Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306723361M
Compliance #: HL306723481C

Date Concluded: October 15, 2024

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

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

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Substantiated, facility responsibility

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 a resident when the facility staff failed to reposition and assist the resident with toileting according to his plan of care. The resident's wounds on his coccyx worsened.

The facility neglected a resident when he had a fall and was left on the ground for several hours with no assistance from the facility staff, leading to hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident had wounds to his coccyx (tailbone), right lateral malleolus (outside ankle bone), right medial malleolus (inside ankle bone), and right heel. The facility failed to document and ensure the resident was repositioned and did not provide any

orders for staff to provide wound care or interventions to prevent skin breakdown, which contributed to the deterioration of the resident's wounds.

The Minnesota Department of Health determined neglect was inconclusive due to conflicting information. The resident had a fall at the facility and was transferred to the hospital. The resident told hospital staff he had been on the floor for four hours before calling emergency services on his own. Facility staff stated they saw the resident less than two hours prior to the resident calling emergency services and he was not on the floor.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigation included review of medical records, staff training, repositioning logs, and wound care orders.

The resident resided in an assisted living facility. The resident's diagnoses included chronic kidney disease, diabetes mellitus, and multiple sclerosis. The resident's service plan included assistance with bathing, dressing, grooming, toileting, medications, meals, and housekeeping. The resident's most recent assessment prior to his leaving the facility indicated the resident had a high risk for skin breakdown and the resident was to be repositioned one time per shift. The assessment indicated the resident required assist of two for transfers using a full lift and he would require assistance for repositioning.

An outside report indicated the resident had open areas on his coccyx measuring 11cm x 7cm and wounds on his heels. The report indicated the resident was found soaked in urine and stool, which was inside the resident's wound on his coccyx. The report indicated the facility nurse did not treat the wound and the resident did not appear to have been repositioned. The report indicated the resident elected to go to the hospital for wound treatment and for assistance in finding a new facility to move to.

The resident's hospital notes indicated the resident admitted to the hospital due to the facility not providing appropriate care for the resident. The resident and his family member called emergency services to take the resident to the hospital due to the resident not receiving basic cares including wound care and repositioning. The hospital notes indicated the resident wanted a new place to live and felt the facility did not take good care of him, and the resident was often left lying in stool and urine at the facility. The hospital notes indicated the resident had a nephrostomy (an artificial opening between the kidney and the skin to divert urine from the upper urinary system) in his right lower back, and had wounds on his scrotum, his coccyx and both of his ankles and heels. The hospital notes indicated the resident had malnutrition due to his chronic illness and an ejection fraction (heart function) of 10% meaning he had poor blood circulation. The hospital notes indicated the resident was discharged from the hospital to a long-term care facility with hospice cares two days prior to his death.

The resident's care plan indicated the resident was to be repositioned twice per day, once in the morning and once in the evening. The care plan indicated the resident was to be toileted one

time on the morning shift, one time on the evening shift and one time overnight. The resident had one safety check overnight. The resident's care plan indicated the resident had a chronic sacral (tailbone area) wound but did not outline care for the wound.

The facility repositioning log for the resident indicated the resident was not being repositioned as ordered on his care plan. The log indicated the 1 ½ months prior to the resident's hospitalization for his wounds the staff documented repositioning the resident 20 times out of the 96 opportunities'.

Hospice orders indicated the hospice nurse would change the resident's wound and nephrostomy dressing two times per week and the facility was directed to change the dressing as needed. The hospice notes indicated the wound on the resident's coccyx was improving and decreasing in size one month prior to the resident's hospitalization and the hospice nurse visits were decreased from two times per week to one time per week due to the decreased need for wound care.

Hospital notes indicated the resident called emergency services on his own after falling in his room. The hospital notes indicated the resident reported he had been on the floor of his room for over four hours before he was able to get to his cell phone and call emergency services after facility staff did not respond to his calls for assistance. The resident was treated for ankle pain with no injury, and nephrostomy placement, then discharged back to the facility the same day.

In an interview, the facility nurse stated the resident had a fast decline in condition after his nephrostomy tube was placed. Within a month after the nephrostomy, the resident required total cares, he lost a lot of weight and was not moving, which caused the resident to develop pressure sores. The resident made the decision to receive hospice care. The nurse stated the resident had every two-hour repositioning orders. The nurse stated she did assessments on the wounds every three months and staff were to notify her if they noticed any new wounds or changes in the current wounds. The nurse stated resident wound care was the responsibility of either skilled nursing or hospice and if the resident needed more specialized care, it would not be provided at the facility. The nurse stated the resident called himself into the hospital and did not come back to the facility.

During an interview, another facility nurse stated the resident did have a fall at the facility and called the paramedics on his own, however, the resident was not on the floor for four hours. The nurse stated the facility staff told her they checked on the resident two hours prior to him calling the paramedics and the resident was not on the floor at that time. The nurse stated after the fall the care plan was updated to check on the resident every two hours.

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

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

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.

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, deceased
Family/Responsible Party interviewed: No, left voicemail
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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 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 06/12/2024

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: #HL306723481C/ #HL306723361M On June 12, 2024 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 40 residents receiving services under Assisted Living with Dementia Care license. The following correction order is issued for #HL306723481C/#HL306723361M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) 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. No plan of correction is required for this tag.	02360		