Electronically Delivered

October 11, 2024

Licensee
Destiny Home Care Services
9725 Oakland Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL31508015

Dear Licensee:

On September 10, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 25, 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,

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Protecting, Maintaining and Improving the Health of All Minnesotans

Amended

Electronically Delivered

July 25, 2024

Licensee
Destiny Home Care Services
9725 Oakland Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL31508015

Dear Licensee:

Please note: This letter amends the previous letter dated July 24, 2024. Specifically, the penalty related to tag 0820 has been removed and therefore no immediate fines are assessed for this survey of your facility.

The Minnesota Department of Health (MDH) completed a survey on June 25, 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 . . ."

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 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

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,

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

HHH

Electronically Delivered

July 24, 2024

Licensee
Destiny Home Care Services
9725 Oakland Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL31508015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 25, 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.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $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

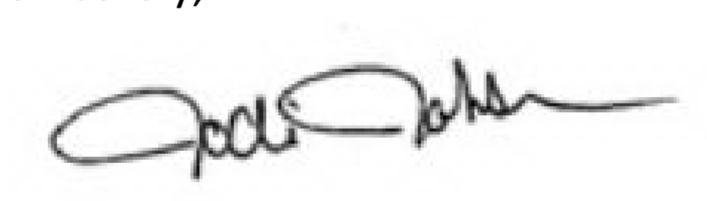
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



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
	31508	A. BUILDING: _____ B. WING _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	9725 OAKLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(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: SL31508015 On June 20, 2024, through, June 25, 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 four residents; four receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on June 20, 2024, issued for SL31508015-0, tag identification 0820. On June 21, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of G.	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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements	0 460		

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0 460	Continued From page 1 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all current residents. 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:	0 460		

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0 460	Continued From page 2 On June 20, 2024, at 12:11 p.m. during the entrance conference, licensed assisted living director (LALD)-A stated the licensee did not have a call light or pendant system residents could use to summon staff. On June 20, 2024, at 12:19 p.m. LALD-A stated the licensee did not provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week. On June 20, 2024, at 1:41 p.m. during the facility tour, the surveyor observed the facility was a rambler style home with a main floor and basement. One resident's room was in the basement while the other resident rooms were on the main floor. No pendants or call light system was observed during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
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	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 470	Continued From page 3 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 appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the staff posting included all the required elements, 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) 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 included: On June 20, 2024, at approximately 2:15 p.m. the surveyor reviewed postings on the wall near the dining area. The posted staff schedule was dated January 8, 2024. Licensed practical nurse	0 470		

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0 470	Continued From page 4 (LPN)-B stated the posted schedule was not current. LPN-B stated schedule included a former employee, and the schedule did not include the correct staff's name who was working that day shift. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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 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 June 20, 2024, for the specific Minnesota Food Code violations. The Inspection	0 480		

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0 480	Continued From page 5 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		
0 680 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 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 observation, interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all of the	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 680	Continued From page 6 required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license, 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 June 20, 2024, at 1:41 p.m. during the facility tour, the surveyor observed the facility was a rambler style home with a main floor and basement. One resident's room was in the basement while the other resident rooms were on the main floor. There was no evidence of signage posted or information regarding the licensee's emergency plan. The licensee lacked a plan to include the following required content: - EP testing/annual testing requirements. On June 25, 2024, at 10:30 a.m. office coordinator (OC)-E stated the licensee had not implemented the facility's emergency preparedness plan/program annual testing requirements. The licensee's Disaster Planning and Emergency Preparedness policy dated January 1, 2022, indicated the licensee will provide annual	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 680	Continued From page 7 emergency and disaster training to all staff. On an annual basis, the licensee will make available training regarding emergency and disaster response to all resident of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 780	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. 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 the potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 20, 2024, at 1:15 p.m., with licensed assisted living director (LALD-A), it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. It was observed that the smoke alarm outside and in the immediate vicinity of main floor resident sleeping rooms one, two and three was not interconnected with other alarms. It was observed that the smoke alarm located in basement resident sleeping room four was not interconnected with other alarms. It was observed that the smoke alarm located outside and in the immediate vicinity of basement resident sleeping room four was not interconnected with other alarms. It was observed that there was not an interconnected alarm located in the basement	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	9725 OAKLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(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
0 780	Continued From page 9 level of the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and LALD-A, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. LALD-A stated that new alarms would be installed. TIME PERIOD FOR CORRECTION: Two (2) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31508	A. BUILDING: _____ B. WING _____	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	9725 OAKLAND AVENUE SOUTH BLOOMINGTON, MN 55420

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0 800	Continued From page 10 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 a facility tour on June 20, 2024, at 1:15 p.m., with licensed assisted living director (LALD-A), the following was observed: It was observed that the unoccupied room adjacent to the basement bathroom had 2 electrical outlets with missing covers. Electrical outlets must be maintained and have covers in place, so electrical components are not exposed to the occupants. It was observed in the main floor bathroom that the ceiling above the tub/shower had black stains, the drywall on the wall next to the tub/shower was loose and cracking, and the exhaust fan was partially covered with dirt and dust. It was observed that the front sidewalk had crumbling concrete which created an uneven walking surface. It was observed that the rear deck floorboards were loose and rotten, and the guard rail was loose and had broken spindles. Deck floors and guards must be maintained or replaced to not create a hazard. It was observed that the exterior light by the rear door was not mounted properly, and the wires	0 800		

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0 800	Continued From page 11 and electrical box were exposed. Exterior fixtures must be properly mounted and fastened so that electrical components are not exposed to weather. It was observed that the rear yard was being used by residents as a smoking area. Cigarette butts were observed on the ground around a table and chairs in the rear yard. The residents were using a plastic container as an ashtray. The facility did not have any non-combustible or fire-rated ashtray available in that area for resident use. Survey staff explained to LALD-A that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts were a potential fire hazard if cigarettes were not completely extinguished before discarding them. It was observed that the posted evacuation floor plan did not have accurate rooms identified for the lower level. The resident room in the lower level was listed as "family room", and an unused storage room was listed as "bedroom" on the evacuation floor plan. There were no Exit signs posted on the doors identified as exits on the evacuation floor plan. During a facility tour on June 20, 2024, at 1:15 p.m., LALD-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as	0 820		

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	31508	A. BUILDING: _____ B. WING _____	06/25/2024

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0 820	Continued From page 12 housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff. 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 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) Findings include: On a facility tour on June 20, 2024, at 1:15 p.m. with licensed assisted living director (LALD-A), it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping room two. Occupied Resident Rooms	0 820	This immediate correction order identified on June 20, 2024, has had the immediacy lifted as of June 22, 2024, however non-compliance remained a scope and level of G.	

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0 820	Continued From page 13 Resident sleeping room two emergency escape and rescue clear window opening measurements are 31 inches wide, 20 inches in height and 620 square inches in openable area. The window was measured with LALD-A, and survey staff present. The window did not meet the minimum requirements for openable area. It was explained to LALD-A that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the floor to the clear opening. LALD-A visually verified the deficient condition while accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate. On June 21, 2024, the immediacy was removed, however non-compliance remained at an scope and level of G.	0 820		
01620 SS=D	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	01620		

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01620	Continued From page 14 resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living 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) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment 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 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:	01620		

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01620	Continued From page 15 R1 began receiving assisted living services on August 6, 2019, with a diagnosis of Schizoaffective disorder. R1's signed service plan dated January 8, 2024, indicated R1 received assistance with dressing, hygiene, bathing, medication reminders, modified diet, medication administration, laundry, housekeeping, behavior management, and medication set-up. R1's record included 90-day nursing assessments dated February 27, 2024, and June 5, 2024. The assessment completed on June 5, 2024, was nine days past the 90-calendar day requirement. On June 24, 2024, at 1:05 p.m. office coordinator (OC)-E stated the assessment was nine days late and out of compliance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	02320		

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02320	Continued From page 16 Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for one of one employee (ULP-B) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally) The findings include: R1's medication administration record (MAR) dated April 4, 2024, indicated ULP-C prepared the following oral medications to administer to R1 at 8:00 a.m.: -bupropion HCL XR 150 milligrams (mg) by mouth every morning; and -Abilify 20 mg by mouth daily On June 21, 2024, at 8:37 a.m. ULP-C obtained a medication binder out of the locked metal cabinet in kitchen. ULP-C reviewed a small slip of paper with "5/29/24 2 tablets 8 am, 2 tablets 8 pm". ULP-C proceeded to dispense oral medications into a glass and provided to R1. After verifying the medications were administered, ULP-C charted administration in R1's electronic medication administration record (EMAR) for each medication given and charted time given as 8:00 a.m. The surveyor asked ULP-C why she charted 8:00 a.m. as time given versus the actual	02320		

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02320	Continued From page 17 time the medications were given. ULP-C stated she was trained by another staff member, not a RN, to always put 8:00 a.m. for the time given, even if it wasn't given at that time. On June 21, 2024, at 8:42 a.m. ULP-C acknowledged she charted the time of medication administration incorrectly. ULP-C stated at the time of hire she was trained by another staff for medication administration and did her competency test with a registered nurse (RN). On June 21, 2024, at 9:59 a.m. clinical nurse supervisor (CNS)-D stated she had trained ULP-C in medication administration and ULP-C was trained to document real time with medication administration and use the EMAR to do medication administration. The licensee's Medication Management-Administration & Set Up policy, undated, indicated assistance with medication and medication administration will be documented on the EMAR by entering the ULP's initials under the date and opposite the medication and dose given and include the full signature and title of the person who provided the medication administration. For medication reminders or administration, the documentation must include the medication name, dosage, date, and time administered, and method and route of the administration. Documentation of the administration will be completed immediately after that task has been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *06/20/24*
Time: 14:22:49
Report: 1005241139

Food and Beverage Establishment Inspection Report

Location:
Destiny Home Care Services
9725 Oakland Avenue South
Bloomington, MN55420
Hennepin County, 27

Establishment Info:
ID #: 0038563
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528887172
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS FOODS IN THE KITCHEN REFRIGERATOR WERE ABOVE 41 DEGREES F. THE FRIDGE WAS TURNED TO A COLDER TEMPERATURE. STAFF WILL MONITOR TEMPERATURE TO ENSURE IT COMES TO 41 DEGREES F OR BELOW.

Comply By: 06/20/24

4-300 Equipment Numbers and Capacities

4-301.12A ***** Priority 2 *****

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

FACILITY IS CURRENTLY WASHING AND RINSING IN A SINGLE SINK BASIN, AND SANITIZING IN A SEPARATE BIN ON THE COUNTER. PROVIDE A 3-COMPARTMENT SINK TO MANUALLY CLEAN EQUIPMENT, OR REPAIR THE DISHWASHER TO PROVIDE MECHANICAL WAREWASHING.

Comply By: 09/20/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

A FOOD THERMOMETER WAS NOT READILY AVAILABLE ON SITE. DIRECTOR HAD AN EXTRA ONE IN HIS CAR THAT WILL BE LEFT AT THE FACILITY.

Comply By: 06/20/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
TEST STRIPS FOR QUATERNARY AMMONIUM WERE NOT ON SITE.
Comply By: 06/27/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
THERE IS NO DEDICATED MN CFPM FOR THIS LOCATION. DIRECTOR IS AWARE OF THE REQUIREMENT AND IS WORKING TO GET CERTIFIED FOOD MANAGER'S AT EACH OF THEIR LOCATIONS.
Comply By: 07/20/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SANITIZER BIN
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 44 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: Yes

Process/Item: Cold Hold/RICE
Temperature: 45 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: Yes

Process/Item: Cold Hold/HAM
Temperature: 44 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: Yes

Process/Item: Cold Hold/TURKEY
Temperature: 41 Degrees Fahrenheit - Location: BASEMENT REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH DIRECTOR AND HRD NURSE EVALUATOR, JENN PANITZKE.

DISCUSSED ALL ORDERS ON REPORT. DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

THE DISHWASHER DOES NOT WORK, SO FACILITY IS WASHING AND RINSING DISHES IN ONE SINK BASIN, AND SANITIZING IN A SEPARATE BIN ON THE SINK WITH QUATERNARY

AMMONIUM. DISCUSSED THAT EITHER A 3-COMPARTMENT SINK NEEDS TO BE PROVIDED, OR THE DISHWASHER NEEDS TO BE REPAIRED / REPLACED SO DISHES CAN BE SANITIZED WITH HEAT (UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE).

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE, COUNTERS ARE LAMINATE, AND CEILING HAS POPCORN TEXTURE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1005241139 of 06/20/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
CHRISTIAN UDEH

Signed:_____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us