DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306727825M
Compliance #: HL306724693C

Date Concluded: December 13, 2023

Name, Address, and County of Licensee Investigated:
Sunlight Senior Living
400 Western Avenue
St. Paul, MN 55301
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 financially exploited a resident when the facility stole money from the resident while acting as the representative payee.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was not substantiated. While the facility did designate themselves as the representative payee for the resident, they did not withhold or steal any of the resident's money. They did manage the resident's money to pay for his care. A facility cannot act as a representative payee for a resident and a licensing order was issued.

The investigator conducted interviews with facility staff members, including administrative staff. The investigator contacted the cadi case manager and resident. The investigation included review of medical record, financial records, and facility policies.

The resident resided in an assisted living facility. The resident's diagnoses included depression, hemiplegia, and chronic pain. The resident's service plan included assistance with bathing, dressing, grooming, housekeeping, and laundry.

During an interview, the resident stated he moved to a new facility several months ago. Prior to the move, the resident stated the facility was his representative payee and had not paid his new facility any rent money. He also stated he had only received basic needs money once.

During an interview, a case manager stated the facility was the resident's representative payee. The resident had not received his personal needs money and rent had not been paid since moving to his new facility. She had been in contact with the facility, and they recently received a lump sum of back pay from social security. The facility informed her they planned to send the resident a check for his personal needs and keep the rest to apply towards his unpaid rent debt.

During an interview, a member of management stated she received a large sum of back pay from social security. She recently sent the resident's personal needs check to cover the last four months. She stated she sent the social security back pay she received to his new facility to cover his current rent. She stated she was originally told by a lawyer that she may keep the money to pay off past debts but later was told to check with social security and find out what months the payment was for. She stated social security told her the money was for months the resident lived at his new facility. Since the payment was for months the resident lived at his new facility, the funds were sent to his current residence. She recently informed the case manger she sent the check. In addition, the member of management stated she was in the process of transferring representative payee of the resident to another entity to manage his funds.

According to the account summary, the recent funds received from social security were sent to the resident's current facility.

Per an email sent from a member of management to his case manager, the email indicated a check was sent.

In conclusion, the Minnesota Department of Health determined financial exploitation 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means: …
(a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:

(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

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

Action taken by facility:
The facility sent the resident’s recent social security check to his current facility and provided his personal needs money from the back payment received.

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 10/17/2023

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: #HL306725374C/#HL306728206M, HL306725128C/ HL306728047M, HL306725124C/ HL306728045M, HL306724722C/ HL306727808M, HL306725122C /HL306728044M, HL306724693C/ HL306727825M, HL306728046M/HL306725125C On October 12, 2023 through October 17, 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 41 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL306725374C/ HL306728206M, HL306725128C/ HL306728047M, HL306725124C/ HL306728045M, HL306724722C/ HL306727808M, tag	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.	

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0 000	Continued From page 1 identification 0470, 1750, 2360. The following correction orders are issued for #HL306724693C/ HL306727825M, tag identification 0590. No correction orders are issued for HL306728046M/HL306725125C.	0 000		
0 470 SS=I	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;	0 470		

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0 470	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels required to meet the schedule services and unexpected needs of all residents. This affected all 41 residents. As a result, only staff member was repeatedly scheduled on night shift and the memory care unit was left unattended for periods of time. 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 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: The licensee's total census was 41 residents. Of the 41 residents, 33 resided in assisted living and eight resided in the secured memory care unit. R1 was admitted to the facility December 21, 2022. R1's diagnoses included paraplegia, pressure ulcer left and right hip. R1's service plan indicated R1 requires assistance with bathing, grooming, dressing, catheter care, two-person transfer with full body lift, repositioning, wound care, medication management including narcotic medication, behavior monitoring, meals, housekeeping, laundry, and safety checks. R2 was admitted to the facility December 7, 2022.	0 470		

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0 470	Continued From page 3 R2's diagnoses included adult failure to thrive, muscle weakness, urinary tract infections. R2's service plan indicated R2 requires assistance with bathing, grooming, dressing, two-person transfer with full body lift, medication management, meals, housekeeping, laundry, and safety checks. R3 was admitted to the facility November 18, 2020. R3's diagnoses included multiple sclerosis, major depression, anxiety, and narcotic dependence. R3's service plan indicated R3 requires assistance with monitoring self-injurious behavior, meals, housekeeping, medication set-up, laundry, and safety checks. During an interview on November 11, 2023, at 12:00 p.m., a nurse stated R1 reported to her the overnight staff never reposition him. He told her that he has pulled his call light at midnight and staff don't answer his call until between 6:00 a.m. and 7:00 a.m. R1 reported he stayed awake at night so he could try to reposition himself to offload pressure to prevent his wounds from worsening. During an interview on October 17, 2023, at 11:40 a.m., R2 stated staff never answered her call lights and had to sit in urine-soaked briefs. She stated this contributed to her urinary infections. During an interview on October 17, 2023, at 11:20 p.m., R3 stated she can't find any staff any members after 9:00 p.m. R3 stated staff leave before the next shift arrives leaving the building without any staff. She stated, "if you're looking for help, forget it." During an interview on October 12, 2023, at 12:25 p.m., assistant executive director (AED)-E stated	0 470		

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0 470	Continued From page 4 one day she arrived to work at 9:00 a.m., and only one staff was in the facility. AED-E stated no cars were in the parking lot and only one staff was working in memory care when she toured the building. AED-E stated she was told staff refused to come to work because they were upset at the previous administration. AED-E stated on a different date when she arrived at work, there were no kitchen staff onsite. AED-E stated she gave the residents cereal, milk, and yogurt around 10:00 a.m. On October 18, 2023, at 2:54 p.m., licensed assisted living director (LALD)-A provided a staff timecard punch log for August 2023. The punch log indicated only one staff worked the night shift for 13 of the 31 days. On November 8, 2023, the staffing plan was requested via email. LALD-A provided the Staffing & Scheduling policy that had been previously provided. A staffing plan was not provided. Review of the staff schedule indicated night shift was from 10:00 p.m. to 6:00 a.m. On November 21, 2023, LALD-A provided a staff timecard punch log for November 1 through November 20, 2023. The November punch log indicated one staff worked alone for four of the 20, night shifts. The punch log also indicated on two other night shifts one staff worked alone for half of the shift. During an interview on November 15, 2023, at 12:45 p.m., unlicensed personnel (ULP)-C stated she has worked alone at night. ULP-C stated she most recently worked alone the previous week. ULP-C stated laundry was completed on the night	0 470		

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0 470	Continued From page 5 shift and the laundry takes three hours to complete. ULP-C stated she left the secured memory care unit unattended to complete safety checks and cares for the residents on the assisted living side. ULP-C stated she was not trained by a registered nurse to pass medication. ULP-C stated she has administered medication to the residents when needed, as she is the only staff in the building. She recently administered Tylenol for a pain to a resident. During an interview on November 16, 2023, at 11:00 a.m., director of nursing (DON)-B stated she assisted LALD-A with developing the staff schedule. DON-B stated she was unaware staff have worked alone at night. DON-B stated she and LALD-A rotate as the on-call administrator. The on-call administrator receives employee sick calls. At times they are unable to cover shifts when staff call in. DON-B stated all residents at the facility receive services including safety checks and laundry is completed at night. DON-B stated a staffing plan was not completed for the facility. DON-B stated only staff who completed medication administration training by a registered nurse should pass medications. The licensee's Staffing & Scheduling policy dated August 1, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the resident's needs, 24-hour-hours a day, seven days a week staffing including reasonably foreseeable needs. TIME PERIOD FOR CORRECTION: Two (2) days	0 470		

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0 590	Continued From page 6	0 590		
0 590 SS=D	144G.42 Subd. 3 Facility restrictions (a) This subdivision does not apply to licensees that are Minnesota counties or other units of government. (b) A facility or staff person may not: (1) accept a power-of-attorney from residents for any purpose, and may not accept appointments as guardians or conservators of residents; or (2) borrow a resident's funds or personal or real property, nor in any way convert a resident's property to the possession of the facility or staff person. (c) A facility may not serve as a resident's legal, designated, or other representative. (d) Nothing in this subdivision precludes a facility or staff person from accepting gifts of minimal value or precludes acceptance of donations or bequests made to a facility that are exempt from section 501(c)(3) of the Internal Revenue Code. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff did not act as the resident's financial designee/representative payee (rep payee) for one of one resident (R6) reviewed. The facility acted as R6's rep payee and controlled R6's finances. 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).	0 590		

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0 590	Continued From page 7 The findings include: R6 had an admit date of October 17, 2022, with diagnoses that included major depressive disorder, hemiplegia, and diabetes mellitus. R6's care plan dated October 13, 2023, indicated R6 received services for medication management, bathing, grooming, housekeeping and safety checks. During interview on December 7, 2023, at 11:05 a.m., R6 stated he recently moved to a new facility. R6 stated his previous facility was his representative payee and he has not received his basic needs money for months. R6 also stated his rent has not been paid at his current facility since he has been living there. During an interview on December 7, 2023, at 2:40 p.m., case manager (CM)-A stated his previous facility was his representative payee. She stated this was set up after his prior representative payee failed to pay R6's bills. CM-A stated R6's representative payee is in the process if being transferred to an agency. During an interview on December 12, 2023, at 11:30 a.m., owner (O)-B stated the facility was R6's representative payee and responsible for handling R6's money. O-B stated the representative was in the process of being transferred to another entity. O-B stated she recently sent R6's social security payment to R6 and his new facility. Review of the residents' and facility financial statements and logs indicated R6's finances where handles by his previous placement.	0 590		

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0 590	Continued From page 8 TIME PERIOD OF CORRECTION: Twenty-one (21) days.	0 590		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure a registered nurse (RN) trained unlicensed personnel (ULP) on medication administration, ensure demonstrated competency and communicate indivudal medication needs of each resident prior to delegating the taks of medication administration services for one of one ULP (ULP-C). ULP-C worked alone on the night shift and had responsibility to provided medications to all residents on medication 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 widespread scope (when	01750		

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01750	Continued From page 9 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: ULP-C began working for the licensee January 25, 2023. During an interview on November 15, 2023, at 12:45 p.m., ULP-C stated she was not trained by a RN to pass medications. ULP-C stated another ULP who was trained as a medication aide showed her how to administer medications. ULP-C stated she has administered medications while working alone on the night shifts. She stated she was told she could administer all medications except narcotics. On November 21, 2023, an email sent from licensed assisted living direction (LALD)-A indicated ULP-C's personnel file was "misplaced." ULP-C's personnel file was never provided. During an interview on November 16, 2023, 3 at 11:00 a.m., director of nursing (DON)-B stated ULP-C was not trained on medication administration by a registered nurse. The licensee's Medication & Treatments policy dated August 1, 2021, indicated the registered nurse will ensure the unlicensed personnel is educated and competent on the medication procedures. TIME PERIOD FOR CORRECTION: SEVEN (7) days	01750		

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02360	Continued From page 10	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure three of five residents reviewed (R1, R2, R3) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction required for tag 2360. Please refer to the public maltreatment report for details.	