Electronically Delivered

January 2, 2025

Licensee
Doodi's Best Care
5624 36th Avenue South
Minneapolis, MN 55417

RE: Project Number(s) SL35100015

Dear Licensee:

On November 26, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 20, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Electronically Delivered

September 19, 2024

Licensee
Doodi's Best Care
5624 36th Avenue South
Minneapolis, MN 55417

RE: Project Number(s) SL35100015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 20, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. 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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35100	A. BUILDING: _____ B. WING _____	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOODI'S BEST CARE	5624 36TH AVENUE SOUTH MINNEAPOLIS, MN 55417

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER 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: SL# 35100015-0 On August 19, 2024 through, August 20, 2024, 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 two residents; two receiving services under the provider's Assisted Living Facility license. On August 19, 2024, an immediate correction order was issued for tag identification 2310. The immediacy of the order was removed on August 21, 2024, based on supervisory review. The scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an 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 the licensed assisted living director (LALD) was listed as the Director of Record (DOR) 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 August 19, 2024, at 10:20 a.m., during the entrance conference, the surveyor reviewed the Board of Executives for Long-term Services and Supports (BELTSS) website with LALD-A. LALD-A's license was current but lacked identification as the DOR for the licensee. Also, LALD-A stated he was not aware of the assisted living license requirement to be identified as DOR for the licensee in the BELTSS website for the licensee. On August 20, 2024, at 1:10 p.m., during the exit conference, the surveyor checked the BELTSS website and LALD-A remained unlisted as the	0 110		

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0 110	Continued From page 2 DOR for the licensee. The surveyor showed LALD-A on the BELTSS website where the DOR information would be listed once corrected. In addition, LALD-A verbalized he planned to update the DOR in the BELTSS website. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the	0 470		

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0 470	Continued From page 3 appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, review, and implement a staffing plan at least twice a year, to determine staffing levels to meet the needs of all residents, potentially affecting all the licensee's 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 the residents). The findings include: On August 19, 2024, at 10:55 a.m., after the entrance conference, the surveyor requested a copy of the licensee's most current staffing plan. On August 20, 2024, at 12:00 p.m., clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-A stated the licensee had not developed a staffing plan as required and was unaware of the requirement to review the staffing plan at least twice yearly. The surveyor provided education on the staffing plan regulation requirements, and LALD-A verbalized the licensee will get this completed. The licensee's Staffing policy dated August 1, 2021, included "3. The staffing plan is based on	0 470		

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0 470	Continued From page 4 an evaluation of the appropriateness of the staffing levels in the facility and is reviewed at least twice a year. Considerations include: -The staffing requirements to meet the scheduled and reasonably foreseeable unscheduled needs of the residents based on the assessment and service plan -The acuity level of the residents based on the nursing assessment -The facility's ability to respond promptly and effectively to residents -Staff experience, training, and competence -Dementia care requirements -The physical layout of the residence." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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 5 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 August 19, 2024, 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 6 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 August 19, 2024, at 11:00 a.m., the surveyor observed the facility postings located on a bulletin board in the facility living room, however, the complaint procedure and contact information for the Ombudsman was not found. On August 19, 2024, at 11:15 a.m., licensed assisted living director (LALD)-A stated he had the grievance information and would go downstairs to get it. Next, LALD-A went downstairs to his office and retrieved the licensee's Grievance policy and posted it on the bulletin board located in the facility living room. On August 19, 2024, at 11:30 a.m., the licensee's	0 550		

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0 550	Continued From page 7 Grievance policy posted failed to include the required information about the facility's grievance procedure contact information including the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. Additionally, the posting lacked contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. On August 20, 2024, at 1:00 p.m., the surveyor educated LALD-A and clinical nurse supervisor (CNS)-B on the required grievance and Ombudsman contact information to be posted. LALD-A verbalized he would get the grievance posting corrected to include all the required information. The licensee's Grievance policy dated August 1, 2021, included a copy of the grievance procedure is conspicuously posted in the residence with the 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; and -Contact information for the Minnesota Adult Abuse Reporting Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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0 810	Continued From page 8	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 810		

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0 810	Continued From page 9 licensee failed to conduct the required training. This had the potential to directly 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) 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 August 20, 2024, at 12:30 p.m., licensed assisted living director (LALD)-A, provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to residents, at least once per year as evident by not providing documentation of training offered or training scheduled for a future date. Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. During an interview on August 20, 2024, at 12:45 p.m., LALD-A stated that they have been using Educare for staff training but have not been training staff or residents on the FSEP. The surveyor showed LALD-A where the requirement	0 810		

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0 810	Continued From page 10 was stated in the facility's policy titled "Fire Safety", dated August 1, 2021, and that the training must be specific to the facility's evacuation procedures and evacuation routes. Educare does not provide this type of training. LALD-A stated they understood the requirement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional;	01370		

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(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
01370	Continued From page 11 (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 observation, interview, and record review, the licensee failed to ensure training was completed for all required skill areas, prior to providing services, for one of two employees (unlicensed personnel (ULP)-C). 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: On August 19, 2024, at 11:58 a.m., the surveyor observed ULP-C assist R2 with medication administration. ULP-C was hired on February 29, 2024, to provide direct care services to residents.	01370		

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	35100	A. BUILDING: _____ B. WING _____	08/20/2024

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01370	Continued From page 12 ULP-C's employee record lacked evidence of the following training: -prevention of falls. On August 20, 2024, at 11:09 a.m., clinical nurse supervisor (CNS)-B stated licensed assisted living director (LALD)-A missed placing the fall prevention training on ULP-C's online training program to be completed upon hire. On August 20, 2024, at 11:28 a.m., LALD-A confirmed with the surveyor he forgot to assign ULP-C the fall prevention training upon hire but planned to assign this now for ULP-C to complete. The licensee's Staff Orientation & Education policy dated August 1, 2021, included orientation may include training on providing services to residents with hearing loss. This training will be research-based and include: a. An explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; b. Health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; and c. Information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time and closed captions." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01440	Continued From page 13	01440		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of a ULP within 30 calendar days of beginning to provide delegated tasks and thereafter as needed based on performance for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01440		

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01440	Continued From page 14 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: On August 19, 2024, at 11:58 a.m., the surveyor observed ULP-C assist R2 with medication administration. ULP-C was hired on February 29, 2024, to provide direct care services to residents. ULP-C's employee record lacked evidence a registered nurse (RN) conducted direct supervision within 30 calendar days of performing delegated tasks from ULP-C's date of hire or first performed delegated tasks. On August 20, 2024, at 11:09 a.m., clinical nurse supervisor (CNS)-B stated the licensee did not complete a 30-day supervision of staff, by observation, within 30 days of performing delegated tasks by a RN. Also, CNS-B verbalized there was a different nurse employed at the time ULP-C was hired, and the 30-day RN supervision was not completed. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, included "4. Direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance." No further information provided.	01440		

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01440	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01650		

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01650	Continued From page 16 review, the licensee failed to ensure the service plan included the required content for one of two residents (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, 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 was admitted on October 3, 2020, and had diagnoses which included schizophrenia (a serious mental health condition that affects how people think, feel, and behave). R2's medical record included an initial signed service plan dated October 13, 2020, which failed to include the following required content: -a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; -the identification of staff or categories of staff who will provide the services; -the schedule and methods of monitoring staff providing services; and -a contingency plan. R2's medical record lacked a current signed service plan which included all the required content. On August 20, 2024, at 11:26 a.m., the surveyor observed licensed assisted living director	01650		

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01650	Continued From page 17 (LALD)-A go into R2's bedroom with some paperwork. On August 20, 2024, at 11:28 a.m. LALD-A provided the surveyor R2's document titled [licensee's name] Service Plan (Waiver) - Addendum to Contract dated August 20, 2024, during the survey, which indicated R2 received services including assistance with housekeeping, meals, laundry, toileting, personal cares, vital signs, safety checks, transfers, blood glucose monitoring, and medication administration. On August 20, 2024, at 11:30 a.m., the surveyor asked LALD-A if he just had R2 sign the service plan and LALD-A verbalized yes, he did just have him sign the service plan at the time of survey. The licensee's Service Plan policy dated August 1, 2021, included 8. The service plan includes the following: a. A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party; b. The fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences; c. The identification of the staff or categories of staff who will provide the services; d. The schedule and methods of monitoring reviews or assessments of the resident; and e. The schedule and method of monitoring staff providing services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		

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01940	Continued From page 18	01940		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual treatment management plan to include all the required	01940		

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01940	Continued From page 19 content for one of one resident (R2) who had a treatment order. 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 was admitted on October 3, 2020, and had diagnosis which included schizophrenia (a serious mental health condition that affects how people think, feel, and behave). R2's [licensee's name] Service Plan (Waiver) - Addendum to Contract dated August 20, 2024, at the time of survey, indicated R2 received services including assistance with housekeeping, meals, laundry, toileting, personal cares, vital signs, safety checks, transfers, blood glucose monitoring, and medication administration. R2's medical record included a signed provider order dated August 1, 2024, which indicated R2 was ordered blood glucose testing to be completed one time per week. R2's medical record included a Treatment and Therapy Plan - Assessment dated August 19, 2024, the date the licensee's assisted living survey was initiated. R2's Treatment plan included an assessment on "Statement of Medication Management Services, Description of Medication Storage, Incontinence, Med	01940		

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01940	Continued From page 20 Management tasks that may be delegated to unlicensed personnel, Impaired Functional Mobility, and Environmental Hazards." R2's Treatment and Therapy Plan - Assessment dated August 19, 2024, lacked the following required content: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On August 20, 2024, at 10:18 a.m., clinical nurse supervisor (CNS)-B stated the licensee had not developed a treatment management plan for R2. CNS-B verbalized he called the electronic medical record provider, and they told him there is a section where the nurse needed to check a box and the nurse will be able to create an individualized treatment plan for a resident. Also, CNS-B stated he was not aware of the required content to be included in the treatment plan. The surveyor educated CNS-B on the treatment plan statute and CNS-B stated he would get this completed for R2.	01940		

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01940	Continued From page 21 The licensee's Treatment and Therapy Management policy dated August 1, 2021, included 6. The RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: a. Type of service to be provided; b. Procedures for documenting treatments or therapies; c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; d. Identification of treatment or therapy tasks delegated to unlicensed personnel; and e. Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care,	02310		

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02310	Continued From page 22 medical, or nursing standards for one of two residents (R2) with side rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R2 was admitted on October 13, 2020, and had diagnoses which included schizophrenia (a serious mental health condition that affects how people think, feel, and behave). R2's medical record lacked: -a side rail assessment; -documentation of measurements of zones of entrapment; and -documentation of discussion of the risk and benefits with R2 and/or R2's responsible party. On August 19, 2024, at 11:58 a.m., the surveyor observed unlicensed personnel (ULP)-C provide medication administration for R2. Upon entry into R2's bedroom, the surveyor observed a hospital style bed with bilateral upper side rails in the upright position. R2 was sitting in his chair next to the bed eating lunch. On August 19, 2024, at 12:06 p.m., the surveyor asked clinical nurse supervisor (CNS)-B about R2's hospital style bed with upper side rails and CNS-B stated he was not aware R2 had a hospital style bed with side rails. Also, CNS-B	02310		

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02310	Continued From page 23 verbalized there was not a side rail assessment completed since he was not aware R2 had a hospital style bed with side rails. On August 19, 2024, at 12:10 p.m., R2 stated, via translation with assistance from ULP-C, he used the side rails to help him with mobility and pulling himself up in bed. R2 verbalized he liked the side rails, and they helped him. On August 19, 2024, at 12:14 p.m., licensed assisted living director (LALD)-A stated when R2 moved into a different bedroom, the room was a little smaller and the resident chose to use the hospital style bed with side rails that was in another bedroom, so they moved the bed into R2's bedroom. Also, the surveyor educated LALD-A and CNS-B about the required device assessment to be completed. The surveyor shared the Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently Asked Questions (FAQ's) website with the licensee via email. On August 19, 2024, at 12:17 p.m., CNS-B stated he had not completed measurements, ensured the bed rails were Food and Drug Administration (FDA) compliant, discussed risk versus benefits with the resident, and documented those actions and responses. The FDA's A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must	02310		

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02310	Continued From page 24 be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. The licensee's Side Rail Use policy dated August 1, 2021, indicated: "1. Before implementing side rails for a resident, the RN will conduct a side rail assessment that includes the following: a. Level of mobility, including bed mobility b. Level of consciousness c. Level of cognition d. Presence of orthostatic hypotension e. Vision 2. The RN will consider the request of the resident, the resident's legal representative and/or the resident's designated representative request for side rails during the evaluation. 3. The RN will discuss with the resident/representative(s) alternatives to the use of side rails. 4. A physical therapy evaluation may be obtained, as appropriate. 5. If the need for side rails is indicated and the resident/resident representative(s) agree to their use, the RN will provide education related to side rails. 6. The RN will document the purpose of the side rails and the education provided. 7. The resident, resident's legal representative or resident's designated representative will co-sign the document agreeing to the benefits and risks of the side rails. 8. The RN is responsible to ensure that the side rails in use are of a safe design and properly	02310		

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DOODI'S BEST CARE	5624 36TH AVENUE SOUTH MINNEAPOLIS, MN 55417

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02310	Continued From page 25 maintained. 9. Side rails will be used consistent with the manufacturer's recommendations. If the manufacturer's recommendations are not available, the RN will use appropriate nursing judgement related to the implementation of the side rails. 10. The need for side rails will be reassessed and documented as needed, but not less than every 90 days." The Minnesota Department of Health's (MDH) Assisted Living: Resources and Frequently Asked Questions (FAQ's) website accessed on August 19, 2024, at 12:20 p.m., read under Hospital-style bed rails licensees should ensure, "measurements were completed and documented, the rails were FDA compliant, and the risk versus benefits were discussed and documented with the resident/responsible party." TIME PERIOD FOR CORRECTION: Immediate The immediacy of the order was removed effective August 21, 2024. Non-compliance remained and the scope and level remain unchanged.	02310		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: *09/05/24*
Time: 15:34:07
Report: 1043241247

Food and Beverage Establishment Inspection Report

Location:
Doodi'S Best Care
5624 36th Avenue South
Minneapolis, MN55417
Hennepin County, 27

Establishment Info:
ID #: 0038830
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122270810
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 08/19/24 have NOT been corrected.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS STORED OVER FRESH PRODUCE IN COOLER. ADVISED STAFF TO STORE RAW FOODS AT THE BOTTOM TO PREVENT CROSS-CONTAMINATION. COMPLY WITH ABOVE RULE.

Issued on: 08/19/24 *Comply By: 08/19/24*

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14F

MN Rule 4626.0285F Single-use disposable sanitizer wipes must be used according to US EPA approved manufacturer's label use instructions.

FACILITY USES SINGLE-USE SANITIZER WIPES. WIPES WERE FRESH SCENTED AND LEMON SCENTED. ADVISED STAFF TO DISCONTINUE USAGE AND TO PROVIDE UNSCENTED SINGLE-USE SANITIZER WIPES APPROVED FOR FOOD CONTACT SURFACES. COMPLY WITH ABOVE RULE.

Issued on: 08/19/24 *Comply By: 08/19/24*

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

RESTROOM MISSING HANDWASHING SIGN. ADVISED STAFF TO PROVIDE. SIGN PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Issued on: 08/19/24 *Comply By: 08/19/24*

Type: Follow-Up
Date: *09/05/24*
Time: 15:34:07
Report: 1043241247
Doodi'S Best Care

Food and Beverage Establishment Inspection Report

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 161 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

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

Follow-up report written to assess compliance with previous order(s) from the 8/19/2024 inspection with Dede Hinnendael as the lead Health Regulation Division Nurse Evaluator completing the site survey at the time.

Facility provided photo verification of the new dish machine and the test result for the utensil surface temperature via email. A residential dish machine with a sanitizing option was provided - sanitizing option must be used at all times when running a cycle. All other orders remaining on the report will be assessed during the next on-site inspection.

***

Foods cooked in house must only be available for same day service for highly susceptible populations, discard any leftovers by the end of the day. Per staff, food is occasionally cooked by clients. Staff supervision must be provided to ensure proper food handling procedures and cooking temperatures.

This facility has a residential kitchen with residential equipment, wooden cabinetry, laminate countertops and vinyl flooring. Installed cutting board underneath the kitchen countertop must not be used as the base is wooden (MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface).

Utensil surface temperature of residential/commercial dish machine must reach at least 160F degrees (or 150F degrees for a NSF/ANSI 184 residential dish machine). Sanitizing option on dish machine must always be used when running a cycle.

Stove does not have a ventilation system. Facility may be required to install one in the future depending on the condition of the kitchen if any issues with smoke, odor, grease, etc. arises. Staff was advised to monitor and provide ventilation system as needed, or as required. Contact Health Regulation Division for plan review approval when facility/kitchen undergoes any remodeling.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

Type: Follow-Up
Date: *09/05/24*
Time: 15:34:07
Report: 1043241247
Doodi'S Best Care

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 1043241247 of 09/05/24.

Certified Food Protection Manager: Abdulkadir A. Elmil

Certification Number: FM110862 Expires: 12/31/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Abdulkadir A. Elmil
PIC

Signed: _____
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/19/24*
Time: 12:20:00
Report: 1043241217

Food and Beverage Establishment Inspection Report

Location:
Doodi'S Best Care
5624 36th Avenue South
Minneapolis, MN55417
Hennepin County, 27

Establishment Info:
ID #: 0038830
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122270810
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 were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS STORED OVER FRESH PRODUCE IN COOLER. ADVISED STAFF TO STORE RAW FOODS AT THE BOTTOM TO PREVENT CROSS-CONTAMINATION. COMPLY WITH ABOVE RULE.

Comply By: 08/19/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14F

MN Rule 4626.0285F Single-use disposable sanitizer wipes must be used according to US EPA approved manufacturer's label use instructions.

FACILITY USES SINGLE-USE SANITIZER WIPES. WIPES WERE FRESH SCENTED AND LEMON SCENTED. ADVISED STAFF TO DISCONTINUE USAGE AND TO PROVIDE UNSCENTED SINGLE-USE SANITIZER WIPES APPROVED FOR FOOD CONTACT SURFACES. COMPLY WITH ABOVE RULE.

Comply By: 08/19/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

SEE COMMENT.

Comply By: 08/30/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

RESTROOM MISSING HANDWASHING SIGN. ADVISED STAFF TO PROVIDE. SIGN PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 08/19/24

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: BUTTER
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

Inspection was completed with Dede Hinnendael as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, illness policy, sanitizer use, ware washing, temperature control, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

4-501.11AB
4-500 Equipment Maintenance and Operation
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
**Unable to test dish machine as it was under maintenance at time of inspection from 8/18/2024. Per staff, dish machine will either be repaired or replaced. For replacement, staff was advised to provide a dish machine with a sanitizing option.
**Staff was advised to temporarily use a 3 compartment/container set up for dishwashing, one for washing, rinsing, sanitizing until the dish machine is repaired/replaced. Per staff, bleach will be used as a sanitizer, bleach must be unscented, approved for food contact surfaces, and with the sanitizer/water solution measuring 50-200 ppm.
***Sanitarian will follow-up with facility until the dish machine has been repaired/replaced and equipment is able to produce a test result for verification of at least 160F degrees for the utensil surface temperature by the sanitarian.
Comply with above rule.

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If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

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 1043241217 of 08/19/24.

Certified Food Protection Manager: Abdulkadir A. Elmil

Certification Number: FM110862 Expires: 12/31/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Abdulkadir A. Elmil
PIC

Signed: Blia Lor

Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us