

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL306728302M  
**Compliance #:** HL306729583C

**Date Concluded:** June 15, 2026

## **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 staff failed to provide nephrostomy (a thin tube directly inserted into the kidney to drain urine) cares, medications, and general hygiene care to the resident per medical provider orders.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was inconclusive. While the resident's records indicated many missed doses of medications and lacked documentation of bathing services received, the resident was often non-compliant with his plan of care and frequently left the facility for long periods of time without notifying the facility staff which led to the missed services.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident records, pharmacy records, facility incident reports, personnel files, staff schedules, and related facility policy and

procedures. Also, the investigator observed medication administration to residents while on site.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes and atrial fibrillation. The resident's service plan included assistance with behavior management, bathing services two days a week, safety checks three times daily and medications set up every week. The resident's assessment indicated the resident was alert, oriented, and used an electric wheelchair for mobility.

The resident's medication administration record (MAR) indicated the resident did not receive five doses of his provider ordered anticoagulant (blood thinner) medication due to the resident's refusal or was not present in the facility to receive it. The resident did not receive eight doses of his provider ordered insulin due to the resident's refusal or was not present in the facility.

The following month, the resident's MAR indicated the resident did not receive 13 doses of his provider ordered anticoagulant medication due to the resident's refusal or was not present in the facility to receive it. The resident did not receive 25 doses of his provider ordered insulin due to the resident's refusal or was not present in the facility.

The third month, the resident's MAR indicated the resident did not receive 11 doses of his provider ordered anticoagulant medication due to the resident's refusal or was not present in the facility to receive it. The resident did not receive 25 doses of his provider ordered insulin due to the resident's refusal or was not present in the facility.

The resident's progress notes indicated facility staff made multiple phone calls to the resident's medical providers regarding the resident's anticoagulant medication and variety of issues such as the order being sent to the wrong pharmacy resulting in delay of administration to the resident. The notes indicated staff reached out the resident's provider for medication clarification and sought further directive for continuing the anticoagulant medication. The provider notified the facility staff they have not been able to get ahold of the resident due to the resident not being at the facility or answering his phone. The notes also indicated staff reached out to the resident's provider for anticoagulation medication clarification and sought further directive for continuing the medication.

The residents service delivery record indicated the resident received four showers in a month, and only one shower the following month. The record did not indicate a reason showers were not provided. The record indicated resident safety checks were completed as scheduled and frequently noted the resident to not be at the facility at the time of the safety check.

During an interview, a facility management staff member stated the facility offered all care needs the resident required. The staff member stated it was facility policy for residents to let staff know two hours ahead of time if they planned to leave the facility for an extended period,

so they could prepare their medications to go with them. The staff member stated staff reapproach the resident who had refused a service to reoffer the service and notify their supervisor if the resident continued to refuse. The resident's provider was notified if a pattern of refusals of care was present.

During an interview, a nurse stated the resident used an external provider who came to the facility to perform care on his nephrostomy tubes, and the facility staff completed as needed care on the tubes. The nurse stated it was the resident's responsibility to notify staff they were leaving the facility so staff can package their medications to send with them. The nurse stated he notified the resident's provider when he missed medications and documented the notifications. The nurse stated the resident was not compliant with his nephrostomy bag cares, tube cares, bathing, or medication administration. The nurse stated the resident left the facility all the time and did not give staff notice. The nurse stated the resident never expressed any complaints or concerns to him and would not allow staff in his room.

The resident was his own representative and declined to complete an interview. There was no other family contact listed.

In conclusion, the Minnesota Department of Health determined neglect was 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:** No, declined.

**Family/Responsible Party interviewed:** No, resident was own responsible party.

**Alleged Perpetrator interviewed:** Not Applicable.

**Action taken by facility:**

No action taken.

**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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30672</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/21/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SUNLIGHT SENIOR LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>400 WESTERN AVENUE SAINT PAUL, MN 55103</b>
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0 000	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>HL306729583C/HL306728302M HL306721640C</p> <p>On May 20, 2026 through May 21, 2026, 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.</p> <p>The following correction order is issued for HL306729583C/HL306728302M, tag identification 1760.</p> <p>The following correction order is issued for HL306721640C, tag identification 2320.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
01760 SS=I	<p><b>144G.71 Subd. 8 Documentation of administration of medication</b></p>	01760		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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01760	<p>Continued From page 1</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to document the reason medication administration was not completed as prescribed and failed to indicate any follow up procedures provided when medication was not administered, as required for 2 of 2 residents (R1 and R4) reviewed. Additionally, the licensee failed to correctly transcribe a medication order, as required for 1 of 1 residents (R1) reviewed.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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).</p> <p>The findings include:</p> <p>R1's diagnosis includes diabetes and atrial fibrillation. R1's service plan dated July 28, 2025,</p>	01760		
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01760	<p>Continued From page 2</p> <p>indicated R1 received behavior management, catheter care, and medication set up.</p> <p>R1's physician notes dated June 5, 2025, indicated R1 saw his medical provider post hospitalization. R1 had recurrent lower leg deep vein thrombosis (blood clot and risk for stroke) from missed doses of Xarelto (blood thinner/anticoagulant).</p> <p>R1's assessment dated November 1, 2025, indicated R1's medications were managed by nursing staff. The assessment did not indicate any individualized plans or interventions for R1's known refusals and missed medication patterns.</p> <p>R1's progress notes dated November 16, 2025, at 8:32 a.m. indicated an order was received from the medical provider to stop Xarelto (blood thinner) and start coumadin (blood thinner).</p> <p>R1's medication administration record (MAR) dated November 2025, indicated by staff signature that Xarelto and coumadin were both given at 5:00 p.m. on November 16, 2025, because both orders remained on the MAR.</p> <p>R1's MAR dated November 2025, indicated R1 did not receive five doses of anticoagulant medication as ordered in the month due to R1's leave of absence. R1's records lacked documentation to indicate any actions or follow up completed by staff for the missed medications.</p> <p>R1's MAR dated November 2025, indicated R1 did not receive eight doses of insulin as prescribed in the month due to R1's refusal or leave of absence. R1's records lacked documentation to indicate any actions or follow up completed by staff for the missed doses.</p>	01760		
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01760	<p>Continued From page 3</p> <p>R1's MAR dated December 2025, indicated R1 did not receive 25 doses of insulin as prescribed in the month due to R1's refusal or leave of absence. R1's records lacked documentation to indicate any actions or follow up completed by staff for the missed doses.</p> <p>R1's MAR dated December 2025, indicated R1 did not receive 13 doses of anticoagulant medication as prescribed in the month due to R1's refusal or leave of absence. R1's records lacked documentation to indicate any actions or follow up completed by staff for the missed doses.</p> <p>R1's MAR dated January 2026, indicated R1 did not receive 25 doses of insulin as prescribed in the month due to R1's refusal or leave of absence. R1's records lacked documentation to indicate any actions or follow up completed by staff for the missed doses.</p> <p>R1's MAR dated January 2026, indicated R1 did not receive 11 doses of anticoagulant medication as prescribed in the month due to R1's refusal or leave of absence. R1's records lacked documentation to indicate any actions or follow up completed by staff for the missed doses.</p> <p>R1's assessment dated February 2, 2026, indicated R1 was able to safely self-administer his own medications, however all of R1's medications were stored in a locked medication cart of the facility's and administered by medication trained staff. Medication was managed and reviewed by the nurse.</p> <p>R4's diagnosis are unknown due to no indication of them on the documents received from the</p>	01760		
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01760	<p>Continued From page 4</p> <p>licensee. R4's service plan, unsigned and undated, indicated R4 received behavior management, medication set ups and medication assistance.</p> <p>R4's MAR dated April 2026, indicated R4 did not receive 52 doses of medications as prescribed in the month due to refusal or unknown reason due to no staff signature noted. R4's medical record lacked documentation to indicate any actions or follow up completed by staff for the missed medications.</p> <p>R4's MAR dated May 2026, indicated R4 did not receive 100 doses of medications as prescribed in the month due to resident refusal or unknown reason due to no staff signature noted. R4's medical record lacked documentation to indicate any actions or follow up completed by staff for the missed medication</p> <p>During an interview on June 4, 2026, at 9:30 a.m., registered nurse (RN)-E stated a resident must notify staff when they are leaving so the staff can give the resident their medications before leaving. RN-E stated staff must attempt at least two times to give a resident their medications, and if the resident ultimately refused the medications, they documented the refusal and notified RN-E. RN-E stated he notified resident's providers if the resident refused their medications. RN-E stated he always documented resident refusals and provider notifications. RN-E stated R1 left the facility frequently and did not give the facility notice and did not ask about his medications or tell staff where he was going.</p> <p>During an interview, licensed assisted living director (LALD)-D stated residents were to notify staff two hours prior to leaving the facility so staff</p>	01760		
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01760	<p>Continued From page 5</p> <p>can gather their medications for them to go with them or take the medications before they leave. LALD-D stated staff should reapproach a resident who has refused their medications and notify the supervisor for a further plan or to determine the root cause of rejected medications. LALD-D stated it was documented that the resident's medical provider was notified, and the resident was re-educated if medication refusal was a pattern.</p> <p>The licensee-provided policy titled Medication and Treatment Record- Documentation and Refusal, dated August 1, 2021, indicated if a medication was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided.</p> <p>The licensee-provided policy titled Medication Management- Administration and Setup, dated August 1, 2021, indicated the licensed nurse who set up the medications in the dosage box will observe and monitor the past week's medication administration documentation and compliance and will initial that this has been done. The document indicated that unlicensed personnel would document any reason why a medication was not administered as prescribed and document any follow up procedures that were provided to meet the resident's needs when medication was not administered.</p> <p>The licensee-provided policy titled Medication Management Individualized Plan dated August 1, 2021, indicated a resident assessment must contain a resident specific information related to medication administration, verification all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.</p>	01760		

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02320 SS=D	<p>144G.91 Subd. 4 (b) Appropriate care and services</p> <p>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and observation, the licensee failed to provide appropriate bathing services, as required for 1 of 1 residents (R2) reviewed.</p> <p>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}.</p> <p>The findings include:</p> <p>R2's diagnosis includes cerebral palsy, quadriplegia, and chronic pain. R2's service plan dated May 20, 2026, indicated R2 received bathing assistance three days a week and grooming assistance two times a day.</p>	02320		

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02320	<p>Continued From page 7</p> <p>R2's service delivery record dated August 2025, indicated R2 received six out of 12 showers in the month. The record lacked documentation of why showers were not received per R2's plan of care. The record indicated unlicensed personnel (ULP)-F completed two of the showers, and ULP-G completed the other four showers.</p> <p>R2's service delivery record dated September 2025, indicated R2 received five out of 12 showers in the month. The record lacked documentation of why showers were not received per R2's plan of care. The record indicated ULP-G completed four of the showers.</p> <p>ULP-F's training records dated October 19, 2021, indicated ULP-F passed skills and competency training on resident bathing.</p> <p>ULP-G's training records dated March 14, 2025, and signed by registered nurse (RN)-A, lacked documentation to indicate whether ULP-G passed or failed skills and competency testing for resident bathing.</p> <p>A photo of R2's head and scalp, undated, revealed excessive oil and large dandruff flakes throughout R2's head.</p> <p>During an interview on June 2, 2026, at 9:30 a.m., family member (FM)-B stated she moved R2 out of the facility due to poor care. FM-2 stated there were a lot of days staff did not get R2 out of bed in time to eat breakfast and did not bring her tray to her room. FM-B stated snacks were not available and family brought snacks for R2.</p> <p>During an interview on June 2, 2026, at 2:00 p.m., licensed assisted living director (LALD)-D</p>	02320		
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02320	<p><b>Continued From page 8</b></p> <p>stated residents receive showers twice a week or per their plan of care. LALD-D stated if a resident declined a shower, staff should reapproach, document the refusal, and notify a clinical supervisor.</p> <p>During an interview on June 4, 2026, at 9:30 a.m., RN-E stated resident meal intakes are not documented, but staff make sure residents are up and make it to the dining room to eat. A licensee-provided policy titled Bathing Assistance, dated August 1, 2021, indicated staff are to wash body parts a resident cannot.</p> <p>There was no licensee-provided policy received regarding feeding assistance or mealtime procedures.</p> <p><b>TIME PERIOD FOR CORRECTION: Seven (7) days</b></p>	02320		