Electronically delivered

July 18, 2022

Administrator
Destiny Home Care Services
8036 Upton Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL28028015

Dear Administrator:

On April 29, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on December 2, 2021. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the December 2, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on December 2, 2021, found not corrected at the time of the April 29, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on April 29, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28028	A. BUILDING: _____ B. WING _____	R 04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8036 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(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 Initial comments Citation Text for Tag 0000, Regulation EF5D Carroll, Mary ******ATTENTION****** ASSISTED LIVING 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 has 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: SL28028015-2 On April 29, 2022, the Minnesota Department of Health conducted a revisit at the above provider, to follow-up on orders issued pursuant to a survey completed on February 4, 2022. At the time of the survey, there were four active residents receiving services under the provider's Assisted Living facility license. As a result of the revisit the following order has been re-issued, and the licensee is in substantial compliance.	{0 000}		
{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	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28028	A. BUILDING: _____ B. WING _____	R 04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	**8036 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431**

(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
{0 810}	Continued From page 1 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee training on fire safety and evacuation, failed to provide resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the	{0 810}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
{0 810}	Continued From page 2 potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident 's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On April 29, 2022, a record review was conducted of the fire safety and evacuation plan, employee and resident training on the fire safety and evacuation plan, and the facility evacuation drills based on documents that were provided by Operations Manager (M)-E at approximately 3:06 p.m. on April 29, 2022. Record review of the available documentation indicated that the fire safety and evacuation plan did not have fire protection procedures or actions to be taken by residents in a fire or similar emergency. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The provided plan had procedures on how to evacuation people that may need assistance but did not show any other unique or unusual needs, where to evacuate to, and any relocation processes or procedures to relocate to another facility.	{0 810}		

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{0 810}	Continued From page 3 Record review of the available documentation indicated that employees receive annually after initial hire on the facility fire safety and evacuation plan and twice per year as required by statute. Record review of the available documentation did not indicate that the licensee provides annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. A follow up with conducted with M-E on April 29, 2022, at approximately 4:00 p.m. to see if there were any additional documentation to provide in regard to fire safety and evacuation plan, employee and resident training on fire safety and evacuation, and the evacuation drills for the facility. M-E stated there was no further documentation to provide on the requested items at that time.	{0 810}		

Electronically delivered

February 23, 2022

Administrator
Destiny Home Care Services
8036 Upton Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL28028015

Dear Administrator:

On February 4, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on December 2, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the December 2, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on December 2, 2021, found not corrected at the time of the February 4, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) = $500.00
1770-Documentation Of Medication Setup-144g.71 Subd. 9 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on February 4, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28028	A. BUILDING: _____ B. WING _____	R 02/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8036 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(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 Initial comments ******ATTENTION****** ASSISTED LIVING 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 has 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: SL28028015 On January 31, through February 4, 2022, the Minnesota Department of Health conducted a revisit at the above provider, to follow-up on orders issued pursuant to a survey completed on December 2, 2021. At the time of the survey, there were four active residents receiving services under the provider's Assisted Living facility license. As a result of the revisit the following orders have been re-issued, and the licensee is in substantial compliance.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480}	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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: No further action required.	{0 480}		
{0 780}	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;	{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 2 (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; This MN Requirement is not met as evidenced by: No further action required.	{0 780}		
{0 800}	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: No further action required.	{0 800}		
{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	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 810}	Continued From page 3 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 record review, interview, and observation the licensee failed to provide a maintained fire safety and evacuation plan that contains employee actions to be taken in the event of a fire or similar emergency, fire protection procedures necessary for residents, and procedures necessary for resident movement, evacuation, or relocation during fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation.	{0 810}		

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{0 810}	Continued From page 4 The licensee also failed to conduct evacuation drills for employees at least twice per year per shift with at least one evacuation drill every other month. These deficient practices had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident 's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On February 3, 2022, at approximately 10:30 AM a phone interview was conducted with the Operations Manager (M)-E on the fire safety and evacuation plan for the facility, employee and resident training on the fire safety and evacuation plan, and the facility evacuation drills. During interview, (M)-E stated that he was unsure of the contents of the fire safety and evacuation plan in regard to employee actions to be taken in the event of a fire or similar emergency, fire protection procedures necessary for residents, or procedures for resident movement, evacuation, or relocation during a fire including identification of any unique or unusual resident needs for movement or evacuation. (M)-E stated that the licensee has not decided on the frequency of employee training at this time and is still working to implement a process.	{0 810}		

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{0 810}	Continued From page 5 (M)-E stated that the licensee is still working on the resident training and has had verbal conversations with the residents but has nothing formal and is still working to implement a process. (M)-E stated that there is no current plan for evacuation drills to be conducted and is hoping to implement this process in spring when the weather is warmer. Policies were requested on all these items and (M)-E stated that a follow up email with the policy would be provided by end of day. On February 4, 2022, (M)-E provided policy 9.06 titled Fire Policy; policy 9.07 titled Fire Safety, Evacuation Plan, Fire Drills; and DHCS Emergency Plan. Based on a review of the policy 9.06 titled Fire Policy, the fire safety and evacuation plan was not maintained, did not show safe employee actions to be taken in the event of a fire or emergency, safe fire protection procedures necessary for residents and not valid for the facility for the following: The policy states "When the fire alarm is triggered all fire doors on magnetic holders will automatically close to contain smoke and fire. Tenants should stay behind the fire doors. All other doors should be closed immediately to contain the fire or smoke, unless tenants need to be evacuated." Based on a physical inspection, the facility is a residential home and has no fire doors present in the facility, nor a fire alarm system that would trigger a release of doors". The policy states "The fire department will dispatch immediately. The system is wired	{0 810}		

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{0 810}	Continued From page 6	{0 810}		

directly to the fire station. Once they arrive, staff will take orders and direction from them. They are in charge". Based on a physical inspection, the facility does not have a monitored fire alarm system and the fire department, or any other response will not be initiated without someone specifically calling for assistance.
The policy states "Alarm is Sounding - No Apparent Fire - Remain calm and keep residents as calm as possible. The fire department needs to come and shut off the alarm. If no one comes to give you further directions, and the alarm is off, you may open the fire doors and continue operations." Based on physical inspection, the facility does not have fire doors or a fire alarm system that is monitored. The fire department is also generally not responsible for disabling a fire alarm system unless it is part of an emergency response.

Based on a review of DHCS Emergency Plan, the facility did provide fire protection procedures necessary for residents, or procedures for resident movement, evacuation, or relocation during a fire but did not include identification of any unique or unusual resident needs for movement or evacuation.

Based on a review of policy 9.07 titled Fire Safety, Evacuation Plan, Fire Drills, the licensee has indicated that employees are to be trained on the Fire Safety and Evacuation Plan upon hiring and at least twice per year thereafter and that residents capable of self-evacuation are to be trained at least once a year, but the facility did not provide any documentation of this training. This policy also indicated that evacuation drills are to be conducted six times a year with a drill conducted every other month, but the licensee did not provide any documentation of conducted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28028	A. BUILDING: _____ B. WING _____	R 02/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8036 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(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
{0 810}	Continued From page 7 drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 810}		
{01770} SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1) with record reviewed. 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). Findings include: R1's record lacked medication set-up documentation to include the names of R1's medications, quantity of doses, times to be administered, and routes of administration at the	{01770}		

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{01770}	Continued From page 8 time of set-up. R1's Service Plan dated January 31, 2022, and a single page document "Health Related Services by Nurse" dated August 10, 2021, noted "weekly medication arrangement" by the registered nurse (RN), was intended as R1's weekly medication setups. R1's prescriber orders dated December 21, 2021, included: aspirin (anticoagulant) 81 mg (milligrams) daily, pravastatin (anti-cholesterol) 40 mg daily, Depakote (anti-seizure and mood stabilizer) 1000 mg in the morning and 1500 mg in evening, levothyroxine (synthroid supplement) 88 mcg (micrograms) daily, Zyprexa (anti-psychotic) 20 mg daily, and metformin (diabetes) 1000 mg daily, Flomax 0.4 mg (relaxes prostate) daily, and mirtazapine 30 mg. every night. On January 31, 2022, at 3:00 p.m. manager (M)-E confirmed the licensee provided weekly RN medication set-up services to four of the licensee's four residents. On January 31, 2022, at approximately 3:50 p.m. unlicensed personnel (ULP)-F confirmed he had administered R1's scheduled oral medications from a Mediset (a medication organizer used to sort medications into time of day/weekly dispensing boxes) in the morning as scheduled.; and R1 did not have any medications scheduled until 8:00 p.m. that evening. R1's record indicated a "Setup of Weekly Medication" form dated January 27, 2022, signed by registered nurse (RN)-D as a documented entry that noted a phrase in the paper record form of medications set up for one week, as	{01770}		

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{01770}	Continued From page 9 completed. R1's record did not include the required language content for documentation of medication set-up for later administration. On January 31, 2022, at 4:45 p.m. M-E verified R1's record lacked documentation of the required content for medication set-ups, as noted above. M-E stated he was not aware of the requirement, although he thought the licensee's RN was aware of the resident medication setup required documentation. M-E verified none of the residents records with medication set-up services would have the proper documentation. The licensee's 7.09 Medication Management-Dosage Box Setup policy dated January 1, 2022, noted a licensed nurse would ensure medication orders were transcribed onto the resident's individual medication administration record (MAR) to include all the required information noted above. After the nurse had completed setting up the medications in the dosage box the setup would be documented onto the MAR. No further information was provided.	{01770}		

Electronically Delivered

January 5, 2022

Administrator
Destiny Home Care Services
8036 Upton Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL28028015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 2, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. 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, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970

85 East Seventh Place
St. Paul, MN 55164-0970

85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55164-0970 / 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28028	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING 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 has 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: SL28028015 On November 30, 2021, through December 2, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 had the potential to affect the licensee's two 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) 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, dated December 1, 2021, for the specific Minnesota	0 480		

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0 480	Continued From page 2 Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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 e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have 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, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). 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	0 550		

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0 550	Continued From page 3 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: The licensee did not post the licensee's grievance procedure including the name, telephone number, and e-mail contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or information for reporting suspected maltreatment to MAARC. On November 30, 2021, at approximately 3:00 p.m., the surveyor toured three common areas, shared by residents, staff and visitors, a living room, attached small dining area and kitchen. The surveyor observed no postings containing information about the grievance procedure, the individual responsible to handle grievances, contact information, or reporting suspected maltreatment to MAARC. On November 30, 2021, at approximately 3:35 p.m., administrator (A)-B confirmed the required content noted above was not posted as required. A-B stated she was unaware of the requirement; and she and was not sure if licensee's other management staff were aware of the requirement. The licensee did not have a policy that addressed the posting requirements under Minnesota Statute 144G. No further information was provided.	0 550		

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0 550	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility; and the Minnesota Adult Abuse Reporting Center (MAARC) information and to report suspected maltreatment of a vulnerable adult under section 626.557. 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	0 640		

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0 640	Continued From page 5 portion or all of the residents). The findings include: The licensee did not post the 911 emergency number in common areas and near a telephone provided by the assisted living or the MAARC contact information and reporting number. On November 30, 2021, at approximately 3:00 p.m., the surveyor observed the three common areas, shared by residents, staff and visitors: a living room, attached small dining room and kitchen. The surveyor noted no postings containing the 911 emergency number or MAARC contact and reporting information. On November 30, 2021, at approximately 3:35 p.m., administrator (A)-B confirmed the required content noted above was not posted as required. A-B stated she was unaware of the requirement and she was not sure if licensee's other management staff were aware of the requirement. The licensee did not have a policy that addressed the posting requirements under Minnesota Statute 144G. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 6 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure and maintain a current comprehensive tuberculosis (TB) infection control program according to the most current TB infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. In addition. the licensee failed to ensure completion of a TB baseline screening and TB training at the time of hire for one of two employees registered nurse (RN-A)) with employee records reviewed. 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	0 660		

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0 660	Continued From page 7 a limited number of staff are involved or the situation has occurred only occasionally). Findings include: The licensee's most current TB facility risk assessment dated October 11, 2021, noted a low risk. RN-A was hired on October 20, 2021. RN-A's employee record lacked documentation of a TB history and symptom screen, evidence of a previous positive TB screen, and testing for the presence of mycobacterium tuberculosis by administering a two-step tuberculin skin test, or a single blood test. RN-A's employee record included a chest X-ray report dated 10-19-2019 (one year prior to hire date) and a notation of "Clinical history: Positive mantoux. No evidence of tuberculosis." RN-A's employee record also lacked documentation of TB education at the time of hire. On December 1, 2021, at 2:45 p.m. administrator (A)-B confirmed RN-A's employee record lacked evidence of required TB baseline screening and education completed at the time of hire. The licensee's undated Tuberculosis Screening and Prevention policy provided by A-B noted each new employee would complete baseline TB screening and TB training to include all the topics noted above at the time of hire. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 660	Continued From page 8 (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant 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	0 680		

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	28028	A. BUILDING: _____ B. WING _____	12/02/2021

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DESTINY HOME CARE SERVICES	8036 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(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
0 680	Continued From page 9 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 disaster preparedness plan with all the required content; and post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the Assisted Living license. 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 November 30, 2021, at approximately 2:45 p.m., the surveyor requested the licensee's emergency disaster preparedness plan. Administrator (A)-B confirmed the assisted living facility did not have an emergency plan procedure manual or emergency exit diagrams posted within the split level family style home. The assisted living facility had three shared common areas for residents, staff and visitors to include a living room, small dining area and kitchen, all on the same level: a living room, small dining area and kitchen. The surveyor observed no information posted in the three shared common, the areas,	0 680		

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0 680	Continued From page 10 entrance, or elsewhere in the facility regarding the licensee's emergency plan. The licensee's written emergency plan consisted of an incomplete (blank) Hazard Vulnerability Assessment form. The form identified several natural emergency events (such as fire, tornado, and winter storm) with a category to score each event based on probability, risk and preparedness. The licensee's plan lacked evidence of the following required content: - a comprehensive program to include infectious diseases and pandemics. - a process for emergency preparedness (EP) cooperation with state and local EP officials and organizations; - a current resident roster form for tracking residents. - development of policies/procedures to address: - evacuation plan (not customized for the facility). - fire (not customized for the facility). - a tracking system used to document locations or residents and staff. - the medical record documentation system to preserve resident information. - emergency staff strategies; and - the facility's role in providing care and treatment at alternative sites. - EP training and testing program. - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On December 2, 2021, at approximately 1:40 p.m. administrator (A)-B confirmed she nor other management staff were familiar with Appendix Z (a section of the Centers for Medicare and	0 680		

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0 680	Continued From page 11 Medicaid Services [CMS] State Operations Manual which includes the guidelines). A-B verified the licensee had not fully developed and implemented the facility's EP plan/program. The licensee's undated Emergency Plan policy provided by A-B noted the licensee would complete and retain a current EP plan to include the above required information. 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	0 780		

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0 780	Continued From page 12 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability 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 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: During a facility tour with the Operations Manager (M)-E between approximately 10:25 a.m. and 11:20 a.m. on December 2, 2021, the engineering surveyor observed that upon testing the smoke alarms, the smoke alarms were not interconnected so that actuation of one alarm causes all alarms to operate, as required, when there is more than one smoke alarm in a dwelling unit. This deficient condition was visually verified by (M)-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 800	Continued From page 13	0 800		
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 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. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On facility tour with the Operations Manager (M)-E between approximately 10:25 a.m. and 11:20 a.m. on December 2, 2021, the engineering surveyor observed that the lower level bathroom had water standing on the floor and a sign on the toilet indicated it was not working. The engineering surveyor also observed there was standing water on the floor adjacent to a floor	0 800		

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0 800	Continued From page 14 drain in the laundry room and on the opposite side of the lower level from the bathroom, as well as a hole in the sheetrock ceiling outside the laundry room. During interview, (M)-E indicated the water and toilet issues were recent, and the licensee had called a plumber to investigate the water and toilet issue. (M)-E could not provide any details about the hole in the ceiling. These deficient conditions were visually verified by (M)-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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.	0 810		

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0 810	Continued From page 15 (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 record review, interview, and observation, the licensee failed to maintain a fire safety and evacuation plan that showed the location and number of resident rooms, employee actions to be taken in the event of a fire or similar emergency, fire protection procedures necessary for residents, and procedures necessary for resident movement, evacuation, or relocation during fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation. The licensee also failed to provide employee training on fire safety and evacuation at least twice per year after initial hire, have fire safety and evacuation plans readily available in the facility, provide training to residents capable of assisting in their own evacuation, and require evacuation drills for employees at least twice per year per shift with at least one evacuation drill every other month. These deficient practices had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 16 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 December 2, 2021, between approximately 9:55 a.m. and 10:25 a.m., the engineering surveyor conducted a record review and interview with the Operations Manager (M)-E about employee training with fire safety and evacuation plan for the facility, employee and resident training on the fire safety and evacuation plan, and the facility evacuation drills. The licensee did not provide a maintained fire safety and evacuation plan that showed the location and number of resident rooms, employee actions to be taken in the event of a fire or similar emergency, fire protection procedures necessary for residents, and procedures necessary for resident movement, evacuation, or relocation during fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation. (M)-E indicated that as of August 1, 2021, the licensee had started working on the fire safety and evacuation plan, but the plan had not been completed at time of survey. (M)-E provided a fire safety and evacuation diagram posted in the kitchen of the facility. However, during a facility tour with (M)-E between approximately 10:25 a.m. and 11:20 a.m., the engineering surveyor observed the provided fire safety and evacuation	0 810		

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0 810	Continued From page 17 diagram was not accurate with the laundry room being depicted as one of resident rooms. (M)-E visually verified and acknowledged these deficient practices and conditions. The licensee did not have documentation indicating the licensee provided training on fire safety and evacuation to employees upon hiring and at least twice per year after and to residents capable of assisting in their own evacuation. (M)-E indicated that as of August 1, 2021, the licensee had started working on the fire safety and evacuation plan training policies for employees and residents, but these policies were note completed at time of survey. The licensee did not have documentation indicating the licensee performed evacuation drills for employees twice a year per shift with at least one drill being conducted every other month. (M)-E indicated the licensee had not conducted evacuation drills for the employees. A policy was requested, but could not be provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each	01460		

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01460	Continued From page 18 staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide employees with orientation to assisted living facility licensing requirements and regulations for one of two employees, (registered nurse (RN)-A) with records reviewed. 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). Findings include: RN-A was hired on October 20, 2021, to provide direct assisted living services to the licensee's residents as needed. RN-A's employee record did not contain documentation of orientation to assisted living facility licensing requirements at the time of hire, which would include: RN-A's employee record lacked orientation to home care requirements at the time of hire to include: (1) an overview of chapter 144G.08 through 144G.93; (2) an introduction and review of the facility's policies and procedures related to the provision of	01460		

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01460	Continued From page 19 assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On December 1, 2021, at approximately 9:40 a.m. RN-A stated he was unaware of the assisted living orientation requirements. He stated he had not received assisted living requirement orientation for the licensee. RN-A stated his priority was becoming familiar with the residents' cares and needs first. RN-A confirmed he was oriented to the licensee's individual resident care needs and most resident forms. RN-A stated he was becoming familiar with the licensee's	01460		

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01460	Continued From page 20 policies. On December 2, 2021, at approximately 2:00 p.m. administrator (A)-B confirmed RN-A had not received orientation to assisted living facility requirements. A-B stated she was aware of the assisted living orientation requirement for employees. She stated she thought the licensee's manager (M-E) ensured RN-A completed the required training on the licensee's on-line training program, at the time of hire. The licensee's undated Staff Orientation and Training policy provided by A-B noted each new employee would complete assisted living orientation and training, at the time of hire prior to provision of direct assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty One (21) days	01460		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	01470		

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01470	Continued From page 21 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01470		

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01470	Continued From page 22 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure employees received all required assisted living orientation content for one of two employees (unlicensed personnel (ULP)-C) with records reviewed. 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). Findings include: The licensee converted from a Comprehensive Home Care license to an Assisted Living Facility license on August 1, 2021. ULP-C had a hire date of April 3, 2009. ULP-C's employee record did not contain documentation verifying ULP-C completed all required assisted living licensing and regulation orientation content before providing assisted living services to residents which included: - an overview of chapter 144G.08 through 144G.93; - the assisted living bill of rights and staff	01470		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8036 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

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01470	Continued From page 23 responsibilities related to ensuring the exercise and protection of those rights; and, - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On December 2, 2021, at 1:30 p.m. administrator (A)-B verified ULP-C did not complete orientation to the assisted living requirements and regulations. The licensee's undated Staff Orientation and Training policy provided by A-B noted each new employee would complete orientation and training, to include all the topics noted above, at the time of hire prior to provision of direct assisted living services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01470		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this	01530		

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01530	Continued From page 24 initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to provide employee dementia care training (at least eight hours within 120 working hours of the employment start date), on required topics for one of two employees (registered nurse (RN)-A) with records reviewed. 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). Findings include: RN-A was hired on October 20, 2021, and provided regularly scheduled supervision of direct-care staff services to the licensee's residents.	01530		

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01530	Continued From page 25 RN-A's employee record did not contain documentation RN-A completed the initial eight hours of training required related to dementia care, within 120 working hours of RN-A's employment start date. RN-A's record did not contain an orientation checklist to indicate training topics RN-A completed at the time of hire. On December 2, 2021, at 1:30 p.m. administrator (A)-B verified RN-A had provided supervision of unlicensed personnel (ULPs) and direct care services, and worked more than the above listed hours since beginning employment. A-B confirmed RN-A had not completed eight hours of training related to dementia care training in the required time frame. RN-A's employee record contained a certificate from the Alzheimer's Association, titled Understanding Alzheimer's and Dementia dated October 16, 2021; however, the certificate did not indicate the number of training of hours completed. The licensee's undated Staff Orientation and Training policy provided by A-B noted each new employee would complete orientation and training, including dementia care, at the time of hire prior to provision of direct assisted living services. The policy language noted the required training topics and content. The policy lacked language related to the required training upon hire for and and within 160 hours of employment start date, and the required training upon hire and within 120 working hours of the employment start date that supervisors of direct care staff would complete eight (8) hours of dementia care education. No further information was provided.	01530		

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01530	Continued From page 26 TIME PERIOD FOR CORRECTION: Seven (7) days.	01530		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (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 interview and record review the	01650		

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01650	Continued From page 27 licensee failed to ensure the service plan contained all the required content for one of one resident (R1) with record reviewed. 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). Findings Include: R1's record contained an eight page "Residency Service Agreement [service plan]" and a single page document "Health Related Services by Nurse" dated August 10, 2021. R1 received 24 hour assistance with medication administration, diabetes monitoring, behavior management, personal hygiene verbal reminders, meal preparation, housekeeping, laundry, and coordination of transportation and health care appointments, if needed, by the licensee's unlicensed personnel and licensed nurse. On December 2, 2021, at approximately 1:15 p.m., administrator (A)-B confirmed the forms were intended as the service plan. The service plan documents lacked evidence of: (1) a description of the ULP services to be provided, 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 would provide the services; (3) the schedule and methods of monitoring	01650		

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01650	Continued From page 28 assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that included: (iii) the names and contact information of persons the resident wished to have notified in an emergency or if there was a significant adverse change in the resident's condition, including identification of and information as to who had authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services would not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On December 2, 2020, at approximately 1:40 p.m., A-B confirmed R1's service plan lacked evidence of the all the required content as noted above. A-B stated the licensee's office manager may not have provided all the documents attached or intended for R1's service plan. A-B confirmed R1's service plan document was not individualized with the circumstances in which to contact emergency medical services. A-B stated she was unsure if the licensee's other resident service plans would have noted all the required content. The licensee's undated Service Plan policy provided by A-B noted the required language content identified above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		

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01770	Continued From page 29	01770		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication set-up included all the required content for one of one resident (R1) with records reviewed. 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). Findings include: R1's record lacked documentation of medication set-up to include the name of the medication, quantity of dose, times to be administered, and route of administration at the time of set-up. R1's "Residency Service Agreement [service plan]" and a single page document "Health Related Services by Nurse" dated August 10, 2021, noted "weekly medication arrangement" by the registered nurse (RN), intended as weekly medication setups.	01770		

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01770	Continued From page 30	01770		

R1's prescriber order dated October 19, 2021, not all inclusive noted: aspirin (anticoagulant) 81 mg (milligrams) daily, pravastatin (anti-cholesterol) 40 mg daily, Depakote (anti-seizure and mood stabilizer) 1000 mg in the morning and 1500 mg in evening, levothyroxine (synchronic supplement) 88 mcg (micrograms) daily, Zyprexa (anti-psychotic) 20 mg daily, and metformin (diabetes) 100 mg daily.

On November 30, 2021, at 3:00 p.m. administrator (A)-B provided a current resident roster that indicated two of the licensee's residents received RN medication set-up services weekly.

On December 1, 2021, at 8:00 a.m. unlicensed personnel (ULP)-C was observed administering R1's scheduled oral medications from a Mediset (a medication organizer used to sort medications into time of day/weekly dispensing boxes).

R1's record had multiple weekly dated RN documentation entries that consistently noted a phrase in the paper record "medications set up" as completed. None of the RN medication set-up narrative notes indicated the required language for documentation of medication set-up for later administration, to include the required content.

On December 1, 2021, at 9:30 a.m. RN-A verified R1's record lacked documentation of the required content for medication set-ups, as noted above. RN-A stated he was not aware of the requirement and verified none of the residents records with medication set-up services would have the proper documentation.

The licensee's undated Medication

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01770	Continued From page 31 Documentation policy noted medication set-ups as one of the licensee's medication management services and the required licensed nurse documentation needed in the resident record, which included the language noted above. Minnesota Home Care Statute 144G.08 Subd. 41- Definition of Medication setup: "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
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	01940		

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01940	Continued From page 32 (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 ensure a resident's prescribed treatments or therapies are included in a written statement on residents' service plans with blood glucose (sugar) monitoring managed by the provider for one of two residents (R1) with records reviewed. 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 service plan dated August 10, 2021, did not have a written statement for the treatment services provided to R1, including blood glucose (sugar) monitoring. R1's record also lacked evidence of procedures for staff to notify a registered nurse (RN) or appropriate licensed health professional when a problem arose with	01940		

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01940	Continued From page 33 treatments or therapy services provided. R1's "Residency Service Agreement [service plan]" dated August 10, 2021, lacked evidence of prescribed daily blood sugar (glucose) administration and monitoring by the licensee's nurse, as a treatment. R1's prescriber orders dated October 19, 2021, included an order for blood glucose checks once daily before a meal. R1's record report "Diabetic Record" dated from October 31, 2021, through December 1, 2021, indicated staff completed R1's blood glucose checks once daily. R1's record noted R1's blood glucose checks results ranged from 150 to 277 milligrams (mg)/deciliter (dl). The form did not contain any procedures instructing staff when to notify a licensed nurse if a problem arose with a low or high blood sugar result. On November 30, 2021, at approximately 3:00 p.m. during the entrance conference administrator (A)-B and registered nurse (RN)-A indicated the licensee provided treatment or therapy management services to one of the licensee's two residents, R1. On December 2, 2021, at approximately 1:40 p.m. A-B confirmed R1's current service plan did not include a written statement of the prescribed treatment services provided, or of any procedures to instruct staff when to notify the nurse if a problem arose, as noted above. The licensee's undated Treatment and Therapy Management policy indicated the licensee's nurse was responsible for development of the individual treatment or therapy service plan, which should	01940		

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01940	Continued From page 34 include procedures instructing staff when to notify a nurse when a problem arose. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. 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) specified in writing, specific instructions for each resident and documented	01950		

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01950	Continued From page 35 those instructions in the resident's record regarding receiving blood glucose monitoring for one of one resident (R1) with records reviewed. 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). Findings Include: R1's record "Diabetic Record" (intended as documentation of the delegated treatment task of blood glucose results) dated October 31, 2021, through December 1, 2021, noted unlicensed personnel (ULP)-C assisted with the blood glucometer check procedures on multiple occasions. R1's record did not contain any specific written instructions from a RN related to R1's blood glucose monitoring or when staff notify a nurse when R1's blood glucose results were outside parameters. On December 1, 2021, at approximately 7:45 a.m., ULP-C was observed assisting R1 with a blood glucose check which resulted in a reading of 231 milligrams/deciliter (mg/dl). Upon query, ULP- C stated he thought a low blood glucose level would be under 70 (mg/dl) and a high reading would be 300 (mg/dl). ULP-C stated he would call the RN for blood glucose results under 70 or over 300.	01950		

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01950	Continued From page 36 ULP-C confirmed there were no written procedures in R1's record instructing him when to notify a nurse if an issue arose related to R1's elevated or low blood glucose result. On December 1, 2021, at approximately 9:40 a.m., RN-A confirmed R1's treatment plan for blood glucose monitoring lacked any printed instructions or parameters, intended for the ULP to follow, of when to notify the nurse if a problem arose. The licensee's undated Treatment and Therapy Management policy noted the licensee's nurse was responsible for development of a resident's individual treatment or therapy service plan which should include procedures staff should follow regarding when to notify a nurse if a problem arose. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		

Minnesota Department of Health

625 Robert Street North
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Time: 12:55:52
Report: 7994211144

Food and Beverage Establishment Inspection Report

Location:
Destiny Home Care Services
8036 Upton Avenue South
Bloomington, MN55431
Hennepin County, 27

Establishment Info:
ID #: 0037513
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.

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.
FACILITY CURRENTLY DOES NOT HAVE AN APPROVED METHOD OF SANITIZING DISHES. SPOKE WITH OWNER ABOUT VARIOUS OPTIONS TO WASH, RINSE AND SANITIZE DISHES.
Comply By: 02/01/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
NO CURRENT CFPM WAS FOUND ON SITE.
Comply By: 02/01/22

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.
MEAT FOUND THAWING IN SINK. USE ON OF THE ABOVE METHODS WHEN THAWING.
Comply By: 02/01/22

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6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.114AB

MN Rule 4626.1580AB Remove all items unnecessary to the operation or maintenance of the establishment and litter from the premises.

BROKEN FRIDGE/FREEZER IN THE BASEMENT WILL NEED TO BE REMOVED OR REPAIRED.

Comply By: 01/31/22

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

THIS IS A RESIDENTIAL HOME. CURRENTLY THERE ARE TWO RESIDENTS WITH A MAXIMUM NUMBER OF FOUR.

INSPECTOR SPOKE WITH OWNER ABOUT VARIOUS REQUIREMENTS AND OTHER ITEMS FROM THE FOOD CODE. THIS INCLUDES REQUIREMENTS FOR USING HOUSEHOLD KITCHEN EQUIPMENT.

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 7994211144 of 12/01/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: Crystal Elva

Crystal Elva
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