Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306727746M
Compliance #: HL306724626C

Date Concluded: October 10, 2023

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

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

Evaluator's Name: Willette Shafer, 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 neglected a resident when the facility failed to assist a resident with showering and toileting resulting in a yeast infection and urinary tract infection.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility followed the resident's care plan, attempted interventions, documented the outcome of interventions, and followed up with the resident's care team.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case manager and guardian. The investigation included review of medical records, incident reports, and facility policies. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included schizoaffective disorder, major depression, post-traumatic stress disorder. The resident's service plan included assistance with bathing, toileting, grooming, dressing, housekeeping, and verbal reminders. The resident's assessment indicated the resident was at risk of self-neglect. The resident frequently refused cares and treatments.

During an interview, the case manager stated the resident's room has a strong urine odor. The resident sits in her recliner most of the day and frequently urinates in recliner. The resident prefers to sleep in her recliner. The case manager stated the resident can be difficult to care for as she often declines assistance for care. It's hard to find staff in the memory care area when they visit. The resident is moving soon to a smaller setting for increased level of care. The case manager recently ordered a new chair for the resident and hopes this will reduce the odor in the resident's room.

During an interview, the resident stated staff are unavailable to assist her with bathing and toileting. She is scheduled to shower twice a week. When asked if she would shower if staff were available today, the resident declined. She is concerned her laundry and housekeeping are not done timely. When asked if staff could clean room today, she declined. When the resident declined cares the care plan indicated staff should call the guardian. The resident said staff pressure her to complete showers and grooming when they remind her of the intervention to contact the guardian. The resident is angry she was moved to memory care and said they watch her constantly. The resident stated she chooses to be incontinent rather than request assistance to use the toilet.

The progress notes indicated showers and toileting are documented regularly including completed and declined cares. The resident's care plan was updated, and new interventions were added.

The investigator attempted to contact the previous licensed assisted living director but did not get a response for an interview.

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

Action taken by facility:
The facility has recently hired a new licensed assisted living director and director of nursing. They have implemented new policies, provided staff training, and added processes surrounding medication administration and patient care. Staff attempt to provide cares, implement interventions, and document declination of services.

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 09/15/2023

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: #HL306724388C and #HL306724626C/ #HL306727746M On September 14,2023 through September 15, 2023, 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 45 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL306724626C/ #HL306727746M, tag identification 1290, 1690, 2350. The following correction order is issued for #HL306724388C, tag identification 0510.	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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (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, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards related to COVID-19. This had the potential to affect all 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 of the residents). The findings include: The Center for Disease Control and Prevention (CDC) website updated May 8, 2023, indicated while caring for residents with suspected or confirmed COVID-19 "use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or	0 510		

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0 510	Continued From page 2 a face shield that covers the front and sides of the face)." On September 14, 2023, at 9:05 a.m., the surveyor observed unlicensed personnel (ULP)-H enter the memory care unit without a facemask or protective eyewear. On September 14, 2023, at 9:15 a.m., the surveyor observed several residents with personal protective equipment storage carts outside their rooms. No protective eyewear including shields were observed in the personal protective carts. Surveyor observed five different staff wearing their facemask incorrectly, facemask not covering nose or tucked under chin leaving mouth and nose uncovered, while in resident care areas. On September 14, 2023, at 9:30 a.m., ULP-H was asked if staff wore eye protection while providing cares to residents with COVID-19. ULP-H stated "no, are we supposed to?" ULP-H stated staff were not instructed to wear eye protection when in direct contact with COVID-19 positive residents and the licensee did not provide protective eyewear. On September 14, 2023, at 11:25 a.m., director of nursing (DON)-G stated ten residents tested positive for COIVID-19. The licensee tested all residents on September 13, 2023, after multiple residents complained of symptoms. DON-G stated the licensee was short on supplies but recently placed an order for more personal protective equipment including face shields. The licensee's untitled document related to COVID-19 dated September 12, 2023, failed to address personal protective equipment.	0 510		

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0 510	Continued From page 3 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete background studies four of five employees. This had the potential to affect all 45 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 of the residents).	01290		

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01290	Continued From page 4 The findings include: ULP-I ULP-I started at the licensee June 16, 2022. A review of the MN DHS background study online verification system on September 14, 2023, indicated the licensee did not have ULP-I identified on its roster. A search of ULP-I in this system did not yield any results. The MN DHS did not issue a background study clearance letter for ULP-I. ULP-J ULP-J started at the licensee March 25, 2022. A review of the MN DHS background study online verification system on September 14, 2023, indicated the licensee did not have ULP-J identified on its roster. A search of ULP-J in this system did not yield any results. The MN DHS did not issue a background study clearance letter for ULP-J. ULP-K ULP-K started at the licensee September 5, 2023. A review of the MN DHS background study online verification system on August 22, 2023, indicated the licensee requested a background study August 29, 2023. The MN DHS issued a letter titled MNDHS Fingerprints Time Elapsed Immediate Removal on September 13, 2023, indicated the licensee must immediately remove ULP-K from her position. Additionally, this letter indicated ULP-K could not have a job where she provided direct	01290		

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01290	Continued From page 5 contact services and required a DHS background study. ULP-L ULP-L started at the licensee September 5, 2023. A review of the MN DHS background study online verification system on August 22, 2023, indicated the licensee requested a background study August 29, 2023. The MN DHS issued a letter titled MNDHS Fingerprints Time Elapsed Immediate Removal on September 13, 2023, indicated the licensee must immediately remove ULP-L from her position. Additionally, this letter indicated ULP-L could not have a job where she provided direct contact services and required a DHS background study. During an interview on September 14, 2023, at 1:50 p.m., executive director (ED)-F stated ULP-I, ULP- J, ULP-K, and ULP- L work in direct contact with residents. ED-F stated he was unaware a second step fingerprint was needed until recently. The licensee's Background Studies policy dated August 1, 2021, indicated employees who provide direct services or have independent direct contact with residents must have a completed background study with acceptable results. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living	01690		

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01690	Continued From page 6 facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the security and accountability of controlled substances were maintained for four of four residents (R4, R5, R6, R7).	01690		

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01690	Continued From page 7 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: On September 14, 2023, at 9:45 a.m., unlicensed personal (ULP)-H stated controlled medications are not counted between shifts. ULP-H stated when a narcotic medication is administered, the controlled medication is counted by the staff administering the medication and entered in the electronic narcotic count. On September 14, 2023, at 9:55 a.m. surveyor observed narcotic medications and reviewed narcotic count in electronic medication administration record (EMAR). Discrepancies were observed in three of four resident's narcotic medication counts during observations: R4's EMAR had an order for Morphine (a narcotic pain medication) 5 miligrams (mg) solutab every eight hours and every four hours. R4 had 29 solutabs in the medication cards. The medication count in the electronic medical record was 32. R5's EMAR had an order for Tramadol (controlled pain medication) 50 mg twice a day. R5 had 18 tablets in medication cards. The count in the electronic medical record was 23. R6's EMAR had an order for Clonazepam (controlled antianxiety medication) 0.5 mg one time a day as needed. R6 had seven tabs in	01690		

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01690	Continued From page 8 medication card. The count in the electronic medical record was 23. On September 14, 2023, at 10:00 a.m., director of nursing (DON)-G stated the licensee planned to review the narcotic medications and adjust the counts so they all matched. DON-G stated she was unaware staff were not counting narcotic medication between shifts. DON-G stated staff never informed her of the discrepancies. The licensee's Narcotic Log policy dated April 1, 2020, indicated all scheduled II medication must be counted at the end of each shift by two staff. Both employees must visualize the medication and report to the nurse if there is a discrepancy. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interviews, and record review, the licensee failed to ensure one of one resident (R8) reviewed, was treated with dignity and respect when unlicensed personnel (ULP)-C completed cares with door open and exposed resident's naked body to people outside of R8's room. 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	02350		

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02350	Continued From page 9 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: R8's medical record indicated R8's diagnoses including dementia, Huntington's disease, and depression. During an observation September 14, 2023, at 9:20 a.m., R8's door was wide open while ULP-D and unknown caregiver provided incontinence cares. Another resident from memory care was standing in the doorway watching. During an interview on September 15, 2023, at 11:25 p.m., director of nursing (DON)-G stated privacy should be maintained during resident cares. The licensee's Bill of Rights policy dated August 1, 2021, indicated staff will be trained on the resident's Bill of Rights. TIME PERIOD FOR CORRECTION: Seven (7) days.	02350		