Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306724441M
Compliance #: HL306725462C

Date Concluded: September 26, 2024

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

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

Evaluator's Name: Lori Pokela
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):
It is alleged the facility neglected the resident when appropriate wound care and wound supplies were not provided. In addition, financial exploitation occurred when money was stolen from a drawer in the resident's room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Wound care was provided in coordination with an outside home care agency and in accordance with physician's orders. Although the resident was missing money, it could not be determined if financial exploitation occurred. No alleged perpetrator was identified; however, the facility replaced the resident's missing money.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator also contacted outside agency staff and the resident's case manager. The investigation included review of resident records, hospital records, facility

records, internal investigation documentation, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed the facility environment, cares provided by staff, and resident and staff interactions.

The resident resided in an assisted living facility. The resident's diagnoses included a traumatic brain injury and quadriplegia. The resident's service plan included assistance with all activities of daily living (ADLs), including medication management, repositioning three times per day, daily skin monitoring, range of motion exercises two times per day, transfers to a wheelchair twice per day with a mechanical lift, and skin care every three days. The resident's assessment indicated the resident had periods of confusion that included disorientation of person or place.

The resident's medical records indicated the resident had a history of noncompliance with cares including bathing, washing, safety measures, occupational therapy services (OT), and medication administration.

The resident was admitted to the facility with a history of complex wounds including a left foot and buttock pressure wound. Facility nursing staff assessed and treated the resident's pressure wounds per physician's orders and maintained necessary wound care supplies.

When new skin concerns were observed by nursing staff, the resident's physician was updated. Facility staff followed wound care treatment orders as prescribed and implemented interventions to prevent further development of the wounds. Following a hospital stay, an outside agency home care assumed care and treatment of the resident's wounds. Facility staff coordinated care with the home care agency and continued to provide care as directed by home care agency staff.

During an interview, the resident stated he had a history of buttock pressure wounds and severe foot wounds. The resident recalled being transported to hospital and diagnosed with a blood infection due to the pressure wounds on his feet. The resident stated he was never without wound supplies and a nurse frequently completed pressure wound dressing changes.

During an interview, nurse management staff stated skin assessments were completed every time skin care was provided. Nurse management staff stated she observes when wound care is completed by a home care agency service, and notes from the agency staff are transcribed into the resident's chart.

During interview with the family of the resident, the family stated that the resident developed new wounds while residing at the facility and stated a home care agency was now managing the resident's wound care.

In conclusion, the Minnesota Department of Health determined neglect 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.

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 provided wound care as directed and coordinated care with an outside home care agency.

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 08/08/2024

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: #HL306725462C/#HL306724441M On August 8, 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 the provider's Assisted Living license with Dementia Care. The following correction orders are issued for #HL306725462C/#HL306724441M, tag identification 1640, 1810.	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.	
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 1 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to provide care as directed by the service plan for one of one resident (R1) reviewed. 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).	01640		

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01640	Continued From page 2 The findings include: R1 started receiving services from the licensee on March 4, 2024 to assist R1 with positioning and repositioning three times per day. R1's diagnosis included traumatic brain injury and quadriplegia. R1's change in condition nursing assessment indicated R1 needed two-person staff assistance for turning and repositioning, six times at night, and a total of twenty-minutes on the day and evening shifts. This nursing assessment also included R1 needed staff assist when R1 was in his wheelchair, thirty-minutes each shift. R1's service delivery records lacked documentation R1 was positioned or repositioned as directed by the service plan on the following dates from June 1, 2024 to July 25, 2024: June 1, 2024, June 2, 2024, June 3, 2024, June 4, 2024, June 8, 2024, June 9, 2024, June 10, 2024, June 11, 2024, June 12, 2024, June 13, 2024, June 14, 2024, June 15, 2024, June 16, 2024, June 17, 2024, June 18, 2024, June 19, 2024, June 22, 2024, June 23, 2024 through July 5., 2024, July 6, 2024 through July 7, 2024,	01640		

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01640	Continued From page 3 July 8, 2024, July 9, 2024, July 11, 2024, July 18, 2024 through July 25, 2024. The MDH investigator sent an email dated August 19, 2024 at 11:59 a.m., to the licensee's licensed assisted living director, (LALD)-G, inquiring regarding all of the gaps in documentation of R1's service delivery records pertaining to positioning and repositioning. LALD-G responded via email on August 19, 2024, at 11:59 a.m., and LALD -G acknowledged the documentation was not completed and indicated the licensee did constant re-education with staff on the importance of timely and proper documentation. During an interview with R1 on August 12, 2024, at 2:25 p.m., R1 stated he had sores on his feet from pressure because licensee staff do not turn him enough. R1 stated since he was hospitalized and his wounds treated, staff turn and reposition on a more regular basis. During an interview dated August 15, 2024 at 1:06 p.m. R1's case manager, (SW)-E, stated, R1's family member, power of attorney, (FM)-D, informed that she thought R1's foot wounds were from staff placing R1 in his wheelchair without shoes or socks on his feet. SW-E stated she did a follow-up with the licensee's assisted living director, (ALDIR)-A, who informed that staff always put footwear on R1 when he was up in his wheelchair and were trained to do so. During an interview on August 16, 2024 at 11:52 a.m., the director of nursing, registered nurse, (RN)-B was asked why there was a lack of	01640		

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01640	Continued From page 4 documentation of positioning and repositioning in R1's service delivery records. RN-B stated that perhaps staff did not document, which is a continuous problem and education regarding had been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
01810 SS=D	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure over-the-counter (OTC) drugs were stored as appropriate for one resident (R1). 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).	01810		

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01810	Continued From page 5 The findings include: R1: R1's diagnoses included but were not limited to traumatic brain injury and quadriplegia. R1's change in condition, nursing assessment dated, July 30, 2024, indicated R1 could be orient, but had periods of confusion, depression and anxiety. This nursing assessment indicated R1's medication would be managed by the licensee's registered nurse, R1 was assessed to not be able to self-administer medication to himself and all medication were to be stored in a locked medication cart and administered by trained medication personnel. On August 8, 2024, at 1:00 p.m., while observing cares, the investigator observed the following over-the-counter, (OTC), medications on R1's room table: (1) box of Benadryl Tablets, (1) tube of hydrocortisone cream and (1) nebulizer. R1's medication administration records (MAR), dated July 2024, indicated R1's orders for nebulizer to include: Sodium Chloride Nebulizer 3%, inhale 4 milliliters (ml), (1 vial), via nebulizer three time per day (tid). Ipratropium Solution Albuterol, inhale 3ml, (1 vial), via nebulizer two times per day, (bid). During an on-site interview on August 8, 2024, at 1:00 p.m., the director of nursing, registered nurse, (RN)-B, stated the resident's family member, power of attorney, (FM)-D, had informed the licensee's staff that she (FM)-D) will administer the medications and would like them	01810		

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01810	Continued From page 6 kept in R1's room at all times. During an interview on August 12, 2024, at 2:25 p.m., R1 stated he self administered his "inhaler" that was kept on his room table, every night to breathe easier. During an interview on August 15, 2024, at 1:06 p.m., R1's case manager, (SW)-E, stated she had been aware that FM-D had administered OTC medications to R1 and when visiting R1, observed R1 had Benadryl and Ibuprofen in his room. SW-E had concerns about the OTC medications in his room, such as, how does the licensee monitor the amount of OTC medications that are administered to R1. When SW-E asked the licensee's staff regarding the monitoring of the OTC medication, staff informed SW-E that staff had observed FM-D administering the OTC medications to R1 and there had been nothing in place to ensure R1's safety when the OTC medications were administered by FM-D. During an interview on August 16, 2024, at 11:52 a.m., RN-B stated although FM-D has had no training by the licensee to administer medications to R1, including any OTC medications and FM-D had gotten upset when RN-B tried to take R1's medications out of his room and place them in the medication cart. RN-B stated she had never seen R1 administer any medications, including the OTC medications to per self. During an interview on August 16, 2024, at 2:09 p.m., FM-D, stated she brought in the following OTC medications for R1 and administered them herself: Meta-mucous for a cold and Benadryl-suggested by R1's provider for itching. FM-D stated R1 had a nebulizer that staff were supposed to administer TID. FM-D stated she	01810		

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01810	Continued From page 7 had no idea if licensee staff had documented the administered OTC medications. The licensee provided Medication Management and Administration Policy dated August 1, 2021, indicated The nursing staff and unlicensed personnel trained to provide medication administration at Sunlight Senior Living will document any medication administration provided accurately in each resident record. A licensed nurse will correctly and accurately document any medication setup provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810		