following training: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - maintenance of a clean and safe environment; - medication, exercise, and treatment reminders; - preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On February 9, 2022, at approximately 11:20 a.m., O-G stated she could not find	01370		

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01370	Continued From page 35 documentation to indicate ULP-F completed the training as indicated above. The license's 6.14 Delegation of Assisted Living Services policy dated August 1, 2021, indicated unlicensed personnel must be trained and demonstrate competency in the required areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required	01380		

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01380	Continued From page 36 training for two of three employees (unlicensed personnel (ULP)-E, and ULP-F) with records 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, but was not likely to cause 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: ULP-E was hired on September 27, 2021, to provide direct care under the assisted living with dementia care license. On February 8, 2022, at approximately 7:15 a.m., the surveyor observed ULP-E assisting R2 with bathing, dressing, grooming and transferring. ULP-E's employee record lacked evidence they had received the following training: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning. On February 9, 2022, at approximately 11:20 a.m., owner(O)-G stated she could not find documentation to indicated ULP-E had completed	01380		

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01380	Continued From page 37 the training as indicated above. ULP-F ULP-F was hired on September 24, 2021, to provide direct care under the assisted living with dementia care license. On February 8, 2022, at approximately 8:30 a.m., the surveyor observed ULP-F assisting R3 with medication administration. ULP-F's employee record lacked evidence they received the following training: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; and - range of motion and positioning. On February 9, 2022, at approximately 11:20 a.m., O-G stated she could not find documentation to indicate ULP-F completed the training as indicated above. The license's 6.14 Delegation of Assisted Living Services policy dated August 1, 2021, indicated unlicensed personnel must be trained and demonstrate competency in the required areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01440	Continued From page 38	01440		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of direct supervision of unlicensed personnel (ULP) for two of three employees (ULP-E, ULP-F) with employee records 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, but was not likely to cause serious injury, impairment, or death), and	01440		

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01440	Continued From page 39 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: ULP-E was hired on September 27, 2021, to provide direct care under the assisted living with dementia care license. On February 8, 2022, at approximately 7:15 a.m., the surveyor observed ULP-E assisting R2 with bathing, dressing, grooming and transferring. On February 9, 2022, at approximately 1:00 p.m., owner (O)-G provided a Staff Supervision form dated October 6, 2021, for ULP-E and confirmed the Staff Supervision form lacked evidence the registered nurse (RN) supervised ULP-E performing a delegated task. ULP-F ULP-F was hired on September 24, 2021, to provide direct care under the assisted living with dementia care license. On February 8, 2022, at approximately 8:30 a.m., the surveyor observed ULP-F assist R3 with medication administration. On February 9, 2022, at approximately 1:00 p.m., O-G confirmed ULP-F's record lacked evidence the RN supervised ULP-F performing a delegated task. The licensee's 6.14 Supervision of Staff-Delegated Task policy, dated August 1, 2022, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30672	A. BUILDING: _____ B. WING _____	02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNLIGHT SENIOR LIVING	400 WESTERN AVENUE SAINT PAUL, MN 55103

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01440	Continued From page 40 the individual begins working for [facility name] and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of three direct-care employees (unlicensed personnel (ULP)-E and ULP-F) completed at least eight hours of initial dementia training with records	01540		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01540	Continued From page 41 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, but was not likely to cause 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: ULP-E was hired on September 27, 2021, to provide direct care under the assisted living with dementia care license. On February 8, 2022, at approximately 7:15 a.m., the surveyor observed ULP-E assisting R2 with bathing, dressing, grooming, and transferring. ULP-E's employee record indicated ULP-E had completed 7.5 hours of dementia training. On February 9, 2022, at approximately 11:20 a.m., owner (O)-G confirmed ULP-E completed just 7.5 hours of dementia training. O-G confirmed ULP-E had worked more than 80 hours. ULP-F ULP-F was hired on September 24, 2021, to provide direct care under the assisted living with dementia care license. On February 8, 2022, at approximately 8:30 a.m., the surveyor observed ULP-F assist R3 with medication administration. ULP-F's employee record indicated ULP-F had	01540		

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	30672	A. BUILDING: _____ B. WING _____	02/10/2022

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01540	Continued From page 42 completed 7.5 hours of dementia training. On February 9, 2022, at approximately 11:20 a.m., O-G confirmed ULP-F completed just 7.5 hours of dementia training. O-G confirmed ULP-F had worked more than 80 hours. The license's 5.03 Dementia Training policy dated August 1, 2022, indicated direct care employees would complete eight (8) hours of initial training within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were stored according to manufacturer's recommendations. 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 an isolated scope (when one or a limited number of residents are affected or one or	01880		

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01880	Continued From page 43 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 7, 2022, at approximately 12:30 p.m., in the presence of the licensed assisted living director (LALD)-A, the surveyor observed the medication refrigerator in the locked medication room had a thermometer connected to the outside of the refrigerator that read 40 degrees Fahrenheit (F). LALD-A was not sure if the refrigerator temperatures were recorded daily. The medication refrigerator contained the following medications; -six (6) unopened Novolog 100 units/milliliters (ml) insulin pens (a multiple dose pen shaped injector device for insulin administration) for R6; and -eight (8) Lantus insulin pens and two (2) unopened boxes of Novolog insulin pens for R7. The manufacturer's instructions for Lantus insulin pens dated November 2018, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not allow to freeze. The manufacturer's instructions for Novolog insulin pens dated November 2019, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze. On February 8, 2022, at approximately 2:00 p.m., owner (O)-G stated they did not have a log of the daily medication refrigerator temperatures. The licensee's 7.11 Storage of Medication policy dated August 1, 2021, indicated medications	01880		

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	30672	A. BUILDING: _____ B. WING _____	02/10/2022

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01880	Continued From page 44 would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify hazard vulnerabilities and mitigations on and around the property. The hazards identified on the HVA plan must be mitigated to protect the residents from harm. This has the potential to directly affect all memory care residents receiving assisted living services. This practice resulted in a level two violation (a	02040		

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02040	Continued From page 45 violation that did not harm a client's health or safety but had the potential to have harmed a client'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 systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On February 10, 2022, between the hours of 9:10 a.m. to 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A and the maintenance director (M)-C. The LALD-A dismissed herself at approximately 9:40 a.m. and rejoined the tour again at approximately 10:00 a.m. to 10:47 a.m. On February 10, 2022, at approximately 11:30 a.m., survey staff received the HVA documentation for review: -The HVA plan documentation lacked all the required contents of the hazard vulnerability assessment. The plan must specifically include a comprehensive hazard assessment on and around the property of the facility to protect the memory care residents from harm. The hazard assessments on the facility's HVA plan need to be expanded further in scope to include specific safety risks or potential hazard vulnerabilities such as resident elopement throughout and around the memory care wing including deactivation of power doors due to loss of power or fire alarm activation as well as exit seeking residents, the potential risks of the misuse of portable fire extinguishers or architectural accessories for use as tools, and additional assessed site-specific hazards such as nearby	02040		

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02040	Continued From page 46 highways and busy streets.. - The HVA plan documentation lacked mitigations to the hazard identified in the plan. All hazards assessed on the plan and additional hazards identified on and around the property to protect all memory care residents from harm must be provided with mitigations and/or safety measures to minimize harm. On February 10, 2022, at approximately 1:15 p.m., the M-C, and the LALD-A acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	02040		
02410 SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan.	02410		

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02410	Continued From page 47 (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained during medication administration for two of five residents (R8 and R9) with records 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, 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). On February 8, 2022, at approximately 8:23 a.m., the surveyor observed unlicensed personnel (ULP)-D lift up R8's shirt, exposing her abdomen, to administer eight (8) units of Lantus insulin. R8 was seated at a dining room table eating breakfast. There were eight (8) other residents sitting in the dining room. On February 8, 2022, at approximately 8:34 a.m., the surveyor observed ULP-D administer Anoro Ellipta Aer inhaler (treatment for COPD (chronic obstructive pulmonary disease) to R9 while he	02410		

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02410	Continued From page 48 was eating breakfast in the dining room. On February 8, 2022, at approximately 10:00 a.m., owner (O)-G stated insulin and inhalers are to be administered in a private place. The license's 7.36 Insulin policy dated August 1, 2022, indicated privacy is to be provided when administering insulin. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/07/22*
Time: 14:10:14
Report: 1004221028

Food and Beverage Establishment Inspection Report

Location:
Sunlight Senior Living
400 Western Avenue
St Paul, MN55103
Ramsey County, 62

Establishment Info:
ID #: 0037819
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517145056
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CURRENT STATE CERTIFIED FOOD PROTECTION MANAGER. MANAGER HAS TAKEN A FOOD SAFETY COURSE BUT DID NOT COMPLETE STATE CERTIFICATION. INFORMATION PROVIDED TO THE MANAGER.

Comply By: 04/01/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

QUATERNARY AMMONIUM CONCENTRATION IN THE WET WIPING CLOTH BUCKETS MEASURED BETWEEN 0PPM-50PPM. ENSURE A CONCENTRATION OF 150-400PPM IS MAINTAINED TO PREVENT BACTERIAL GROWTH.

Comply By: 02/07/22

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

ICE MACHINE BAFFLE FOUND WITH AN ACCUMULATION OF RESIDUES. CLEAN THOROUGHLY AND MAINTAIN CLEAN AS PER PART 4 OF ABOVE RULE.

Comply By: 02/07/22

Surface and Equipment Sanitizers

Chlorine: = 50PPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 0PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET (STOVE)
Violation Issued: Yes

Quaternary Ammonia: < 50PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET (PREP TABLE)
Violation Issued: Yes

Quaternary Ammonia: = 50PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET (PREP)
Violation Issued: Yes

Quaternary Ammonia: = 0PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET (CART)
Violation Issued: Yes

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANITIZER DISPENSER (3-COMP)
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: M3 TURBO AIR COOLER
Violation Issued: No

Process/Item: CHICKEN
Temperature: 128 Degrees Fahrenheit - Location: M3 TURBO AIR COOLER *COOLING 10 MIN
Violation Issued: No

Process/Item: CHEESE
Temperature: 35 Degrees Fahrenheit - Location: M3 TURBO AIR COOLER
Violation Issued: No

Process/Item: TURKEY
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: CHEESE
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: LETTUCE
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: AMBIENT TEMPERATURE
Temperature: <34 Degrees Fahrenheit - Location: TRUE REFRIGERATOR REACH-IN COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	3

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY SHARON SZAMATULA.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-STATE CERTIFIED FOOD PROTECTION MANAGER CERTIFICATION
-HANDWASHING
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-WET WIPING CLOTH BUCKETS (SATURATE CLOTHS BEFORE PUTTING IN BUCKETS. ALLOW DISPENSER TO RUN FOR ~10 SECONDS BEFORE FILLING BUCKET)
-DATE MARKING PROCEDURES
-COOLING PROCEDURES (DO NOT TIGHTLY COVER UNTIL 41*F OR BELOW)
-REHEATING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-RECEIVING DELIVERIES PROCEDURES
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-TEMPERATURE LOGS
-PHYSICAL FACILITIES AND MAINTENANCE
-ALL VIOLATIONS ON THIS REPORT

ESTABLISHMENT IS LICENSED FOR UP TO 69 RESIDENTS AND CURRENTLY HOUSES 55 RESIDENTS.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT, OR CALL ON THEIR BEHALF. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

THE REPORT WAS DISCUSSED WITH THE KITCHEN MANAGER, DIANA, THE ESTABLISHMENT DIRECTOR, AND THE NURSE EVALUATOR, SHARON (HRD).

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1004221028 of 02/07/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
DIANA VAZQUEZ
KITCHEN MANAGER

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us