Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306726947M
Compliance #: HL306721493C

Date Concluded: March 10, 2025

Name, Address, and County of Licensee Investigated:
Sunlight Senior Living
400 Western Avenue North
Saint Paul, MN 55103
Ramsey County

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

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Inconclusive

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

Initial Investigation Allegation(s):
The facility neglected the resident when they failed to meet the resident's care needs, causing pressure sores.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident developed a skin wound on his buttocks, but the medical provider evaluated it as a result of macerated tissue, not a pressure injury. The medical provider ordered barrier cream. The nurse assessed the resident's change in condition and updated services with positioning and toileting services due to increased incontinence and decreased mobility. The services however did not have written directive of frequency and was not initiated in the service record until almost a month later. Additionally, staff documented there was two occasions when the resident was up in his chair for many hours or all shift. The barrier cream was not transcribed on the resident's medication administration record, conflicting with staff report of applying barrier cream and

indicating the resident was repositioned every two hours. The nurse documented the wound healed eight days later after the skin concern was noted.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed resident cares while on site.

The resident resided in an assisted living memory care unit. The resident's diagnoses included traumatic brain injury and anxiety disorder. The resident's service delivery record included assistance with toileting, incontinence care, bathing, dressing, grooming, walking and medication administration. The assessment indicated the resident was independent with repositioning himself in bed and used a walker with assistance. The resident needed stand by assistance with transfers and walking. The resident had significant cognitive impairments, required safety checks and frequent redirection. The assessment indicated the resident had no skin impairments aside from dry scalp.

A facility incident report indicated there was skin redness, irritation and minor scratch marks noted to the resident buttocks, with unknown cause. The report indicated the nurse was notified and there was no need for emergency services.

Nurse's notes authored by registered nurse (RN)-2 indicated RN- 2 was notified by the resident's family of concerns they had about the resident's skin. The notes indicated RN-2 went to the resident and completed a focused assessment on the resident's skin, where RN-2 noted mild redness and less than five scratch marks on the resident's buttocks. The notes indicated RN-2 directed unlicensed personnel (ULP) to frequently walk, reposition, and ensure the resident's toileting needs were met. The notes indicated RN-2 directed staff to alternate application of A&D ointment and barrier cream to the resident's buttocks.

Medical provider notes indicated the provider evaluated the resident's skin concern in person following its discovery. The provider notes indicated this skin concern appeared to be macerated tissue (moisture associated skin damage) related to the resident's incontinence, and not pressure damage. The notes indicated the provider gave an order for a barrier skin cream to be applied twice daily and as needed. The provider notes did not indicate any other concerns.

The resident's medication administration records indicated the facility failed to transcribe the barrier cream order and nursing order of RN-2 for A&D ointment.

A nurses note authored by RN-1 eight days after the skin concern on the resident's buttocks was noted, indicated the area was healed with warm, dry and intact skin. The note indicated the treatment plan would be continued for preventative care.

The resident's service plan indicated staff are to assist the resident with turning and repositioning as well as toileting three times daily.

The resident's service delivery records reviewed two months prior to the notation of the skin concern indicated there were seven days of missing charting for cares completed by staff. The records did not indicate acknowledgement of staff completing turn and repositioning assistance until one month after the resident had developed the skin concern on his buttocks. Additionally, the services were not identified with a frequency to monitor if ULP were providing the services as verbally directed by the RN, every two hours.

During an interview, RN-1 stated she expected staff to monitor a resident's skin each time they take care of the resident and inform a nurse right away if they note a skin concern. RN-1 stated she was notified of the skin concern on the resident when the licensed assisted living director (LALD) called her and stated he received a call from adult protection services stating the resident needed to go to the emergency room for a severe stage three pressure ulcer. RN-1 stated she went to the facility to assess the resident, and the skin concern was not something to send the resident to the emergency room for. RN-1 stated she called the resident's provider and initiated the orders received from the provider. RN-1 stated staff followed the resident's plan of care and signed for the cares provided at the end of their shift acknowledging turning and repositioning had been completed every two hours. RN-1 stated it had been a challenge to get staff to comply with completing their charting and had continued to train the staff on the importance of completing resident care charting. RN-1 stated she monitored resident charting daily to ensure cares were completed.

During an interview, a ULP stated ULP complete resident rounds every two hours to do their cares and make sure they have what they need. The ULP stated the online care system the facility utilized, called Rtasks, alerts the ULP of what care needed to be completed for each resident. The ULP stated the resident sometimes had bouts of diarrhea that will irritate his skin, so they apply barrier cream to prevent any issues. The ULP stated the resident was known to scratch his skin, so they used ointment on his skin. The ULP stated the resident enjoyed completing his cares with staff, and staff spent more time with him than anyone else.

During an interview, the LALD stated he rounded the facility a couple times a day and monitors the Rtask charting daily to ensure resident cares were completed. The LALD stated resident cares and needs were also discussed daily during the staff huddle. The LALD stated once he was aware of the resident's skin concern on his buttocks, he notified the DON right away to start the clinical process. The LALD stated the resident's provider came to the facility to assess him and confirmed it was not a pressure wound, that it was scratches and irritation from moisture. The LALD stated the skin concern healed in a few days and has not returned since.

During an interview, a family member stated she was assisting the resident in the bathroom when she noted open sores on both buttocks. The family member stated she immediately called to have the LALD come to the room. The family member stated the LALD stated the skin

concern was new information to him, he would get a cream to apply and make sure the medical provider came to assess the resident. The family member stated she did not understand how the resident's skin could have got to that point if staff were changing him and bathing him.

During an interview, the resident stated things were going well at the facility, that staff were good to him, and took good care of him.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Staff followed the plan of care and appropriately responded to the skin concern once it was noted.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30672	A. BUILDING: _____ B. WING _____	C 01/29/2025

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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL306721493C/HL306726947M On January 29, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 36 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL306721493C/HL306726947M, tag identification 450, 630, 800, 1620, and 1760.	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.	
0 450 SS=G	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450		

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0 450	Continued From page 1 (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 interview and document review the licensee failed to provide services in a person-centered manner and have a system for the registered nurse (RN) to supervise and evaluate the services provided by unlicensed personnel (ULP) for 1 of 1 residents (R1) reviewed. R1 had complaints of pain and ULP failed to administer Tylenol (over the counter pain medication) when R1 requested; R1 had a buttock wound. The service plan was updated to include repositioning services and updated transfer services, however there was no direction of frequency and for ULP to sign they had provided the service for the RN to evaluate effectiveness to prevent skin breakdown for R1. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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	0 450		

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0 450	Continued From page 2 situation has occurred only occasionally). The findings include: R1's diagnosis includes traumatic brain injury and anxiety disorder. R1's assessment dated September 1, 2024, indicated R1 required assistance of one staff for dressing, grooming, and toileting. R1 required stand by assistance with walking with his walker and was independent repositioning in bed. R1 had no skin impairments aside from dry scalp. R1's TBI resulted in "significant" cognitive impairments requiring frequent redirection, easily confused, wandered, verbal aggression and delirium. R1 understood verbal communication, able to be understood by others, got along with others and participated in social activities. Safety checks throughout shift related to TBI, short term memory, impulsivity and lack of insight/judgement and history of seizures, however no frequency was identified. R1's progress note dated September 4, 2024, written by director of nursing (DON)-A, indicated R1's skin was dry, intact and warm. No concerns noted. R1's service delivery record note dated from September 28, 2024, to October 31, 2024, indicated staff assistance included assistance with meals, transfers, walking, dressing, grooming, peri-care, medication assistance and safety checks. The service delivery records included notes written by ULP which indicated changes in R1's functional status and complaints of pain. A service delivery note dated October 2, 2024,	0 450		

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0 450	Continued From page 3 indicated R1 kept repeating his butt hurt and saying "I need Tylenol", the note indicated "a lot." A service delivery note dated October 3, 2024, indicated R1 wants Tylenol daily and kept saying "help me." A service delivery note dated October 15, 2024, indicated R1 was hard to get out of bed and was incontinent in bed almost every night. A service delivery note dated October 16, 2024, written by ULP-E, indicated ULP-E believed R1 had a "bad habit" of wetting himself each night and kept saying "help me." A service delivery note dated October 31, 2024, indicated it was like lifting dead weight when trying to get R1 up, and R1 needed to be re-evaluated for walking and eating. R1's medication administration record (MAR) dated October 2024, included an order for Tylenol 5000 milligram (mg) three times per day. R1 had no administrations of Tylenol. R1's service delivery record note dated from November 1, 2024, to November 30, 2024, indicated the same services as October 2024. The service delivery records included notes written by ULP which indicated continued changes in R1's functional status, complaints of pain and notes of R1 being left in a chair for several hours. A service delivery note dated November 4, 2024, indicated R1 could not get up by himself and R1 sat in a chair many hours from breakfast until "many" hours after lunch.	0 450		

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0 450	Continued From page 4 R1's progress note dated November 7, 2024, completed by RN-F, indicated R1's family expressed concerns about pressure sores on R1's buttocks. RN-F assessed the area and noted five scratch marks approximately 0.5 centimeters (cm) in size each. RN-F documented he informed ULP to frequently walk R1 and reposition him, ensure toileting needs are met and alternate the application of A&D ointment with barrier cream. R1's provider visit note dated November 9, 2024, indicated R1 expressed there was something on his butt that was sore. The provider noted two scratch marks apparent from itching and one small circle, 0.5 cm. The area appeared to be macerated (skin breakdown from moisture) and not pressure. The provider ordered barrier cream twice daily, educated the ULP and DON/administration. R1's progress note dated November 11, 2024, completed by DON-A, indicated she was informed by a county worker R1 had developed a pressure ulcer to his bottom. DON-A wrote "according to the nursing staff and the provider," photographs of the area indicated scratch marks and opening of 0.5 cm. The medical provider evaluated R1 and provided orders which had been implemented. A service delivery note dated November 12, 2024, written by ULP-E, indicated R1 keeps saying "help me." R1 was left in his chair overnight. ULP-E wrote staff need to be more attentive to residents in memory care. A change in condition assessment dated November 14, 2024, completed by RN-F, indicated R1 experienced slower process of	0 450		

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0 450	Continued From page 5 eating, increased tremors and struggling with gait balance. R1 had an increased need for two staff assist with transfers and used a wheelchair. The assessment inaccurately indicated R1 could independently move in bed. Although skin concerns were evaluated by both RN-F and DON-A, the change in condition assessment inaccurately indicated R1's skin was "dry, good," with skin issues left blank, the same as all previous assessments. The assessment lacked a Braden Scale assessment (used to determine risk of skin breakdown) with a change in mobility and incontinence status. The assessment indicated R1 had exhibited further physical and cognitive decline needing "frequent" repositioning to maintain skin integrity. ULP to encourage repositioning in bed and chair, assisting as needed. The assessment indicated R1 had increased incontinent episodes exacerbated by more frequent tremors, ULP were required to change him "frequently" throughout shift. The assessment failed to identify the frequency of newly identified positioning and toileting services. R1's MAR dated November 2024, included an order for Tylenol 5000 mg three times per day as needed. R1 had no administrations of Tylenol. R1's service delivery record note dated from December 1, 2024, to January 29, 2025, indicated the same services as October 2024 and November 2024, until December 3, 2024, when repositioning and toileting services were added. The service delivery records included notes written by ULP which indicated continued changes in R1's functional status and complaints of pain. A service delivery note dated December 2, 2024, indicated R1 "kept yapping today" and saying his	0 450		

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0 450	Continued From page 6 back hurts. A service delivery record dated December 31, 2024, indicated R1 repeatedly stated his butt hurts. R1's MAR dated December 2024, included an order for Tylenol 5000 mg three times per day as needed. R1 had no administrations of Tylenol. A service delivery record dated January 10, 2025, indicated R1 struggled to walk. R1's service delivery record dated September 28, 2024, through January 29, 2025, lacked documentation for care provided on 45 of the days. The service delivery records indicated assistance with turning and repositioning was not acknowledged as completed until December 3, 2024, and was only provided for 31 of the shifts. R1's service plan dated January 29, 2025, indicated services R1 received included assistance with toileting three times per day (each shift), mobility-walk two times per day, transfers two times per day, repositioning three times per day (each shift) and safety checks three times per day (each shift). The service plan and service delivery record lacked the frequency R1 required a service and require staff to document when they provided the services to ensure services met R1's needs. During an onsite visit on January 29, 2025, the investigator noted R1 required the use of a wheelchair for mobility and required the assist of two staff for turning, repositioning and transfers. R1 did not walk and required assist of one staff for locomotion in a wheelchair.	0 450		

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0 450	Continued From page 7 During a second interview on February 20, 2025, at 1:00 p.m., DON-A stated staff go to the resident's care plan to follow what cares the residents needs to have completed, and document it once at the end of the shift. RN-A stated some staff chart, and some do not. DON-A stated she completes rounds to remind staff to complete the resident charting. DON-A stated she and RN-F monitor the charting daily. DON-A stated staff chart once a shift on R1's turning and repositioning to acknowledge it had been completed every two hours. DON-A stated getting staff to complete resident charting has been one of the biggest problems and the facility is working on it. During an interview on February 5, 2025, at 10:00 a.m., family member (FM)-B stated R1 has declined since residing at the facility and needed a wheelchair. During an interview on February 10, 2025, at 1:45 p.m., ULP-C stated residents are changed and repositioned every two hours. ULP-C stated staff apply skin ointment and reposition R1 every 2 hours. ULP-C stated R1 can stand with a walker and reposition himself in bed. During an interview on February 11, 2025, at 9:02 a.m., licensed assisted living director (LALD)-D stated he monitors the resident charting and completes rounds daily to ensure resident cares are completed. During an interview on February 14, 2025, at 9:00 a.m., ULP-E stated he noticed a decline with R1's walking, eating and cognitive abilities and notified DON-A.	0 450		

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0 450	Continued From page 8 The licensee policy titled, "ALDC Dementia Care Philosophy," dated August 1, 2021, indicated the licensee valued of inclusion, dignity, respect, encouraging freedom of choice and independence, and quality care. The policy indicated person centered services focus on individual needs of the resident and adjust the individuals service plan accordingly. The Mayo Clinic website page titled, Bedsores (pressure ulcers), dated February 22, 2024, indicated bedsores are injuries to the skin and tissue below the skin due to pressure on the skin for a long time, arising of bony areas. The people most at risk are those who have medical conditions that keep them from changing positions or moving, spending most of their time in a bed or chair. Risk factors include incontinence due to skin vulnerability exposed to urine and stool, and immobility. Tips for repositioning included, changing position every two hours, special pressure relieving mattresses or cushions, keeping the skin clean and dry, protecting the skin with barrier creams and checking the skin daily for warning signs. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 450		
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults;	0 630		

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0 630	Continued From page 9 and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to develop an individualized abuse prevention plan (IAPP) with specific interventions to address a residents repetitious behaviors for one of one residents (R1) reviewed. R1's IAPP directed to "redirect" the resident when exhibiting behaviors with no specific direction. Unlicensed personnel (ULP) removed R1 from congregate areas as they deemed R1 disruptive, secluding him. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R1's diagnosis includes traumatic brain injury and anxiety disorder. R1's assessment dated September 1, 2024, indicated R1's TBI resulted in "significant" cognitive impairments requiring frequent redirection, easily confused, wandered, verbal aggression and delirium. R1 understood verbal communication, able to be understood by others,	0 630		

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0 630	Continued From page 10 got along with others and participated in social activities. R1's progress note dated September 26, 2024, indicated R1 was in a common area chatting with other residents and reported he was fine. R1's service delivery record note dated from September 28, 2024, to January 29, 2025, indicated staff were monitoring for behaviors of anxiety, repetitive behavior, verbal aggression, wandering and orientation. The record did not include interventions to be used when the behaviors were noted. The service delivery records included notes written by ULP which indicated changes in R1's functional status and complaints of pain. The service delivery records included several notes where ULP indicated R1 repeatedly stated "help me," "I need Tylenol," and "my butt hurts," and was redirected to their room. A service delivery note dated October 1, 2024, written by ULP-E, indicated R1 kept repeating "help me," and was redirected the behavior by having R1 go to his room. A service delivery note dated October 11, 2024, written by ULP-E, indicated R1 kept repeating "help me," and was redirected the behavior by having R1 go to his room. A service delivery note dated October 14, 2024, written by ULP-E, indicated R1 was disruptive in the dining room and sent to his room. R1's progress note dated October 15, 2024, written by director of nursing (DON)-A, indicated R1 participated in a sing-along with other residents.	0 630		

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0 630	Continued From page 11 A service delivery note dated October 16, 2024, written by ULP-E, indicated R1 was disruptive in the dining room. Once R1 repeats the same phrase over and over R1 was brought to his room. A service delivery note dated October 16, 2024, written by ULP-E, indicated ULP-E believed R1 had a "bad habit" of wetting himself each night and kept saying "help me." R1 was redirected to his room when "acting up." R1's progress note dated October 30, 2024, written by DON-A, indicated R1 was in the dining room chatting with other residents and stated he was happy. R1's progress note dated November 7, 2024, completed by registered nurse (RN)-F, indicated R1's family expressed concerns about pressure sores on R1's buttocks. RN-F assessed the area and noted five scratch marks approximately 0.5 centimeters (cm) in size each. RN-F documented he informed ULP to frequently walk R1 and reposition him, ensure toileting needs are met and alternate the application of A&D ointment with barrier cream. R1's provider visit note dated November 9, 2024, indicated R1 expressed there was something on his butt that was sore. The provider noted two scratch marks apparent from itching and one small circle, 0.5 cm. The area appeared to be macerated (skin breakdown from moisture)and not pressure. The provider ordered barrier cream twice daily, educated the ULP and DON/administration. New onset shaking concerns were assessed and did not observe shaking on assessment.	0 630		

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0 630	Continued From page 12 A service delivery note dated November 12, 2024, written by ULP-E, indicated R1 keeps saying "help me." R1 irritates other by repeating things. R1 was left in his chair overnight. ULP-E wrote staff need to be more attentive to residents in memory care. A service delivery note dated November 13, 2024, written by ULP-E, indicated staff brought R1 to his room due to annoying other residents and staff. A change in condition assessment dated November 14, 2024, completed by RN-F, indicated R1 exhibited further physical and cognitive decline. R1 had slower process of eating, increased tremors and struggling with gait balance. R1 had an increased need for two staff assist with transfers and used a wheelchair. R1 had significant cognitive impairment requiring frequent redirection and impaired short term memory. R1 had increased incontinent episodes exacerbated by more frequent tremors. Safety checks throughout shift related to TBI, short term memory, impulsivity and lack of insight/judgement and history of seizures. R1's IAPP dated November 14, 2025, indicated R1 was vulnerable due to need for assistance with activities of daily living. R1's IAPP indicated R1 had poor insight and required frequent redirection. ULP were to provide cognitive stimulation and behavior support, but lacked specific direction on measures or interventions to provide. When R1 exhibited fixation on food, ULP were to redirect when not meal or snack time and allow extra time for eating. The safety section of the IAPP indicated R1 was vulnerable to be abused (physically, verbally, emotionally, financially and/or sexually). The specific measures to minimize risk was left blank. R1's	0 630		

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0 630	Continued From page 13 vulnerability with impaired judgement indicated interventions included residency in the memory care unit and staff to provide redirection for confusion, but lacked specific redirection methods. The social and cognitive section indicated R1 was verbally aggressive, socially inappropriate and anxious, but lacked specific interventions to implement when behavior was exhibited. The IAPP did not include any intervention to bring R1 to his room when exhibiting behaviors. A service delivery noted dated November 18, 2024, written by ULP-E, indicated staff brought R1 to his room when he "acts up." A service delivery noted dated November 19, 2024, written by ULP-E, indicated R1 kept repeating "help me" and asks for coffee almost every day. Staff brought R1 to his room when he "acts up." A service delivery note dated November 20, 2024, written by ULP-E, indicated staff brought R1 to his room for acting out and "faking" his shaking condition. A service delivery note dated November 29, 2024, written by ULP-E, indicated R1 was brought to his room when he got "rowdy." A service delivery note dated December 2, 2024, written by ULP-E, indicated R1 "kept yapping today" and saying his back hurts. A service delivery note dated December 4, 2024, written by ULP-E, indicated staff bring R1 to his room when he is "acting up." A service delivery note dated December 5, 2024,	0 630		

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0 630	Continued From page 14 written by ULP-E, indicated R1 was faking being in pain and sent to his room. A service delivery note dated December 9, 2024, written by ULP-E, indicated R1 kept saying "help me" and complained of back/rear aches almost every day. R1 was redirected to his room when acting up. A service delivery note dated December 16, 2024, written by ULP-E, indicated R1 kept repeating "help me" and wanted coffee and pizza. R1 was redirected in conversation or sent to his room. A service delivery noted dated December 20, 2024, written by ULP-E, indicated R1 kept asking for coffee and asked what was on televisions. ULP-E wrote R1 was to be redirected to room whenever possible. A service delivery noted dated December 23, 2024, written by ULP-E, indicated R1 was disturbing others during breakfast, kept talking and saying random phrases. R1 was sent to his room. A service delivery record dated December 24, 2024, written by ULP-E, indicated R1 was loud and could not be calmed in the dining room. R1 was sent to his room and meals provided in his room. A service delivery noted dated December 30, 2024, written by ULP-E, indicated R1 kept repeating things and disrupted others when sitting at the table. R1 was to be redirected to his room when possible. A service delivery record dated December 31, 2024, written by ULP-E indicated R1 kept	0 630		

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0 630	Continued From page 15 "yapping" about his butt hurting. R1 disturbed others at the lunch table. A service delivery noted dated January 1, 2025, written by ULP-E, indicated R1 wanted coffee every day, repeats what he hears on television or what someone else says. R1 was to be redirected to his room when possible. R1's service plan dated January 29, 2025, indicated R1 received behavior monitoring, and assistance with toileting, mobility, repositioning and transfers. During an on site on January 29, 2025, the investigator noted R1 required the use of a wheelchair for mobility and required the assist of two staff for turning, repositioning and transfers. R1 did not walk and required assist of one staff for locomotion in a wheelchair. During an interview on February 4, 2025, at 11:12 a.m., DON-A stated she directed staff to a resident care plan to know what cares the resident needs. DON-A stated if there are changes to a resident's needs, staff need to tell her so she can update the care plan. During a second interview on February 20, 2025, at 1:00 p.m., DON-A stated she and RN-F monitor the charting daily. DON-A stated ULP were trained on what residents have behaviors and it was stated in their care plan what to do with the behaviors. DON-A stated if what they were supposed to do was not working, they should notify her. DON-A stated she updates R1's care plan because of the changes R1 has had, and staff were trained on the changes made. During an interview on February 11, 2025, at 9:02	0 630		

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0 630	Continued From page 16 a.m., the licensed assisted living director (LALD)-D stated he monitors the resident charting and completes rounds daily to ensure resident cares were completed. During an interview on February 14, 2025, at 9:00 a.m., ULP-E stated his job is to assist with resident behaviors and redirect residents. ULP-E stated he takes notes at the end of the day that management can look at. ULP-E stated he was not involved with resident care plans but had received tips from the person who trained him on what to do with behaviors. ULP-E stated he did not receive training at the facility for dementia. ULP-E stated he noticed a decline with R1's walking, eating and cognitive abilities and notified DON-A. ULP-E stated he brings R1 to his room, so he does not disturb anyone. The licensee policy titled, "ALDC Behavioral Symptoms, Interventions and Nonpharmacological Approaches," dated August 1, 2021, indicated the licensee would identify behavioral symptoms that negatively impacted others and evaluate to determine potential interventions to minimize such behaviors. Interventions would be identified on the care plan or service plan. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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	0 800		

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0 800	Continued From page 17 health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on interview and observation, the licensee failed to maintain the physical environment in a continuous state of good repair and operation in regard to the health, safety, and well-being of residents. 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, 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: During observation on January 29, 2025, at 9:30 a.m., the MDH surveyor observed: - Strong odor of marijuana and cigarettes was noted in the double door entry of the facility. - Multiple sites of holes and damage was noted in the drywall of the facility hallways. - Strong odor of urine was noted throughout the facility hallways, with concentration on the memory care unit. During observation on January 29, 2025, at 12:00 p.m., the MDH surveyor observed: -Strong odor of urine remained in the facility	0 800		

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0 800	Continued From page 18 hallways as previously noted. During an interview on February 4, 2025, at 11:12 a.m., director of nursing (DON)-A, who is also a registered nurse, said there were two housekeepers at the facility and one of them was always on the memory care unit. DON-A stated the housekeeping staff followed a schedule of tasks in the online Rtasks system, where they also documented the completion of the tasks. DON-A stated housekeeping cleaned the common areas daily and do a deep clean weekly. DON-A stated if staff noted odors, they tell housekeeping staff and they take care of it. DON-A stated if what housekeeping staff did for the odors was not effective, they tell DON-A and DON-A notified licensed assisted living director (LALD)-D. DON-A stated the maintenance worker came in as needed and she was not aware of set schedule for him. DON-A stated if something was broken, he came right away, depending on his time. DON-A stated smells and drywall damage could affect having a homelike setting, but smells were fixed right away. During an interview on February 5, 2025, at 10:00 a.m., a family member (FM)-B stated during a time that she visited the resident, there was urine and feces all over the floor in the resident's room. FM-B stated the resident must have had an accident in his pants, and when staff removed them they threw them in the closest causing the feces to go flying everywhere. FM-B stated the feces was left all over the closet door and floor. During an interview on February 11, 2025, at 9:02 a.m., LALD-D stated there was a maintenance staff person who worked 20 to 25 hours a week and as needed for emergencies. LALD-D stated staff filled out a request form when there was	0 800		

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0 800	Continued From page 19 maintenance concerns, and the form was provided to maintenance staff so they knew what to fix. LALD-D stated there was also a weekly list of maintenance tasks to complete. LALD-D stated he would expect drywall damage to be completed in two working days. LALD- D stated he monitored for odors when doing rounds in the facility, and notified housekeeping staff if odors were noted. LALD-D stated housekeeping staff took care of odors right away, and caregivers will do cleaning and take care of odors after hours as needed. LALD-D stated resident rooms were cleaned twice weekly on schedule with the resident's shower schedule, that included sweeping, mopping, laundry and deep cleaning of toilet and glass. During the investigation, the surveyor received photographs of what appeared to be feces on a table, carpet in a closet, and floor in a resident room. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 800		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620		

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01620	Continued From page 20 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to assess the resident in persona, accurate to the resident's status and needs are the time of the assessment and failed to conduct an accurate change of condition assessment, as required for 1 of 1 residents (R1) reviewed. R1's change in condition assessment failed to include R1's change in skin condition, complaint of buttock pain and need for assistance with bed mobility documented by unlicensed personnel. R1 developed a macerated tissue wound on his buttocks. 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:	01620		

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01620	Continued From page 21 R1's diagnoses included traumatic brain injury (TBI) and anxiety disorder. R1's assessments; five of them dated from January 18, 2024, through September 1, 2024 contain the exact information in a copy and paste presentation including pain described as a headache with a pain rating of 5 in all five assessments. R1's assessment dated September 1, 2024, indicated R1 required assistance of one staff for dressing, grooming, and toileting. R1 required stand by assistance with walking with his walker and was independent repositioning in bed. R1 had no skin impairments aside from dry scalp. R1's TBI resulted in "significant" cognitive impairments requiring frequent redirection, easily confused, wandered, verbal aggression and delirium. R1 understood verbal communication, able to be understood by others, got along with others and participated in social activities. R1's progress note dated September 4, 2024, written by director of nursing (DON)-A, indicated R1's skin was dry, intact and warm. No concerns noted. R1's progress note dated September 26, 2024, indicated R1 was in common area chatting with other residents and reported he was fine. A progress note dated October 15, 2024, indicated R1 participated in a sing-along with other residents. A progress note dated October 30, 2024, indicated R1 was in the dining room chatting with other residents and stated he was happy. R1's service delivery record dated from September 28, 2024, to January 29, 2025, indicated staff were monitoring for behaviors of	01620		

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01620	Continued From page 22 anxiety, repetitive behavior, verbal aggression, wandering and orientation. The record did not include interventions to be used when the behaviors were noted. Other assistance included assistance with meals, transfers, walking, dressing, grooming, peri-care and medication assistance. R1's service delivery record note dated from September 28, 2024, to January 29, 2025, indicated changes in R1's functional status and complaints of pain. A service delivery note dated October 2, 2024, indicated R1 kept repeating his butt hurt and saying "I need Tylenol", the note indicated "a lot." A service delivery note dated October 3, 2024, indicated R1 wants Tylenol daily and kept saying "help me." A service delivery note dated October 15, 2024, indicated R1 was hard to get out of bed and was incontinent in bed almost every night. A service delivery note dated October 31, 2024, indicated it was like lifting dead weight when trying to get R1 up, and R1 needed to be re-evaluated for walking and eating. A service delivery note dated November 4, 2024, indicated R1 could not get up by himself and R1 sat in a chair many hours from breakfast until "many" hours after lunch. R1's 90 day assessment dated November 4, 2024, completed by DON-A, included all of the same information from R1's 90 day assessment dated September 1, 2024, including no change to R1's mobility status and inaccurately indicated R1	01620		

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	30672	A. BUILDING: _____ B. WING _____	C 01/29/2025

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01620	Continued From page 23 continued to require stand by assistance with walking and transfers and did not use a wheelchair. No changes to the assessment were made, although unlicensed personnel (ULP) documented R1 was difficult to stand when previously independent with stand by assist. R1's progress note dated November 7, 2024, completed by registered nurse (RN)-F, indicated R1's family expressed concerns about pressure sores on R1's buttocks. RN-F assessed the area and noted five scratch marks approximately 0.5 centimeters (cm) in size each. RN-F documented he informed ULP to frequently walk R1 and reposition him, ensure toileting needs are met and alternate the application of A&D ointment with barrier cream. R1's provider visit note dated November 9, 2024, indicated R1 expressed there was something on his butt that was sore. The provider noted two scratch marks apparent from itching and one small circle, 0.5 cm. The area appeared to be macerated (skin breakdown from moisture)and not pressure. The provider ordered barrier cream twice daily, educated the ULP and DON/administration. New onset shaking concerns were assessed and did not observe shaking on assessment. R1's progress note dated November 11, 2024, completed by DON-A, indicated she was informed by a county worker R1 had developed a pressure ulcer to his bottom. DON-A wrote "according to the nursing staff and the provider," photographs of the area indicated scratch marks and opening of 0.5 cm. The medical provider evaluated R1 and provided orders which had been implemented.	01620		

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01620	Continued From page 24 A change in condition assessment dated November 14, 2024, completed by RN-F, indicated R1 experienced slower process of eating, increased tremors and struggling with gait balance. R1 had an increased need for two staff assist with transfers and used a wheelchair. The assessment inaccurately indicated R1 could independently move in bed. The assessment indicated staff are to encourage and assist with turning and repositioning as needed. Although skin concerns were evaluated by both RN-F and DON-A, the change in condition assessment inaccurately indicated R1's skin was "dry, good," with skin issues left blank, the same as all previous assessments. The assessment lacked a Braden Scale assessment (used to determine risk of skin breakdown) with a change in mobility and incontinence status. R1's service plan was not updated until January 29, 2025. The service delivery record indicated December 3, 2024, new services for repositioning and toileting were started. During an onsite visit on January 29, 2025, the investigator noted R1 required the use of a wheelchair for mobility and required the assist of two staff for turning, repositioning and transfers. R1 did not walk and required assist of one staff for locomotion in a wheelchair. During a second interview on February 20, 2025, at 1:00 p.m., DON-A stated she updates R1's care plan because of the changes R1 has had, and ULP are trained on the changes made. DON-A stated assessments are the same unless something changed. DON-A stated she completes a change of condition assessment as soon as she is notified of the change of condition. DON-A stated she completes resident	01620		

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01620	Continued From page 25 assessments by mostly asking the staff if there are any changes and going and seeing the resident. During an interview on February 5, 2025, at 10:00 a.m., family member (FM)-B stated R1 had declined since residing at the facility and needed a wheelchair. FM-B stated the facility did not offer any physical therapy services as she wanted R1 to receive. During an interview on February 14, 2025, at 9:00 a.m., ULP-E stated he noticed a decline with R1's walking, eating and cognitive abilities and notified DON-A. The licensee policy titled, Assessments, Review and Monitoring, dated August 1, 2021, indicated resident reassessment and monitoring must be conducted based on changes in needs and cannot exceed 90 days from the last assessment. The licensee policy titled, Resident Change in Condition or Need, dated August 1, 2021, indicated if a change in service was not a service provided by the licensee, the resident or their representative will be given the option to contract for such service to be provided by an outside provider and delivered to the resident. Neither policy addressed reassessment of residents to be conducted using the uniform assessment tool as required by Minnesota Rules 4659.0140, subpart 2. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

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01760	Continued From page 26	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to transcribe and implement order barrier cream and nursing orders for ointment for a resident with an open buttock wound for one of one residents (R1) 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: R1's diagnoses included traumatic brain injury (TBI) and anxiety disorder.	01760		

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01760	Continued From page 27 R1's service delivery record dated from September 28, 2024, to January 29, 2025, indicated staff assistance included assistance with meals, transfers, walking, dressing, grooming, peri-care and medication assistance. R1's medication administration record (MAR) dated October 2024, included medicated cream orders for ammonium lacate cream (lotion for dry skin) applied twice daily and as needed orders for dibucaine ointment (pain and itch relief) for rectal pain and ketoconazole shampoo for dry scalp. R1's progress note dated November 7, 2024, completed by registered nurse (RN)-F, indicated R1's family expressed concerns about pressure sores on R1's buttocks. RN-F assessed the area and noted five scratch marks approximately 0.5 centimeters (cm) in size each. RN-F documented he informed ULP to frequently walk R1 and reposition him, ensure toileting needs are met and alternate the application of A&D ointment with barrier cream. R1's provider visit note dated November 9, 2024, indicated R1 expressed there was something on his butt that was sore. The provider noted two scratch marks apparent from itching and one small circle, 0.5 cm. The area appeared to be macerated (skin breakdown from moisture)and not pressure. The provider ordered barrier cream twice daily, educated the ULP and DON/administration. New onset shaking concerns were assessed and did not observe shaking on assessment. R1's progress note dated November 11, 2024, completed by director of nursing (DON)-A, indicated she was informed by a county worker	01760		

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01760	Continued From page 28 R1 had developed a pressure ulcer to his bottom. DON-A wrote "according to the nursing staff and the provider," photographs of the area indicated scratch marks and opening of 0.5 cm. The medical provider evaluated R1 and provided orders which had been implemented. R1's MAR dated November 2024, did not include any new cream orders including the barrier cream scheduled twice daily by the medical provider nor A&D ointment. No as needed medicated creams were administered during the month. During an interview on February 4, 2025, at 11:12 a.m., DON-A stated she ensure R1 was repositioned every two hours and apply barrier cream to R1's buttocks. TIME PERIOD FOR CORRECTION: Seven (7) Days	01760		