

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306726141M
Compliance #: HL306728980C

Date Concluded: January 21, 2025

Name, Address, and County of Licensee

Investigated:

Sunlight Senior Living
400 Western Ave N
Saint Paul, MN 55101
Ramsey County

Facility Type: Assisted Living Facility with
Dementia Care (ALFDC)

Evaluator's Name: Yolanda Dawson, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:

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

Initial Investigation Allegation(s):

The facility staff neglected a resident when CPR was not initiated when the resident became unresponsive.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. The facility followed their emergency policy to contact 911 for emergencies. f

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, employee records, staff schedules, and facility policies and procedures. Observation was made of staff interaction with residents.

The resident resided in an assisted living facility. The resident's diagnoses included chest pain, suicidal ideation, depression, and polysubstance abuse. The resident's service plan included

assistance with behavior monitoring, dressing, grooming, positioning, transfers, safety checks, medication management, and range of motion.

One morning the resident was moving from the laundry room to her bedroom when she began to exhibit slurred speech and eventually became unresponsive. Unlicensed staff members responded and called 911.

During an interview, an unlicensed staff member stated he gave the resident her medication and applied leg cream after which he noticed the resident slumped down in her wheelchair. The staff member called another staff member for assistance and called 911. The staff member stated he answered the 911 operator's questions and the paramedics arrived. The staff member stated he was not instructed by the operator to begin CPR. The staff member stated he was not trained by the facility to perform CPR.

During an interview, the nurse stated unlicensed staff were not required to have CPR training and the facility did not provide CPR training. In an emergency, staff members were trained to call 911 and follow the instructions given.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

"Neglect" means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: NA.

Action taken by facility:

Internal investigation conducted.

Action taken by the Minnesota Department of Health:

No further action at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30672	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/15/2024
NAME OF PROVIDER OR SUPPLIER SUNLIGHT SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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 On Oct 15, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL306728980C/#HL306726141M. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE