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 #: HL306729002M
Compliance #: HL306727224C

Date Concluded: May 6, 2025

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

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

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 resident was neglected by the facility when the resident was missing from the facility for two days and hospitalized for malnourishment. In addition, the resident was financially exploited by a facility staff member, an alleged perpetrator when unapproved charges were made with the resident's debit card.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Following concerns about the resident's mental health, the resident left the facility unsupervised and was missing for two nights. The facility failed to ensure the resident's safety by searching for the resident, notifying law enforcement, and/or the resident's primary care provider. Although the facility provided an incident report indicating law enforcement was notified the day the resident left, law enforcement stated there was no call or report in the time frame the resident was missing from the facility.

The Minnesota Department of Health determined financial exploitation was not substantiated. During the investigation, there was no evidence that the resident was financially exploited by an AP.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident's case worker. The investigation included review of the resident records, hospital records, facility incident reports, staff schedules and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living memory care unit. At the time of the incident, the resident resided in assisted living. The resident's diagnoses included Parkinson's disease, impaired cognition, and bipolar disorder. The resident's assessment indicated the resident's services included medication management, diabetes management, and safety management. The resident could walk independently and had poor nutrition intake due to depression. The resident was a vulnerable adult, needed monitoring, supervision and redirection, and was paranoid that someone was stealing from her.

The resident's progress notes indicated five days prior to the resident leaving the facility, the facility began a monitoring plan for the resident due to the resident's declining mental health in order to provide support, safety, and assistance. The progress notes indicated the resident took her medications for a day or two, then would not take them for several days. Licensed staff assessed the resident for self-neglect. Two nights after the resident left the facility, the resident returned to the facility, the nurse assessed the resident to be weak, dehydrated, and more confused than normal. The resident was transported to the hospital because of increased paranoia and abnormal vital signs.

An incident report indicated one day staff could not find the resident in her room. Staff notified management and called 911. However, the incident report lacked an electronic signature and date to indicate that it was completed and authenticated on the date of the incident.

The resident's medical record lacked evidence that the resident left the facility, and any efforts made to locate the missing resident.

Hospital records indicated the resident was transported to the hospital after paranoia led the resident to leave the facility for a couple of days. The resident was initially placed on a 72-hour psychiatric hold because of worsening psychosis (a state where a person experiences a disconnect from reality, often involving hallucinations and delusions). The hospital records indicated the resident's mental health was stabilized after being hospitalized for 84 days and returned to the facility.

During an interview, the resident did not recall spending two nights out in the community. The resident stated someone had her debit card and credit card information and made purchases

for food and groceries. The resident stated she did not know who the person was making charges on her debit card and credit card and did not have bank statements to show the charges.

During an interview, the nurse stated a monitoring plan for the resident included safety checks and were started because of concerns for the resident's mental health and behaviors. The nurse stated one day in the afternoon despite the safety checks the resident left the facility and spent two nights out in the community. After two days, facility staff notified the police. The police found the resident wandering in the community a few blocks from the facility and returned the resident to the facility. The nurse stated the resident should not have spent two nights in the community by herself. When the resident returned to the facility, staff arranged for the resident to be evaluated at a hospital because she was experiencing increased paranoia. The nurse stated the resident did not report anything about missing money and she was not aware if the resident had a debit or credit card.

A representative from the local law enforcement stated there was no report of a missing resident that matched the resident's name, facility, and time frame of incident. The representative stated when a facility reports a missing resident, an investigator gets assigned to the case and there would always be a report created.

In conclusion, the Minnesota Department of Health determined neglect was substantiated and financial exploitation was not 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.

"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.

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: No. Resident was responsible for self.
Alleged Perpetrator interviewed: No. An AP could not be identified.

Action taken by facility:
When the resident returned to the facility, facility staff arranged for the resident to be evaluated at a hospital.

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

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 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNLIGHT SENIOR LIVING	**400 WESTERN AVENUE SAINT PAUL, MN 55103**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL306729002M/#HL306727224C On April 16, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 39 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL306729002M/#HL306727224C, tag identification 0590 and 2360.	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.	
0 590 SS=E	144G.42 Subd. 3 Facility restrictions (a) This subdivision does not apply to licensees	0 590		

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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 not act as the resident's financial designee/representative payee (rep payee) for 16 of 39 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15 and R16) reviewed. The licensee acted as the residents representative payee and controlled their 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

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The findings include:

Review of R1's medical record indicated R1's diagnosis included Parkinson's disease, impaired cognition and bipolar disorder. R1's assessment dated December 26, 2024, indicated the licensee was the rep payee for R1. R1's assessment indicated R1 was a vulnerable adult.

Review of R2's medical record indicated R2's diagnosis included schizophrenia and paranoid. R2's assessment dated April 3, 2025, indicated R2's family members assisted with financial decisions. R2's assessment indicated R2 was a vulnerable adult, had memory loss and was unable to recall events.

Review of R3's medical record indicated R3's diagnosis included stroke, difficulty swallowing and depression. R3's assessment dated February 18, 2025, indicated R3 had a rep payee but that the licensee would need to manage the petty cash so licensee can buy personal items. R3's assessment indicated R3 was a vulnerable adult.

Review of R4's medical record indicated R4's diagnosis included stroke, muscle weakness, aphasia (loss of ability to understand or express speech, caused by brain damage) and dementia. R4's assessment dated February 10, 2025, indicated R4's family member assisted with financial decisions. R4's assessment indicated R4 was a vulnerable adult and at risk for being abused by others.

Review of R5's medical record indicated R5's diagnosis included congestive heart failure. R4's assessment dated February 10, 2025, indicated R4 was independent with financial decisions. R4's assessment indicated R4 had ongoing support for

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0 590	Continued From page 3 vulnerabilities that included physical, verbal, emotional and financial abuse. Review of R6's medical record indicated R6's diagnosis included anxiety, agitation, organic personality disorder and schizophrenia. R6's assessment dated March 9, 2025, indicated the licensee was rep payee for R6. R6's assessment indicated R6 was a vulnerable adult. Review of R7's medical record indicated R7's diagnosis included diabetes and muscle weakness. R7's assessment dated February 5, 2025, indicated R7 was independent with financial decisions. R7's assessment indicated R7 was not at risk to be abused. Review of R8's medical record indicated R8's diagnosis included depression and muscle weakness. R8's assessment dated April 14, 2025, included R8 was independent with financial decisions. R8's assessment indicated R8 was a vulnerable adult and was at risk for abuse. Review of R9's medical record indicated R9's diagnosis included respiratory failure and malnutrition. R9's assessment dated March 30, 2025, indicated R9 was independent with financial decisions. R9's assessment indicated R9 was a vulnerable adult. Review of R10's medical record indicated R10's diagnosis included right ear deafness and paraplegia (paralysis of the lower body). R10's assessment dated April 7, 2025, indicated R10 was independent with financial decisions. R10's assessment indicated R10 was not at risk for abuse and had daily monitoring due to physical limitations and dependence.	0 590		

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0 590	Continued From page 4 Review of R11's medical record indicated R11's diagnosis included schizoaffective disorder with psychosis and bipolar disorder. R11's assessment dated February 10, 2025, indicated R11 was independent with financial decisions. R11's assessment indicated R11 was a vulnerable adult. Review of R12's medical record indicated R12's diagnosis included schizophrenia. R12's assessment dated March 19, 2025, indicated the licensee was the rep payee for R12. R12's assessment indicated R12 was a vulnerable adult. Review of R13's medical record indicated R13's diagnosis included cerebral palsy and quadriplegia. R13's assessment dated April 14, 2025, indicated R13 and a family member made financial decisions. R13's assessment indicated R13 was a vulnerable adult. Review of R14's medical record indicated R14's diagnosis included dementia, paranoid schizophrenia, muscle weakness and depression. R14's assessment dated February 2, 2025, indicated a family member made financial decisions for R14. R14's assessment indicated R14 was a vulnerable adult. Review of R15's medical record indicated R15's diagnosis included paraplegia and muscle weakness. R15's assessment dated April 14, 2025, lacked documentation on who was responsible to make financial decisions for R15. R15's assessment indicated R15 was a vulnerable adult. Review of R16's medical record indicated R16's diagnosis included heart failure, malnutrition,	0 590		

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muscle weakness, and difficulty walking. R16's assessment dated March 3, 2025, indicated R16 had a rep payee but failed to identify who was designated as the rep payee. R16's assessment indicated R16 was a vulnerable adult.

All 16 residents had signed and/or dated document from the licensee titled Resident Fund Management Service, which provided the licensee authorization and agreement to handle resident funds. All 16 documents included the resident's account number and a direct deposit number.

During an interview on April 16, 2025, at 1:39 p.m., Leadership-B stated that 16 of the 39 residents at the licensee residence have a resident fund management services account. Leadership-B stated most of the residents have their social security check deposited directly into the licensee's account and the rent owed to the licensee was first paid out of the account. Leadership-B stated any money left over after the the residents monthly rent was paid would be given to the residents on the 7th or 8th of each month. Leadership-B stated he did not know the licensee could not be the rep payee for the 16 residents.

The licensee policy titled Handling of Resident Finances and Property dated August 1, 2021, indicated the licensee may assist residents with simple financial tasks such as budgeting, paying bills, and purchasing household goods, but will not otherwise manage a resident's property, unless authorized by the resident or his/her responsible party/guardian. The policy further indicated if residents funds are deposited with the licensee, the licensee will assume fiduciary and custodial responsibility for the funds and will be

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0 590	Continued From page 6 directly accountable to the resident for the funds. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 590		
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 one of one resident reviewed (R1) was 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		