

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306728206M,
HL306728047M, HL306728045M,
HL306727808M, HL306728044M

Date Concluded: December 19, 2023

Compliance #: HL306725374C, HL306725128C,
HL306725124C, HL306725122C,
HL306724722C

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: Substantiated, facility responsibility

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 residents when the facility did not ensure enough staff were available to provide assistance with services and supervision according to the resident's care plans.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility was licensed as an assisted living with dementia care and provided services to all 41 residents. Of the 41 residents, 33 resided in assisted living and eight resided in the secured memory care unit. On several dates, there was only one staff working in the facility. The facility failed to evaluate resident scheduled and anticipated unscheduled cares and services to develop a staffing plan that provided appropriate levels of

staffing in the facility. In addition, the facility failed to ensure there was at a minimum two staff on the overnight shift as required by the staff schedule that were trained and competent to provide required resident services, such as medication administration. As a result, the facility failed to ensure staff were available to provide care and ensure safety to all residents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, personnel files, facility policies, staff schedules and staff time clock punch log. Also, the investigator toured the facility and observed interactions between staff and residents.

The investigator requested the facility's staffing plan. The facility provided a staffing and scheduling policy. The investigator informed facility management, the policy did not address the requirements of the staffing plan that determined appropriate staffing levels based on evaluation of resident needs and inquired if the facility had a staffing plan. The facility again sent the staffing and scheduling policy and did not provide a developed staffing plan.

Resident 1 resided in an assisted living facility. Resident 1's diagnoses included paraplegia and non-healing ulcers on both hips. Resident 1's service plan included assistance with repositioning, medication management, grooming, dressing, bathing, catheter care, transfers, housekeeping, laundry, and safety checks.

Resident 2 resided in an assisted living facility. Resident 2's diagnoses included adult failure to thrive, morbid obesity, muscle weakness, major depression, cognitive deficits, and urinary tract infection. Resident 2's service plan included assistance with dressing, bathing, medication administration, transfers, repositioning, toileting, grooming, housekeeping, and laundry.

Resident 3 resided in an assisted living facility. Resident 3's diagnoses included multiple sclerosis, stroke, muscle weakness, major depression, and anxiety disorder. Resident 3's service plan included assistance safety checks including behavior tracking, medication administration, laundry, and housekeeping.

During an interview, a member of management stated when she arrived at work there was only one staff in the facility. There were no cars in the parking lot and the one staff was on the memory care unit. Later, she was told staff refused to work because they were mad at administration. During a separate incident on a different date, she arrived at work and no kitchen staff were onsite at 9:00 a.m. Residents were in the dining room waiting for breakfast. She gave the residents cereal, milk, and yogurt at 10:00 a.m.

During an interview, a housekeeper said he has been the only staff in the building "a couple times." There have been times he has arrived at work in the morning and no staff were in the facility. He stated there were no cars in the parking lot, no staff in the offices, and he was unable to find staff anywhere in the facility. He stated the facility has terminated staff in the past because they were leaving before the other shift arrived which left the facility unattended.

Review of the staff timecard punch log for the month of the allegations, indicated only one staff worked the night shift on 13 of the 31 days to care for all 41 residents, for both memory care and assisted living. Therefore, memory care was left unattended during laundry and assisted living resident cares. The staff scheduled showed the night shift was scheduled from 10:00 p.m. to 6:00 a.m. One staff member would not be able to complete all scheduled resident services for 41 residents in five hours, as laundry took three hours to complete per night shift staff interview.

During an interview, a nurse from an outside agency stated resident 1 reported facility staff never answered his call light at night. Resident 1 reported to her he pulled his call light at midnight and staff never answered his call light until day shift arrived. Resident 1 reported he was never repositioned at night. He stayed awake to adjust his bed to off load pressure because he worried his wound would worsen if left in one position all night. Resident 1 also reported his medications were not administered as ordered. He reported on several occasions when he requested medication, the staff never came back.

During an interview, resident 2 stated she required assist from staff with brief changes and hygiene. She stated she developed a urinary tract infection due to lack of hygiene cares and timely brief changes. She put her call light on, but staff never came to assist her with changing her briefs. Resident 2 stated she had to sit in her urine-soaked briefs. She stated staff also failed to administer her prescribed antibiotic for her urinary tract infection as ordered.

During an interview, resident 3 stated staff smelt like marijuana and leave [their shift] before they were supposed to. She stated “you can’t find anybody after 9:00 o’clock at night. If you’re looking for help, forget it.”

During an interview, an unlicensed personnel (ULP) stated she has worked alone at night. She most recently worked alone during the previous week. She stated laundry is completed on the night shift and takes three hours to complete. She left the secured memory care unit unattended when she completed safety checks and cares for residents on the assisted living unit. She was not trained by a registered nurse to administer medication but administered medications to residents. The ULP stated she recently administered Tylenol to a resident and stated she could administer all medications except narcotics.

During an interview, a nurse stated she helped make the staff schedule. She was unaware one staff has worked alone at night. She and a member of management rotate as the on-call administrator. It was the on-call administrators’ responsibility to find coverage when staff call-in sick. Sometimes they were unable to cover shifts and the facility was left short staffed. The nurse stated all residents received services including safety checks and laundry was completed at night. The nurse stated ULP must be trained by a registered nurse before they administer medications.

During an interview, a second member of management stated he helped create the staff schedule. He shared the on-call duties including employee sick calls and covering shifts. He stated he was informed staff have worked alone at night but not until after the shift was completed.

Review of the staff timecard punch log for November 1 through November 20, 2023, (during the course of the investigation) indicated only one staff worked for all or part of the night shift six times, which showed sufficient staffing to provide required resident care continued to be an issue for the facility beyond the time of the allegations.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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 recently hired new management staff who are implementing new processes surrounding resident care, staffing, and medication administration.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

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

Ramsey County Attorney

St. Paul City Attorney

St. Paul Police Department

Minnesota Board of Nursing

Minnesota Board of Executives for Long Term Services and Supports

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30672	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2023
NAME OF PROVIDER OR SUPPLIER SUNLIGHT SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 400 WESTERN AVENUE SAINT PAUL, MN 55103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****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.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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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 of 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 were handled 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30672	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/17/2023
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
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			

Minnesota Department of Health

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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.		