STATE LICENSING COMPLIANCE REPORT

Report #: HL307398343C

Date Concluded: May 14, 2024

Name, Address, and County of Facility Investigated:
Highland Senior Living
1012 3rd Ave NE
Little Falls, Minnesota 56345
Morrison County

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

Evaluator's Name: Kathy Barnhardt, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30739	A. BUILDING: _____ B. WING _____	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND SENIOR LIVING OF LITTLE FALLS	1012 3RD AVENUE NE LITTLE FALLS, MN 56345

(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****** HOME CARE PROVIDER/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: #HL307398343C On April 30, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 66 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL307398343C, tag identification 2560.	0 000	Assisted Living Provider 144G. 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.	

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02560	Continued From page 1	02560		
02560 SS=F	144G.92 Subdivision 1. Retaliation prohibited A facility or agent of a facility may not retaliate against a resident or employee if the resident, employee, or any person acting on behalf of the resident: (1) files a good faith complaint or grievance, makes a good faith inquiry, or asserts any right; (2) indicates a good faith intention to file a complaint or grievance, make an inquiry, or assert any right; (3) files, in good faith, or indicates an intention to file a maltreatment report, whether mandatory or voluntary, under section 626.557; (4) seeks assistance from or reports a reasonable suspicion of a crime or systemic problems or concerns to the director or manager of the facility, the Office of Ombudsman for Long-Term Care, the Office of Ombudsman for Mental Health and Developmental Disabilities, a regulatory or other government agency, or a legal or advocacy organization; (5) advocates or seeks advocacy assistance for necessary or improved care or services or enforcement of rights under this section or other law; (6) takes or indicates an intention to take civil action; (7) participates or indicates an intention to participate in any investigation or administrative or judicial proceeding; (8) contracts or indicates an intention to contract to receive services from a service provider of the resident's choice other than the facility; or (9) places or indicates an intention to place a camera or electronic monitoring device in the resident's private space as provided under section 144.6502.	02560		

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02560	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of four (R1) residents reviewed were not retaliated against after R1 refused to change pharmacy services and was charged an extra monthly fee of $300. The additional $300 monthly fee had the potential to affect 37 private pay residents that resided at the licensee. 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 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: Review of a licensee notice dated December 1, 2023, and provided to residents and resident representatives indicated as of March 1, 2024, the licensee would be utilizing an in-house pharmacy that specialized in geriatric/elder medications. The notice indicated the licensee would charge residents an additional $300 fee monthly if residents had not transferred to the in-house pharmacy. Additionally, licensee wrote, "a pharmacy choice is yours, however there is a significant amount of additional nursing management and time required when using a non-affiliated pharmacy, the fee for those who choose not to use [in-house pharmacy name] will be implemented beginning March 1, 2024". R1's medical record was reviewed. R1 moved	02560		

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02560	Continued From page 3 into assisted living on July 1, 2019. R1's diagnoses included acute ischemic heart disease and acute diastolic heart failure. R1 was independent with activities of daily living and utilized a four-wheel walker for ambulation. R1's facility charges were privately funded. R1's facility billing statements dated March 22, 2024, and April 22, 2024, included an "Alternate Pharmacy" charge for $300. On April 30, 2024, at 12:40 p.m., R1 stated she was billed an extra $300 monthly since March 1, 2024. R1 stated the facility had sent a notice December 1, 2023, notifying R1 the facility would begin using an in-house pharmacy located out-of-town. The notice stated R1 had the option to stay with her home-town pharmacy, however, the facility would bill R1 an extra $300 monthly for not using the facilities pharmacy of choice. R1 stated she did not feel that was "fair or right" for the facility to demand or give an ultimatum that she change to their pharmacy or she had to pay an extra $300 monthly. On April 30, 2024, at 10:25 a.m., Director of Nursing (DON)-B stated it did not matter which pharmacy residents received pharmaceuticals from, there was no difference in the amount of time it took nurses to process resident medications monthly. Additionally, DON-B stated a lot of people were upset with the requirement to change pharmacies to an in-house pharmacy or be charged an additional $300 fee monthly, which impacted private pay residents only. DON-B stated the pharmacy change requirement was a corporate decision to streamline the licensee's facilities across two states. On April 30, 2024, at 3:15 p.m., Pharmacist (P)-F	02560		

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02560	Continued From page 4 stated residents and families had reached out to the local pharmacist with concerns they were required to change pharmacies. The local pharmacy, residents and family members were told by the licensee it required more nursing time to process medications from the local pharmacy and specific packaging was required. P-F stated the local pharmacy was used by 20 to 25 facility residents and had informed the licensee the local pharmacy would meet packaging requests. P-F stated the local pharmacy operated a long-term care (LTC) pharmacy department, billed pharmaceuticals the same as other pharmacies and had agreed to provide bubble packs (a foil backed cardboard pill holder organized by days or dates) on behalf of the residents. An email dated May 2, 2024, at 12:01 p.m., from licensed assisted living director (LALD)-A, stated, "we are vigilant in maintaining choice for our residents, while balancing quality, efficiency, and expense in our community. There are important reasons why we use an integrated company-wide geriatric pharmacy that has capabilities to serve all of our needs. Like with any services requiring additional time, if a resident chooses to use a non-affiliate pharmacy, we will need to charge for that time". The licensee's Resident Handbook dated February 22, 2022, (pages 14-15) indicated [facility name] recognized each resident's right to choose his/her pharmacy provider. The licensee's Feedback and Grievances policy dated March 2024, indicated there would be no retaliation or discrimination for expressing concerns or filing a complaint. TIME PERIOD TO CORRECT: Seven (7) Days.	02560		

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