STATE LICENSING COMPLIANCE REPORT

Report #: HL357508342C

Date Concluded: March 7, 2024

Name, Address, and County of Facility Investigated:
Whitefish at the Lakes Senior Living
35625 Ostlund Avenue
Crosslake, Minnesota 56442
Crow Wing County

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

Evaluator's Name: Barbara Axness, 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
	35750	A. BUILDING: _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEFISH AT THE LAKES SENIOR	35625 OSTLUND AVENUE CROSS LAKE, MN 56442

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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: #HL357508342C On February 29, 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 99 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL357508342C, tag identification 2350, 2430 and 2480.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's	02350		

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02350	Continued From page 1 property treated with respect This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure residents were treated with courtesy and respect for one of one residents (R2) reviewed. The licensee failed to honor the financially responsible party's choice on utilizing a provider of their choosing and failed to inform the financially responsible party of changes made to the resident's charges. 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). The findings include: R2's record contained a Designated Representative form signed by R2 on September 21, 2021, naming R2's son as his designated representative. R2's face sheet indicated R2's son was the number one emergency contact. R2's February 2024 billing statement was sent to the responsible party, R2's son. R2's service plan dated February 23, 2024, indicated the resident received medication administration and medication management services. The service plan indicated R2's son was	02350		

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02350	Continued From page 2 the number one emergency contact. The service plan indicated fees would be billed to the resident. R2's assessment dated February 20, 2024, indicated the resident's BIMS (brief interview for mental status, a test to evaluate cognitive impairment and dementia in elderly residents) score was 12, which indicated moderate cognitive impairment. At the time the investigation was initiated on February 29, 2024, at 9:00 a.m., R2's record lacked a signed release to authorize the facility's new preferred pharmacy to submit claims on the resident's behalf to insurance or outside providers, fill medications, or obtain any other services from the pharmacy. A letter given to all residents on December 1, 2023, was provided by licensed assisted living director (LALD)-A. LALD-A confirmed all residents received the letter which advised the residents the facility would be transitioning to a new preferred pharmacy. A $300 month fee would be charged to residents who did not use the new preferred pharmacy and implementation would begin on March 1, 2024. A progress note entered on February 29, 2024, at 11:57 a.m. indicated staff "discussed with resident his wishes to stay with [local pharmacy] or change to [facility's new preferred pharmacy.] Resident stated he was not going to pay $300 a month to stay with [local pharmacy] Resident signed [facility's new preferred pharmacy] consent form and this was faxed to [facility's new preferred pharmacy.] On February 29, 2024, at 9:15 a.m., the investigator requested a list of residents who	02350		

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02350	Continued From page 3 were opting to pay the $300 a month fee to continue using the local pharmacy. R2 was identified as the only resident opting to pay the fee. LALD-A stated R2 and his son had decided to stay with the local pharmacy and had not signed a form to switch over to their new preferred pharmacy. On February 29, 2024, at 9:40 a.m., R2 stated he got his medications from the local pharmacy and the facility "charges the living hell out of you for just about everything." R2 stated he was not sure about the pharmacy transition or if he was going to be paying the additional $300 a month to continue using the local pharmacy. R2 was unable to answer any additional questions and was not able to understand questions related to charges or his care and services. R2 deferred additional questions to his son. On February 29, 2024, at 11:10 a.m., LALD-A stated she went to talk to R2 again and "He's changed his mind, he's switching to [facility's new preferred pharmacy]. He signed an agreement, he had until tomorrow [March 1, 2024] to sign so he signed it, he talked to his son and decided to switch." LALD-A provided the investigator with R2's signed authorization to switch to the facility's new preferred pharmacy. The agreement signed by R2 indicated he authorized the facility's preferred pharmacy to dispense medications, submit claims to insurance, and affirmed he had read and fully understood the Pharmacy Agreement. On March 6, 2024, at 2:00 p.m., R2's son stated he was not notified his dad had signed the pharmacy agreement on February 29, 2024, and this was "the first I've heard of it." R2's son stated he had been clear with the facility that it was	02350		

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02350	Continued From page 4 important to them to support the local pharmacy and they would continue to pay the $300 a month fee to do so and that they did not want to switch pharmacies. R2's son stated the facility would send R2's monthly statement to him directly and he would pay it as R2 did not pay his own bills anymore. R2's son stated he just paid R2's monthly statement and was charged the monthly $300 fee and did not realize the facility had switched the resident's pharmacies against their wishes. On March 7, 2024, at 8:30 a.m., clinical nurse supervisor (CNS)-C confirmed R2 was receiving medications from the facility's preferred pharmacy as of February 29, 2024. CNS-C stated R2 was able to make his own decisions. CNS-C stated she would have to reassess R2 to determine if he was cognitive enough to make decisions related to billing. No further information was provided. Time period for correction: Seven (7) days	02350		
02430 SS=D	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records.	02430		

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02430	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident's personal health and medical information was kept private for one of one residents (R1) reviewed. The resident's protected health information was disclosed to an unauthorized pharmacy without the resident or responsible party's consent and the resident's health insurance was billed for medications that were not current and were also not received. 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). The findings include: R1's assisted living contract signed on August 26, 2021, indicated on page 9, section F the facility would "maintain a record related to Resident's tenancy and receipt of services and not to disclose any information regarding Resident without Resident or Resident's authorized representatives' written permission, except that such information may be disclosed as required by state or federal law." R1's record lacked a signed release to authorize the facility's new preferred pharmacy to submit claims on the resident's behalf to insurance or outside providers, fill medications, or obtain any other services from the pharmacy.	02430		

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02430	Continued From page 6 R1's face sheet indicated the resident used two pharmacies, a local pharmacy and the facility's new preferred pharmacy. A letter given to all residents on December 1, 2023, was provided by licensed assisted living director (LALD)-A. LALD-A confirmed all residents received the letter which advised the residents the facility would be transitioning to a new preferred pharmacy. A $300 month fee would be charged to residents who did not use the new preferred pharmacy and implementation would begin on March 1, 2024. The facility's agreement with the new preferred pharmacy signed by the facility on September 19, 2023, indicated on page two, section 2.5. "Resident Records. Subject to compliance with applicable law, FACILITY will give PHARMACY reasonable access to all resident records for the performance of PHARMACY ' s duties under this Agreement." Page four, section 4.6 titled Confidentiality and Privacy indicated "...Each party agrees to comply with the requirements of the Privacy Laws as to such disclosure or exchange of Protected Health Information." Page 11 contained Exhibit C Additional HIPPA Provisions and indicated "PHARMACY agrees not to use, disclose, and request PHI other than as necessary to render Services, as permitted or required by this BAA, or as required by applicable law." R1 received an explanation of benefits (EOB) summary indicating the facility's new preferred pharmacy billed her insurance on December 26, 2023, for a 28 day supply of 50 milligram (mg) losartan, 10 mg memantine, and 10 mg donepezil. In total, the resident's insurance was	02430		

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02430	Continued From page 7 billed $72.59 for the three medications. R1 also received a billing statement dated December 31, 2023, from the facility's new preferred pharmacy indicating the resident owed $21.01 for two medications, preservision and calcium +D 600/400 chewables. Email correspondence indicated R1's power of attorney (POA)-B emailed LALD-A, clinical nurse supervisor (CNS)-C, and a community advocate on January 25, 2024, regarding her concerns on being billed for medications by a pharmacy they had not consented to use. POA-B wrote, "I am very concerned that [facility's preferred pharmacy] has too much access to your computer system or that your files are not up to date for them to be filling prescriptions that have not been active for 4 months...I hope that you will take this seriously and look into this situation." CNS-C replied a few minutes later writing, "Thank you for bringing this to our attention earlier today. We have escalated this and have started our investigation on this. Thank you for your attention to this matter." No additional follow up or replies were sent by the facility. On February 29, 2024, at 11:45 a.m., LALD-A stated the facility had an agreement with the pharmacy where they would provide information on all their residents, even if they did not use that pharmacy. LALD-A stated she was not sure why the pharmacy had billed for medications that weren't current and was not sure On March 4, 2024, at 8:45 a.m., POA-B stated she never signed the authorization for the resident to use the facility's new preferred pharmacy and was surprised to see charges on a Humana billing statement from the new preferred pharmacy. POA-B stated, "I never authorized any	02430		

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02430	Continued From page 8 charges to the new pharmacy first of all, we had until March 1st to do so and I said we'll at least wait until then and determine if it's something we have to do or not. My frustration was that this company had access to her account and her information and she wasn't even on the medications they were charging for." POA-B stated she told LALD-A since she did not authorize the charges and was charged for medications R1 was not currently taking and the medications did not show up at the facility, she was not paying them and the facility would have to pay it. On March 5, 2024, at clinical nurse supevisor (CNS)-C confirmed she was responsible for the implementation of the pharmacy switch over. CNS-C stated the agreement with the new pharmacy had allowed them to disclose information on all residents so the pharmacy could create profiles on them, even if they were not currently receiving their medications from the pharmacy. On March 5, 2024, at 12:45 p.m., pharmacy billing representiative (BR)-D stated the facility had called their triage line on December 26, 2023, and requested the pharmacy fill R1's medications. BR-D stated medications were filled based off the orders they had in the system that had been provided by the facility and the medications were sent out as requested by the facility. BR-D stated the facility had provided the resident's billing information so charges were sent to the resident's insurance. BR-D stated they were contacted by POA-B on January 22, 2024, and by the facility on January 25, 2024, to discuss the resident being billed for medications despite not authorizing the pharmacy to fill her medications. BR-D stated under the facility and	02430		

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02430	Continued From page 9 pharmacy's agreement, the pharmacy would enter all orders and enter all medications into the facility's electronic medical record (eMAR) for all residents, even if the resident was using a different pharmacy provider, however they would only fill and charge for medications for residents who agreed to use their services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430		
02480 SS=D	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know, and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to respond to grievances of one of one resident (R1) reviewed for grievances. 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) 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). The findings include:	02480		

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02480	Continued From page 10 R1's service plan indicated the resident received medication management services, including medication administration. R1's assessment dated December 28, 2023, indicated the nurse would be responsible for reordering medication and or supplies from the pharmacy or supplier. The assessment indicated the resident used a local pharmacy of her choice and was on a regular cycle fill. R1's progress notes indicated a care conference was held on January 25, 2024, and concerns "regarding [facility's preferred pharmacy] sending medications and billing for medications that the resident is not taking any longer" was discussed and "information brought to regional team. No current plan for a care conference follow up at this time." Email correspondence indicated R1's power of attorney (POA)-B emailed LALD-A, clinical nurse supervisor (CNS)-C, and a community advocate after the meeting on January 25, 2024, regarding her concerns on being billed for medications by a pharmacy they had not consented to use. POA-B wrote, "...I hope that you will take this seriously and look into this situation." CNS-C replied a few minutes later writing, "Thank you for bringing this to our attention earlier today. We have escalated this and have started our investigation on this. Thank you for your attention to this matter." R1's record contained a partially completed Feedback Form initiated by LALD-A and CNS-C which indicated "See email attached. [CNS-C] recieved on 1/25/24 on concern to look into matter." The form indicated on Janaury 26, 2024, the facility's new preferred pharmacy	02480		

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02480	Continued From page 11 representative stated they were looking into the matter. The pharmacy was contacted on February 4, 2024, for an update and to advise the pharmacy that R1 would be staying with the local pharmacy. No action after February 4, 2024, was documented. On February 29, 2024, at 11:05 a.m., LALD-A stated the last communication they had with R1 or her representative was on February 5, 2024, but she had "just called them [the preferred pharmacy] and asked where they're at [with resolving the concern]." LALD-A stated their grievance policy was to respond to a grievance within three days but "sometimes it's a while to wrap them up." LALD-A confirmed she felt the grievance was resolved timely, even though the family had not been updated on a resolution yet. LALD-A stated the pharmacy was able to reverse the charges "a while ago" but did not know if R1 was updated. A progress note entered by LALD-A on January 30, 2024, indicated a care conference was set up for February 1, 2024, however the progress notes lacked any documentation on the meeting. No additional documentation related to the grievance were documented in the progress notes. On March 4, 2024, at 8:45 a.m., POA-B stated she never signed the authorization for the resident to use the facility's new preferred pharmacy and was surprised to see charges on a Humana billing statement from the new preferred pharmacy. POA-B stated, "I never authorized any charges to the new pharmacy first of all, we had until March 1st to do so and I said we'll at least wait until then and determine if it's something we have to do or not. My frustration was that this company had access to her account and her information and she wasn't even on the	02480		

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02480	Continued From page 12 medications they were charging for." POA-B stated she brought her concerns to facility management shortly after receiving the billing statement. POA-B stated she told LALD-A since she did not authorize the charges and was charged for medications R1 was not currently taking and the medications did not show up at the facility, she was not paying them and the facility would have to pay it and she wanted to know how this had happened. POA-B stated she had met with facility management to express her concerns in person on January 25, 2024, and she had assumed the facility would take action on the grievance. POA-B stated she had emailed facility management after the January 25, 2024, meeting because she did not feel they were taking her concerns seriously and did not get any kind of follow up until February 29, 2024,after the investigator had initiated the complaint investigation. On March 5, 2024, at 10:45 a.m., CNS-C stated she received an email from POA-B the end of January and she started looking into the concerns. CNS-C stated a grievance form was not initiated and agreed one should have been completed. CNS-C stated she had completed an investigation and was going to schedule a care conference to discuss the findings with POA-B. CNS-C stated the meeting was just recently scheduled with the resident's POA and it was scheduled for March 11, 2024. CNS-C confirmed POA-B had not been updated on the resolution of the case and they were waiting until the March 11, 2024, meeting to discuss the resolution with her. On March 5, 2024, at 12:45 p.m., pharmacy billing representiative (BR)-D stated the facility had called their triage line on December 26, 2023, and requested the pharmacy fill R1's	02480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35750	A. BUILDING: _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02480	Continued From page 13 medications. BR-D stated medications were filled based off the orders they had in the system and the medications were sent out as requested by the facility. BR-D stated the facility had provided the resident's billing information so charges were sent to the resident's insurance. BR-D stated they were contacted by POA-B on January 22, 2024, and by the facility on January 25, 2024, to discuss the resident being billed for medications despite not authorizing the pharmacy to fill her medications. BR-D stated on January 25, 2024, they were able to reverse the charges and "the facility probably figured it was all resolved at that point." BR-D stated the facility called to follow up on the status of the January 25, 2024, call on February 29, 2024. On March 7, 2024, at 8:30 a.m., CNS-C stated she identified in early February the resident's pharmacy switch happened due to an error from facility staff in December but did not update the POA on that finding. CNS-C stated she wanted to get all the information together before sharing details with the POA and was still waiting to hear if the pharmacy would reverse the charges for medications that were sent in error. The licensee's Feedback/Grievances policy last updated December 2023, indicated comments or suggestions may be made orally in which a staff member would complete the form in writing. The Grievance Official would then document receipt of the Feedback Form and forward it to the department that would follow up on it. The investigation and subsequent action planning "must be completed and the Feedback Form returned to the Executive Director within three working days of receiving the concerns." The Grievance Official would be responsible for contacting the person who initiated the concern	02480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02480	Continued From page 14 and would provide them with feedback on the resolution of the concern within three working days of receiving the concern. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02480		