DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 7, 2023

Licensee
Bayview Case Management
14199 Garrett Avenue
Apple Valley, MN 55124

RE: Project Number(s) SL36038015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 25, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

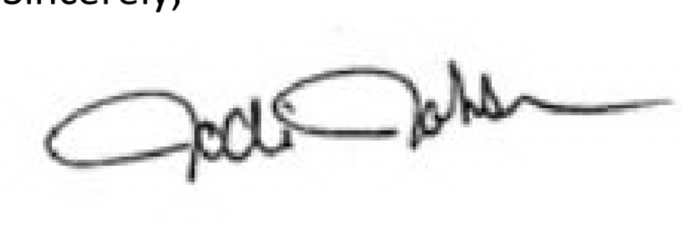
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55155

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36038	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYVIEW CASE MANAGEMENT	14199 GARRETT AVENUE APPLE VALLEY, MN 55124

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36038015 On October 23, 2023, through October 25, 2023, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three active residents; all receiving services under the Assisted Living license.	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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), 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: On October 20, 2023, at 9:58 a.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a LALD license effective through October 31, 2024; however, LALD-A's license lacked an organization listed as the Director of Record for the licensee. On October 23, 2023, at 12:07 p.m. LALD-A reviewed the BELTSS website and confirmed she was not listed as the director of record and further stated she hadn't realized she needed to add that. No further information was provided.	0 110		

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0 110	Continued From page 2 TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to revise and provide an up-to-date Uniform Disclosure of Assisted Living Services & Amenities (UDALSA). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive	0 430		

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0 430	Continued From page 3 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's UDALSA dated January 1, 2022, indicated: Registered Nurse: on site "full time". On October 25, 2023, at 11:02 a.m. licensed assisted living director (LALD)-A stated the registered nurse comes to the facility "every day" but does not work full time or put in 40 hours a week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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	0 480		

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0 480	Continued From page 4 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 25, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.	0 550		

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0 550	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and visitors. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 23, 2023, at 12:49 p.m. the surveyor toured the facility with licensed assisted living director (LALD)-A. There was no evidence the grievance procedure or contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities was posted in a conspicuous place. LALD-A stated the above content was not posted. The licensee's Grievance policy dated August 1, 2021, indicated: 2. A copy of the grievance procedure is conspicuously posted in the residence with the	0 550		

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0 550	Continued From page 6 following information: Name, phone number and email contact information for the individuals who are responsible for handling resident complaints Contact information for the state and any regional Office of Ombudsman for Long-Term Care Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities Contact information for the Minnesota Adult Abuse Reporting Center No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult	0 640		

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0 640	Continued From page 7 Abuse Reporting Center (MAARC) and 911 emergency number as required. This had the potential to affect all residents, staff, and visitors. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 23, 2023, at 12:49 p.m. the surveyor toured the facility with licensed assisted living director (LALD)-A. The facility was observed to be lacking posting of the MAARC hotline and 911 emergency number in the common areas of the facility. LALD-A confirmed the finding. The licensee's Vulnerable Adult policy dated August 1, 2023, indicated: 6. Contact information for the MAARC shall be posted in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	0 660		

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0 660	Continued From page 8 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-D). This has the potential to affect all residents and staff of the facility. 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:	0 660		

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0 660	Continued From page 9 The licensee's TB risk assessment dated January 2, 2023, indicated the licensee was a low risk. ULP-D's employee record showed ULP-D had a start date of November 6, 2022. ULP-D's employee's record contained a one-step TST placed November 2, 2022, and read on November 4, 2022, with a negative result. ULP-D's record did not include evidence a second-step TST had been completed as required. On October 25, 2023, at 10:40 a.m. clinical nurse supervisor (CNS)-B stated she only required staff to complete a one-step TST and if it was positive would direct the employee to go into the clinic for a chest x-ray. The Minnesota Department of Health, Regulations for Tuberculosis Control in Health Care Settings dated July 2013, indicated: Baseline TB screening is required for all HCWs (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay - a blood test used to see whether a person has been infected with the bacteria causing TB). An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days	0 660		

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0 660	Continued From page 10 before hire. The second TST may be performed after the HCW starts working with patients. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated: 1. Employees receive baseline TB screening upon hire to test for infection with M. tuberculosis. 4. The baseline test may be either TST (2-step) or BAMT (a blood test to detect tuberculosis). 5. If the first-step TST is negative, the second-step TST will be administered 1-3 weeks after the first TST result was read. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 11 orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all residents, staff, and visitors. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on October 23, 2023, at 12:04 p.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided and later reviewed by the surveyor. The licensee's plan lacked an all-hazards vulnerability assessment in addition to the following required content:	0 680		

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0 680	Continued From page 12 - procedure for tracking staff and residents; - policies and procedures to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; and - EP testing/annual testing requirements. On October 25, 2023, at 11:32 a.m. licensed assisted living director (LALD)-A stated in the event of an evacuation, a log would be kept for tracking residents and staff. LALD-A stated the EPP did not address tracking of staff and residents and was unaware of the 1135 waiver requirement. LALD-A stated the staff/residents participate in the yearly statewide tornado drill, though they had no documentation to support this. LALD-A further stated not having conducted any other drills or tabletop exercises other than fire drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing	0 730		

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	36038	A. BUILDING: _____ B. WING _____	10/25/2023

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0 730	Continued From page 13 medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included the required documentation of all provided services and documentation related to	0 730		

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0 730	Continued From page 14 hospitalization for one of one resident (R1). In addition, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R2). 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's documented services R1's start of care was October 20, 2022, with diagnoses including diabetes mellitus and schizoaffective disorder. R1's service plan dated October 19, 2022, indicated R1 received services including medication administration, blood glucose monitoring, behavior management, housekeeping, laundry, shopping, assistance making appointments, non-medical transportation and meals. R1's record lacked documentation that all services were provided as scheduled. On October 24, 2023, at 11:28 a.m. licensed assisted living director (LALD)-A stated not having a specific form for services provided other than R1's medication administration and blood glucose monitoring. LALD-A stated staff were expected to write a progress note related to all other services provided.	0 730		

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0 730	Continued From page 15 R1's progress notes dated September 21, 2023, to October 19, 2023, did not include evidence of providing housekeeping and laundry services. The licensee's Clinical Records policy dated August 1, 2021, indicated the clinical record contains documentation of services provided as identified in the service plan. R1's hospitalization R1's progress notes were reviewed. R1's progress note dated August 9, 2023, at 4:45 p.m. indicated R1 was currently hospitalized. The next progress note was dated September 21, 2023, with no mention of R1's hospitalization or what led to the hospitalization. On October 25, 2023, at 10:11 a.m. clinical nurse supervisor (CNS)-B stated R1 had been hospitalized recently for "a couple weeks" due to an increase in mental health symptoms. CNS-B provided the surveyor with a copy of the post hospital nurse reassessment dated September 20, 2023, and stated it was completed on the day R1 returned to the residence. The reassessment indicated R1 had a medication change, but it did not indicate what the change was or any other information related to hospitalization. The surveyor requested a copy of R1's hospital discharge summary; CNS-B stated they did not have a copy. The licensee's Clinical Records policy dated August 1, 2021, indicated the clinical record contains documentation of incidents and/or significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health professional.	0 730		

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0 730	Continued From page 16 R2 R2 was admitted to the licensee on July 24, 2020, with diagnoses including bipolar disorder and Parkinson's disease. R2 discharged from the facility on November 16, 2022. R2's Service Plan dated June 14, 2022, indicated the resident received services including medication administration, behavior management, housekeeping, laundry, meals, and non-medical transportation. R2's record lacked a discharge summary to include: - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On October 25, 2023, at approximately 10:30 a.m. licensed assisted living director (LALD)-A provided R2's discharge summary. After reviewing the statute, LALD-A stated the discharge summary did not include all required content. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790		

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0 790	Continued From page 17 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: The licensee failed to provide the required annual or monthly maintenance on fire extinguishers. This had the potential to affect all current residents, staff, and visitors. 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). Findings include: On October 23, 2023, at approximately 12:49 p.m., survey staff toured the facility with the Assisted Living Director (LALD)-A. It was observed that the fire extinguisher did not have a service tag showing that it had been inspected annually and lacked records to show the required	0 790		

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0 790	Continued From page 18 monthly visual inspections were performed on the portable fire extinguishers. It was observed that each of the fire extinguishers provided were 1-A:10-BC rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required. This deficient condition was verified by LALD-A accompanying the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the	01060		

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01060	Continued From page 19 resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	01060		

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01060	Continued From page 20 R1's start of care was October 20, 2022, with diagnoses including diabetes mellitus and schizoaffective disorder. R1's service plan dated October 19, 2022, indicated R1 received services including medication administration, blood glucose monitoring, behavior management, housekeeping, laundry, shopping, assistance making appointments, non-medical transportation and meals. R1's progress notes were reviewed. R1's progress note dated August 9, 2023, at 4:45 p.m. indicated R1 was currently hospitalized. The next progress note was dated September 21, 2023, with no mention of R1's hospitalization. On October 25, 2023, at 10:11 a.m. clinical nurse supervisor (CNS)-B stated R1 had been hospitalized recently for "a couple weeks" due to an increase in mental health symptoms. CNS-B provided the surveyor with a copy of the post hospital nurse reassessment dated September 20, 2023, and stated it was completed on the day he returned to the residence. On October 25, 2023, at 10:40 a.m. licensed assisted living director (LALD)-A stated they do not provide an emergency transfer notice for hospitalization or notify the ombudsman if greater than four days. They do call the guardian and case manager if a resident is hospitalized. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated: 25. In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: a. The resident	01060		

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01060	Continued From page 21 b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and community-based services, the resident's case manager. e. If the resident has been relocated and not returned to [licensee name] within four days, the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders;	01370		

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01370	Continued From page 22 (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of two unlicensed personnel (ULP-D) to include all required content. 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: ULP-D was hired on November 6, 2022, to provide direct care services to residents of the facility.	01370		

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01370	Continued From page 23 ULP-D's employee record lacked documentation of training for the following topics: - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - standby assistance techniques and how to perform them. On October 25, 2023, at 11:32 a.m. clinical nurse supervisor (CNS)-B stated ULP-D had been trained on standby assistance techniques, but she must have forgotten to check the box on the form. CNS-B further stated not having any residents in the facility that require assistance with hearing aids or teeth, gums, or oral prosthetic devices. The licensee's Staff Competency policy dated August 1, 2021, indicated: 3. Training and competency evaluations for all unlicensed personnel include the following. Refer to the Competency Manual for criteria. Unlicensed personnel may not work for [licensee name] until they have successfully passed the written (at 80%) and demonstration competency evaluation. e. Appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting. g. Standby assistance techniques and how to perform them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01380	Continued From page 24	01380		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of two unlicensed personnel (ULP-D) to include all required content. 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:	01380		

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01380	Continued From page 25 ULP-D was hired on November 6, 2022, to provide direct care services to residents of the facility. ULP-D's employee record lacked documentation of training for the following topics: - safe transfer techniques and ambulation. On October 25, 2023, at 11:32 a.m. clinical nurse supervisor (CNS)-B stated ULP-D had been trained on safe transfer techniques and ambulation, but she must have forgotten to check the box on the form. The licensee's Staff Competency policy dated August 1, 2021, indicated: 4b. Home Health Aides may not work for [licensee name] unit they have successfully passed the written and demonstration competency evaluation, including satisfactory completion of the following: vii. Safe transfer techniques and ambulation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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01620	Continued From page 26 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) failed to conduct ongoing nursing assessments not to exceed 90 days for one of one resident (R1). The licensee further failed to ensure the RN had completed and/or documented a comprehensive reassessment to include required areas of assessment per Assisted Living Facilities: Minnesota Rules Chapter 4659, for one of 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 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).	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36038	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYVIEW CASE MANAGEMENT	14199 GARRETT AVENUE APPLE VALLEY, MN 55124

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01620	Continued From page 27 The findings include: R1's start of care was October 20, 2022, with diagnoses including diabetes mellitus and schizoaffective disorder. R1's service plan dated October 19, 2022, indicated R1 received services including medication administration, blood glucose monitoring, behavior management, housekeeping, laundry, shopping, assistance making appointments, non-medical transportation and meals. R1's 14-day Nurse Reassessment Visit dated October 28, 2022, and 90-day Nurse Reassessment Visit documents dated February 4, 2023, April 28, 2023, June 12, 2023, and September 20, 2023, did not include per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool, the components required in subpart 2, section A, 1-3. In addition, R1's 90-day reassessment dated February 4, 2023, was nine days late. R1's 90-day reassessment dated September 20, 2023, was ten days late. On October 25, 2023, at 10:11 a.m. clinical nurse supervisor (CNS)-B stated they utilized the same reassessment form for all residents for the 14-day, 90-day, and change of condition assessments. CNS-B stated this was the form she had been directed to utilize by the licensed assisted living director, and further stated it was a face-to-face, head-to-toe assessment. CNS-B reviewed the criteria for the Uniform Assessment Tool and stated the reassessment form did not include all required components. The Assisted Living Facilities: Minnesota Rules	01620		

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01620	Continued From page 28 Chapter 4659.0150 Uniform Assessment Tool indicated: - Subpart 1. Definition. For purposed of this part, "Uniform Assessment Tool" means an assessment tool that meets the requirements of this part and is used by a licensee to comprehensively evaluate a resident's or prospective resident's physical, mental, and cognitive needs - Subp. 2. Assessment tool elements. Each facility must develop a uniform assessment tool. The facility may use any acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. A uniform assessment tool must address the following: A. the resident's personal lifestyle preferences, including: (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; (2) spiritual and cultural preferences; and (3) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order or "physician/provider orders for life-sustaining treatment: order. B. activities of daily living, including: (1) toileting pattern, bowel, and bladder control; (2) dressing, grooming, bathing, and personal hygiene; (3) mobility, including ambulation, transfers, and assistive devices; and (4) eating, dental status oral care, and assistive devices and dentures, if applicable; C. instrumental activities of daily living,	01620		

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01620	Continued From page 29 including: (1) ability to self manage medications; (2) housework and laundry; and (3) transportation; D. physical health status, including: (1) a review of relevant health history and current health conditions, including medical and nursing diagnoses; (2) allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; (3) infectious conditions; (4) a review of medications according to Minnesota Statues, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: (a) the reason taken; (b) any side effects, contraindications, allergies or adverse reactions, and actions to address these issues; (c) the dosage; (d) the frequency of use; (e) the route administered or taken; (f) any difficulties the resident faces in taking the medication; (g) whether the resident self administers the medication; (h) the resident's preferences in how to take medication; (i) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and (j) provide instructions to the resident ad resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; (5) a review of medical, dental, and	01620		

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01620	Continued From page 30 emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, an care from a post acute care facility; (6) a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; (7) weight; and (8) initial vital signs if indicated by health conditions or medications; E. emotional and mental health conditions, including; (1) review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorder; (2) current symptoms of mental health conditions and behavioral expressions of concerns; and (3) effective medication treatment and nonmedication interventions; F. cognition, including; (1) a review of any neurocognitive evaluations and diagnoses; and (2) current memory, orientation, confusion, and decision-making status and ability; G. communication and sensory capabilities, including; (1) hearing; (2) vision; (3) speech; (4) assistive communication and sensory devices including hearing aids; and (5) the ability to understand and be understood; H. pain, including; (1) location, frequency, intensity, and duration; and (2) effectiveness of medication and	01620		

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01620	Continued From page 31 nonmedication alternatives; I. skin conditions J. nutritional and hydration status and preferences; K. list of treatments, including type, frequency, and level of assistance needed; L. nursing needs, including potential to receive nursing-delegated services; M. risk indicators, including; (1) risk for falls including history of falls; (2) emergency evacuation ability; (3) complex medication regimen; (4) risk for dehydration, including history or urinary tract infections and current fluid intake pattern; (5) risk for emotional or psychological distress due to personal losses; (6) unsuccessful prior placements; (7) elopement risk including history or previous elopements; (8) smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and (9) alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; N. who has decision-making authority for the resident, including; (1) the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and (2) the scope of decision-making authority of a substitute decision maker under subitem (1); and O. the need for follow-up referral for additional medical or cognitive care by health professionals. No further information was provided.	01620		

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01620	Continued From page 32 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident (R1) insulin was stored securely and according to the manufacturer's recommendations. 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 began receiving assisted living services October 20, 2022. R1's diagnoses included diabetes and bipolar disorder. R1's Service Plan dated October 19, 2022, indicated R1 received services including	01880		

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01880	Continued From page 33 medication administration and management of medications. In addition, the service plan included the medication management plan and identified medications would be stored in a locked cabinet. On October 24, 2023, at 10:58 a.m. the surveyor observed the locked medication refrigerator located in the resident's kitchen, with unlicensed personnel (ULP)-C. The refrigerator contained R1's prescribed unopened Lantus Solostar insulin pens and Humalog insulin KwikPens. The refrigerator also contained one opened Lantus Solostar insulin pen and one Humalog insulin KwikPen. ULP-C stated they always keep R1's insulin pens in the refrigerator even when opened. On October 25, 2023, at 10:11 a.m. clinical nurse supervisor (CNS)-B stated insulin administration was new to the staff and maybe they "forgot" to leave the opened insulin pens in the refrigerator and put them in there "by mistake." The licensee's Insulin Pen Medication Protocol with a Reusable Pen document dated 2016, indicated: 27. Once the pen is opened and used, do not put it in the refrigerator. The Humalog KwikPen manufacturer's Instructions for Use revised July 2023, indicated: Store the pen you are currently using at room temperature [up to 86 degrees Fahrenheit (30 degrees Celsius)]. Keep away from heat and light. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's prescription number as applicable, for one of one discharged resident (R2). 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	01910		

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01910	Continued From page 35 only occasionally). The findings include: The discharge resident roster provided by the licensee indicated R2 discharged on November 16, 2022, to another facility. R2's Service Plan dated June 14, 2022, indicated the resident received services including medication administration. R2's record included a sheet of paper dated November 16, 2022; the paper included medications that had been sent with the nurse from the group home where R2 discharged. The document identified the medication name, strength, quantity, and signature of the licensee's staff that counted the medications and the person receiving the medications. The document did not include the prescription number for any of the identified medications including lisinopril (high blood pressure), metformin (diabetes), propranolol (high blood pressure), quetiapine (antipsychotic), simvastatin (high cholesterol) and tamsulosin (enlarge prostate). On October 25, 2023, at approximately 10:30 a.m. licensed assisted living director (LALD)-A provided R2's document of the disposition of medications. LALD-A stated the discharge summary did not include all required content. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated the licensee will document the following information in the clinical record: a. Name, strength, and prescription number of medication, as applicable.	01910		

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01910	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Follow-Up
Date: *10/25/23*
Time: 14:22:03
Report: 7963231133

Food and Beverage Establishment Inspection Report

Location:
Bayview Case Management
14199 Garrett Avenue
Apple Valley, MN55124
Dakota County, 19

Establishment Info:
ID #: 0039109
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524919732
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders previously issued on 10/24/23 have NOT been corrected.

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

CERTIFICATE NOT POSTED ON SITE. BRING IN ORIGINAL CERTIFICATE AND POST IN A PUBLIC AREA.

Issued on: 10/24/23 *Comply By: 10/24/23*

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: dishwasher rinse
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	1

Type: Follow-Up
Date: *10/25/23*
Time: 14:22:03
Report: 7963231133
Bayview Case Management

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7963231133 of 10/25/23.

Certified Food Protection Manager: Farah Hersi

Certification Number: FM 113430 Expires: 10/04/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Farah Hersi
director

Signed: Peggy Spadafore
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us