



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 15, 2024

Licensee

Destiny Homecare Services, Inc.

9318 Chicago Avenue South

Bloomington, MN 55420

RE: Project Number(s) SL30459015

Dear Licensee:

On March 6, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 14, 2023. This follow-up survey determined your facility had corrected all of the state correction orders issued pursuant to the December 14, 2023 survey.

Also, at the time of this follow-up survey completed on March 6, 2024, we identified the following violation(s):

0900-Contract Required-144g.50 Subdivision 1

1820-Prescriptions-144g.71 Subd. 13

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730 .

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

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

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

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/06/2024
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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 SL30459015-1 On March 5, 2024, through March 6, 2024, 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 14, 2023. At the time of the survey, there were four residents; four receiving services under the Assisted Living license. As a result of the revisit, the following orders were issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/06/2024
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{0 790}			
{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	{0 800}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/06/2024
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 800}	Continued From page 2 repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}			
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/06/2024
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 900	Continued From page 3 existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and execute a written contract with the required content for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 5, 2024, at 2:30 p.m. registered nurse (RN)-H stated R4 was a new admission on March 4, 2024. On March 6, 2024, at 9:20 a.m. licensed practical nurse (LPN)-D was observed by the surveyor administer medications from a medication caddy to R4. On March 6, 2024, at 10:42 a.m. licensed assisted living director (LALD)-B stated R4 did not have a signed contract yet. LALD-B stated they did not want to overwhelm the resident on the day they arrived. The licensee typically would work on the paperwork including the contract over the first few days of admission. She was aware the statutes stated the licensee may not offer or provide housing or assisted living services to any individual unless it has executed a written	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/06/2024
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 900	Continued From page 4 contract with the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 5, 2024, at 2:30 p.m. registered nurse (RN)-H stated R4 was a new admission on March 4, 2024. On March 6, 2024, at 9:20 a.m. licensed practical	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/06/2024
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01820	Continued From page 5 nurse (LPN)-D was observed by the surveyor administering medications from a medication caddy to R4. R4's pharmacy medication list identified multiple medications included antipsychotics, blood pressure medication, an antidepressant, and a medication used for side effects of antipsychotics. R4's Medication Administration Record (MAR) identified medications including antipsychotics, blood pressure medication, an antidepressant, and a medication used for side effects of antipsychotics were administered on March 4, 2024, through March 6, 2024. On March 6, 2024, at 10:02 a.m. LPN-D stated upon R4's admission, the nurse called the pharmacy and verified R4's medications. The licensee received a medication list for R4 via fax from the pharmacy on March 5, 2024. The medication list was not signed or electronically signed by a medical provider. The licensee had called the clinic to obtain a medication list; however, the list that was sent was not signed or electronically signed. The licensee had scheduled an appointment on March 6, 2024, to obtain physician orders. The licensee's 7.20 Medication and Treatment Orders policy dated January 1, 2022, identified "a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber." "An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment." "Upon	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/06/2024
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
01820	Continued From page 6 receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 18, 2024

Licensee

Destiny Homecare Services Inc
9318 Chicago Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL39459015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on December 14, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

- resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/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 of the correction order receipt date.

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

If you have any questions, please contact me.

Sincerely,



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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39459015 On December 11, 2023, through December 14, 2023, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-B was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, at 10:00 a.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-B currently held a LALD license effective through October 31, 2024; however, LALD-B's license failed to identify her as the Director of Record for the licensee. LALD-A currently held a LALD license effective through October 31, 2024; however, LALD-A's license failed to identify him as the Director of Record for the licensee. On December 11, 2023, at 10:15 a.m. during the entrance conference, LALD-B stated LALD-A was the LALD for this license. LALD-B was unaware	0 110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 110	Continued From page 2 of the need to have a director of record listed for the license. On December 11, 2023, at 10:26 a.m. the surveyor emailed a BELTSS representative to clarify LALD-B's and/or LALD-A's status as director of record for the facility. At 10:53 a.m., the BELTSS representative responded neither LALD-B nor LALD-A was listed as Director of Record for this licensee and they needed to update Director of Record for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 250	Continued From page 3 chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 250	Continued From page 4 who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 11, 2023, at 11:00 a.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living Provisional License, section titled Official Verification of Owner or Authorized Agent, (page 17 and 18 of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect.	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 250	Continued From page 5 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 250	Continued From page 6 - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page eighteen was signed by LALD-B on August 11, 2022. The licensee had a provisional assisted living license issued on January 31, 2023, with an	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 250	Continued From page 7 expiration date of January 30, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and (12) medication and treatment management. As a result of this survey, the following orders were issued 0550, 0630, 0660, 1290, 1370, 1380, 1610, 1620, 1700, 1730, 1760, 1890, 1910, 1960, and 2290 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	0 250			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 250	Continued From page 8	0 250			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 470	Continued From page 9 completed by a registered nurse at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's census was two residents, two of whom received services under the assisted living license. During the entrance conference on December 11, 2023, at 10:15 a.m., the evaluator requested a staffing plan. Licensed assisted living director (LALD)-B, stated the staff schedule was posted in the home; however, the licensee was unaware of the requirement to develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 470	Continued From page 10 available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 11 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 11, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post, in a conspicuous place, the required information	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 550	Continued From page 12 related to the grievance procedure. 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: Upon entrance of the facility on December 11, 2023, at 9:30 a.m., the surveyor observed a posting of a complaint form; however, it failed to identify the following required content: - email contact information for the individual responsible for handling residence grievances; - Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities; - information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center; and - statement that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. On December 11, 2023, at 11:15 a.m. licensed assisted living director (LALD)-A stated he was aware of the required information and the policy should have been posted with the complaint form. The licensee's 2.10 Complaint/Grievance Posting policy dated January 1, 2022, identified: "1. [Licensee] will post, in a conspicuous place,	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 550	Continued From page 13 information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. 2. The posting will also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities." 3. In addition, the posting will include information for reporting suspected maltreatment to the Minnesota Adult Abuse Center." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete an individual abuse prevention assessment and plan for the	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 630	Continued From page 14 licensee's two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the facility on September 9, 2023. R1's Individual Abuse Prevention Plan was dated July 5, 2023, prior to his admission to this licensee. The Plan identified multiple areas of vulnerability and interventions for those areas but failed to identify if R1 was at risk for abuse or if R1 was at risk of abusing others. R2 R2 was admitted to the facility on November 6, 2023. R2's Individual Abuse Prevention Plan was dated July 10, 2023, prior to her admission to this licensee. The Plan identified multiple areas of vulnerability and interventions for those areas but failed to identify if R2 was at risk for abuse or if R2 was at risk of abusing others. On December 14, 2023, at 11:24 a.m. licensed assisted living director (LALD)-B stated both residents were living at other homes owned by the licensee prior to admission under this license. She was unaware individual abuse assessment	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 630	Continued From page 15 and plans needed to be completed upon admission to this license. On December 14, 2023, at 1:05 p.m. clinical nurse supervisor (CNS)-C stated the clients were living at other homes owned by the licensee. She was unaware a new individual abuse assessment and plan needed to be completed upon admission to this license. CNS-C stated she was unaware of the missing content on the assessment forms. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current 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:	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 16 Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for three of three employees (unlicensed personnel (ULP)-E, ULP-F and ULP-G). 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: ULP-E ULP-E was hired to provide direct care services for the licensee on September 19, 2023. ULP-E's employee file identified a letter from a medical provider stating ULP-E had a negative TB Quantiferon Gold Plus blood test on November 10, 2023. This was two months after ULP-E began providing care to the residents for the licensee. ULP-F ULP-F was hired to provide direct care services for the licensee on August 28, 2023. ULP-F's employee file lacked evidence a TB	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 17 symptom screening or TB testing had been completed. ULP-G ULP-G was hired to provide direct care services for the licensee on December 8, 2022. ULP-G's employee file lacked evidence a TB screening had been completed. There was a picture in ULP-G's file that identified a TB blood test was negative. The picture did not identify the blood test was for ULP-G nor did it include a date for the TB blood test. On December 14, 2023, at 11:25 a.m. licensed assisted living director (LALD)-B stated the TB screening and testing should have been completed for the employees. The licensee's 8.16 Tuberculosis Screening policy dated January 1, 2022, identified "[Licensee] will 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 (MMWR)." "Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure." "1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs . 2. New staff will have an IGRA blood test or a	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 660	Continued From page 18 two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." 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	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 19 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to post the emergency preparedness plan prominently. 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).	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 680	Continued From page 20 The findings include: On December 11, 2023, at 11:15 a.m. licensed assisted living director (LALD)-A stated the emergency preparedness information was not posted, and was not printed and available to staff and residents. On December 14, 2023, at 11:29 a.m. LALD-B stated the emergency preparedness plan should have been printed and put into a binder in the home so staff and residents would have access to the information in an emergency. She was unaware this had not been completed. The licensee's undated, Emergency Operations Plan identified "A copy of this plan must always stay in the residence and must be readily available for both staff and residents to access." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 790	Continued From page 21 Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual and monthly maintenance on fire extinguishers. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, at 2:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-B. It was observed the fire extinguishers on both levels did not have a service tag showing they had been inspected annually and lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. On December 11, 2023, at 2:30 p.m., LALD-B verified the required annual and monthly maintenance had not been completed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 22	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 in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. 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 December 11, 2023, at 2:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-B. During the facility tour, survey staff observed the following: In the resident's sleeping room #2, it was observed there were brown stains on the	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 23 sheetrock ceiling and wall with evidence of water leakage from above the ceiling. It was also observed the egress window screen was broken and exposed to a sharp edge. In the living room, it was observed multiple outlet plug strips were daisy chained (connected together in a line) to provide power to the TV and other electrical equipment, creating a possible fire hazard. Outside of the main entrance, it was observed burnt used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. During the facility tour on December 11, 2023, at 2:30 p.m, LALD-B visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility.	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 910	Continued From page 24 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have the licensee's health facility identification (HFID) number listed on the contract as required for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's Residency Service Agreement signed September 8, 2023, failed to identify the licensee's HFID. On December 14, 2023, at 11:20 a.m. licensed assisted living director (LALD)-B stated the contracted needed to be updated. The contract would be the same for all residents and it should have included the HFID. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility	0 920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 920	Continued From page 25 is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have all required content in the contract for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 920	Continued From page 26 R1's Residency Service Agreement signed September 8, 2023, failed to include the following required content: (1) a disclosure that it does not hold an assisted living facility with dementia care license; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; and (6) billing and payment procedures and requirements. On December 14, 2023, at 11:20 a.m. licensed assisted living director (LALD)-B stated the contract needed to be updated. The contract would be the same for all residents and it should have included all required content. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920			
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide	0 940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 940	Continued From page 27 customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have all required content in the contract for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 940	Continued From page 28 affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Residency Service Agreement signed September 8, 2023, failed to include the following required content: (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance	0 940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 940	Continued From page 29 waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. On December 14, 2023, at 11:20 a.m. licensed assisted living director (LALD)-B stated the contracted needed to be updated. The contract would be the same for all residents and it should have included all required content. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 950	Continued From page 30 ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing in the contract and provide the required verbatim notice on a document separate from the contract for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Residency Service Agreement signed September 8, 2023, had a section for contact information for resident's designated representative with three blank lines underneath. The contract failed to have the required box the resident must initial if the resident declines to name a designated representative as part of the	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 950	Continued From page 31 contract as required. R1's record lacked evidence R1 had been provided provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On December 14, 2023, at 11:20 a.m. licensed assisted living director (LALD)-B stated the contracted needed to be updated. The contract would be the same for all residents and it should have included all required content. LALD-B stated she was unaware of the verbatim statement for designated representative. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01290	Continued From page 32 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of three employees (unlicensed personnel (ULP)-E, ULP-F, and ULP-G). 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: ULP-E ULP-E was hired to provide direct care services for the licensee on September 19, 2023. On December 12, 2023, at 8:10 a.m. unlicensed personnel (ULP)-E was observed working	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01290	Continued From page 33 independently. ULP-E was observed administering medications and checking blood glucose for R1 and administering medications to R2. ULP-E's employee record contained a background study dated August 18, 2023, affiliated with a separate location operated by the licensee's owner under HFID license 28028. ULP-E's record lacked evidence of a current, cleared background study affiliated with the licensee's current provisional assisted living HFID license 39459, effective January 31, 2023. ULP-F ULP-F was hired to provide direct care services for the licensee on August 28, 2023. The licensee's staff schedule identified ULP-F worked independently on December 9, 10, 12 and 13, 2023. ULP-F's employee record contained a background study dated September 14, 2023, affiliated with a separate location operated by the licensee's owner under HFID license 28028. ULP-F's record lacked evidence of a current, cleared background study affiliated with the licensee's current provisional assisted living HFID license 39459, effective January 31, 2023. ULP-G ULP-G was hired to provide direct care services for the licensee on December 8, 2022. On December 11, 12, and 13, 2023, ULP-G was observed working independently in the facility. ULP-G's employee record contained a	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01290	Continued From page 34 background study dated December 2, 2022, affiliated with a separate location operated by the licensee's owner under HFID license 28028. ULP-E's record lacked evidence of a current, cleared background study affiliated with the licensee's current provisional assisted living HFID license 39459, effective January 31, 2023. On December 11, 2023, at 1:10 p.m. licensed assisted living director (LALD)-A stated the HFID on the background studies was for a different facility owned by the licensee. LALD-A was unaware the employees needed to be affiliated to each license the employee worked under. The licensee's 4.02 Background Studies policy dated January 1, 2022, identified "[Licensee] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [licensee]. No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [Licensee] will not employ individuals whose results of the background study indicate disqualification for the position." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided;	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01370	Continued From page 35 (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of three unlicensed personnel (ULP-E and ULP-F)	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01370	Continued From page 36 completed training and competency evaluations in all required training topics. 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: ULP-E ULP-E was hired to provide direct care services for the licensee on September 19, 2023. On December 12, 2023, at 8:10 a.m. ULP-E was observed administering medications and checking blood glucose for R1 and administering medications to R2. ULP-E's employee record lacked evidence training and/or competency testing was completed on the following required topics: (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety,	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01370	Continued From page 37 and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; and (15) awareness of commonly used health technology equipment and assistive devices. ULP-F ULP-F was hired to provide direct care services for the licensee on August 28, 2023. The licensee's staff schedule identified ULP-F worked independently on December 9, 10, 12 and 13, 2023. ULP-F's employee record lacked evidence training and/or competency testing was completed on the following required topics: (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them;	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01370	Continued From page 38 (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; and (15) awareness of commonly used health technology equipment and assistive devices. On December 14, 2023, at 1:05 p.m. clinical nurse supervisor (CNS)-C stated she was unaware of the missing content for ULP training. The licensee's 5.02 Competency Training Evaluations policy dated January 1, 2022, identified: "Training and competency evaluations for all ULPs will include: a) Documentation requirements for all services provided b) Reports of changes in the resident's condition to the supervisor designated by the facility c) Basic infection control, including blood-borne pathogens d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01370	Continued From page 39 f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment reminders i) Basic nutrition, meal preparation, food safety, and assistance with eating j) Preparation of modified diets as ordered by a licensed health professional k) Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family l) awareness of confidentiality and privacy m) Understanding appropriate boundaries between staff and residents and the resident's family n) Procedures to use in handling various emergency situations o) Awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01380	Continued From page 40 (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three unlicensed personnel (ULP-E, ULP-F, and ULP-G) completed training and competency evaluations in all required training topics. 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: ULP-E ULP-E was hired to provide direct care services for the licensee on September 19, 2023. On December 12, 2023, at 8:10 a.m. unlicensed personnel (ULP)-E was observed administering medications and checking blood glucose for R1 and administering medications to R2. ULP-E's employee record lacked evidence training and/or competency testing was completed on the following required topics:	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01380	Continued From page 41 (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; and (6) range of motioning and positioning. ULP-F ULP-F was hired to provide direct care services for the licensee on August 28, 2023. The licensee's staff schedule identified ULP-F worked independently on December 9, 10, 12 and 13, 2023. ULP-F's employee record lacked evidence training and/or competency testing was completed on the following required topics: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; and (6) range of motioning and positioning. ULP-G ULP-G was hired to provide direct care services for the licensee on December 8, 2022. On December 11, 12, and 13, 2023, ULP-G was observed working independently in the facility. ULP-G's employee record lacked evidence training and/or competency testing was	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01380	Continued From page 42 completed on the following required topics: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; and (6) range of motioning and positioning. On December 14, 2023, at 1:05 p.m. clinical nurse supervisor (CNS)-C stated she was unaware of the missing content for ULP training. The licensee's 5.02 Competency Training Evaluations policy dated January 1, 2022, identified: "Training and competency evaluations for all ULPs will include: 6. In addition to the above training and competency evaluation for unlicensed personnel providing assisted living services must include: a. Observing, reporting, and documenting resident status , b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident d. Recognizing physical, emotional, cognitive, and developmental needs of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning g. Administering medications or treatments as required No further information was provided.	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01380	Continued From page 43	01380			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial assessment prior to the date on which a prospective resident executed a contract with a facility or on the day the resident moved in for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
01610	Continued From page 44 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: R2 was admitted on November 6, 2023. On December 12, 2023, at 8:30 a.m. unlicensed personnel (ULP)-E was observed administering medications to R2. R2's service plan dated November 6, 2023, identified R2's services included activities of daily living (ADLs), medication administration, and behavior management. R2's Uniform Assessment Tool was completed on November 7, 2023, identified R2 was admitted on November 6, 2023. On December 14, 2023, at 1:05 p.m. clinical nurse supervisor (CNS)-C stated she was unaware the initial assessment had to be completed prior to, or the day of admission. The licensee's 6.01 Assessments, Reviews,& Monitoring policy dated January 1, 2022, identified "[Licensee] will conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier."	01610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01610	Continued From page 45 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a 14-day assessment on two of two residents (R1 and R2). In addition, the licensee failed to complete a	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 46 90-day assessment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 R1 was admitted on September 8, 2023. On December 12, 2023, at 8:10 a.m. unlicensed personnel (ULP)-E was observed administering medications and checking blood glucose for R1. R1's service plan dated September 8, 2023, identified R1's services included activities of daily living (ADLs), medication administration, behavior management, and blood glucose monitoring. R1's Uniform Assessment Tool was completed on September 8, 2023. On the bottom of the Uniform Assessment Tool were the following sections: - 14-day Assessment, which included date of assessment September 22, 2023; - method face to face/in-person box was checked; - notes with a dash in the box; - updates/changes to service plan none; and - clinical nurse supervisor (CNS)-C signature. - 90-day Assessment which included date of assessment "September 8, 2023;" - method face to face/in-person box was checked;	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 47 - notes with a dash in the box; - updates/changes to service plan none; and - clinical nurse supervisor (CNS)-C signature. R2 R2 was admitted on November 6, 2023. On December 12, 2023, at 8:30 a.m. ULP-E was observed administering medications to R2. R2's service plan dated November 6, 2023, identified R2's services included activities of daily living (ADLs), medication administration, and behavior management. R2's Uniform Assessment Tool was completed on "September 8, 2023." On the bottom of the Uniform Assessment Tool were the following sections: - 14-day Assessment which included date of assessment November 20, 2023; - method face to face/in-person box was checked; - notes with a dash in the box; - updates/changes to service plan none; and - clinical nurse supervisor (CNS)-C signature. On December 14, 2023, at 1:05 p.m. clinical nurse supervisor (CNS)-C stated she was unaware a comprehensive assessment had to be completed for the 14-day and 90-day assessments, and was informed completing the bottom section of the assessments was sufficient. The licensee's 6.01 Assessments, Reviews, & Monitoring policy dated January 1, 2022, identified "Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 48 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment." "The individualized review or subsequent reviews must include all the required elements as specified in Rule". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 49 section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. 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) conducted a face-to-face medication management reassessment to include all required content for two of two residents (R1, R2) who received medication management services. 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 the entrance conference on December 11, 2023, at 11:00 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to all of the licensee's residents. R1 On December 11, 2023, at 12:52 a.m. unlicensed personnel (ULP)-E was observed administering medications to R1. On December 12, 2023, at 8:16 a.m. ULP-E was observed checking blood glucose and administering medications to R1.	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 50 R1's diagnoses included schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), hypertension, diabetes, gastroesophageal reflux disease (stomach reflux), and fall risk due to tremors. R1's Service Plan dated September 8, 2023, indicated R1 received services including medication management and medication administration. R1's prescriber orders dated September 1, 2023, included vitamins, Fibercon (fiber), lactase (dairy digestion), omeprazole (reflux), Januvia (diabetes), aspirin (heart health), pravastatin (cholesterol), artane (tremor), clonidine (blood pressure), lithium (antipsychotic), levothyroxine (thyroid), Klonopin (anxiety), lisinopril (blood pressure), Zyprexa (antipsychotic), glimeperide (diabetes), mirtazapine (antidepressant), Haldol (antipsychotic), Flomax (urination), and metformin (diabetes). R1's Uniform Assessment Tool dated September 8, 2023, Review of Medications section identified "see medication management plan, medication assessment, med orders". A review of the medication management plan, medication assessment, and medication orders failed to include a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. R2 On December 12, 2023, at 8:30 a.m. ULP-E was	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 51 observed administering medications to R2. R2's diagnoses included schizoaffective disorder or schizophrenia (chronic condition with acute exacerbation), major depression disorder, and substance use disorder. R2's Service Plan dated November 6, 2023, identified R2 received medication management and medication administration. R2's prescriber orders dated December 12, 2023, included depakote (seizure medication also used for mood stabilizer), trazodone (antidepressant), Haldol (antipsychotic), vitamins, olanzapine (antipsychotic), amlodipine (heart), metformin (diabetes), lisinopril (blood pressure), and atorvastatin (cholesterol). R1's Uniform Assessment Tool dated November 7, 2023, Review of Medications section identified "see med order/med assessment". A review of the medication management plan, medication assessment, and medication orders failed to include a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. On December 14, 2023, at 1:05 p.m. clinical nurse supervisor (CNS)-C stated the information should be on the physician orders. She was unaware of the missing content. The licensee's 7.01 Medication Management-Assessment, Monitoring & Reassessment dated January 1, 2022, identified: "1) The assessment must be conducted face-to-face with the resident by an RN. 2) The assessment must include an	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01700	Continued From page 52 identification and review of all medications the resident is known to be taking. 3) The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. 4) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01730	Continued From page 53 (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include a written statement of medication set up services in the service plan and the medication management plan for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
01730	Continued From page 54 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: R1 R1 was admitted on September 8, 2023. On December 12, 2023, at 8:10 a.m. unlicensed personnel (ULP)-E was observed administering medications from a medication caddy to R1. On December 13, 2023, at 9:02 a.m. licensed practical nurse (LPN)- D was observed setting up R1's medication caddy. R1's Uniform Assessment Tool completed on September 8, 2023, identified "see medication management plan, medication assessment, and medication orders. R1's service plan dated September 8, 2023, identified R1's services included activities of daily living (ADLs), medication administration, behavior management, and blood glucose monitoring. R1's service plan failed to identify medication set up. R1's Individualized Medication Management Plan dated September 8, 2023, identified R1 received medication administration services, however; it failed to identify medication set up. R2 R2 was admitted on November 6, 2023. On December 12, 2023, at 8:30 a.m. ULP-E was observed administering medications from a medication caddy to R2.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01730	Continued From page 55 On December 13, 2023, at 10:00 a.m. LPN- D was observed setting up R1's medication caddy. R2's Uniform Assessment Tool completed on November 7, 2023, identified "see medication orders and medication assessment". R2's service plan dated November 6, 2023, identified R2's services included activities of daily living (ADLs), medication administration, and behavior management. R2's service plan failed to identify medication set up. R2's Individualized Medication Management Plan dated November 6, 2023, identified R1 received medication administration services; however; it failed to identify medication set up. On December 14, 2023, at 1:05 p.m. clinical nurse supervisor (CNS)-C stated she was unaware medication set-up needed to be included on the service plan. The licensee's 7.03 Medication Management Individualized Plan policy dated January 1, 2022, identified "For each resident at [licensee] medication management services, the facility will prepare and include in the service plan a written statement of the medication management services that will be provided to the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 56 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of two residents (R1). In addition, the licensee failed to ensure medications administered were documented as administered for two of two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 R1 was admitted on September 8, 2023.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 57 R1's diagnoses included schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), hypertension, diabetes, gastroesophageal reflux disease (stomach reflux), and fall risk due to tremors. R1's Service Plan dated September 8, 2023, indicated R1 received services including medication management and medication administration. R1's service plan failed to include medication set-up services. R1's prescriber orders dated September 1, 2023, included vitamins, Fibercon (fiber), lactase (dairy digestion), omeprazole (reflux), Januvia (diabetes), aspirin (heart health), pravastatin (cholesterol), Artane (tremor), clonidine (blood pressure), lithium (antipsychotic), levothyroxine (thyroid), Klonopin (anxiety), lisinopril (blood pressure), Zyprexa (antipsychotic), glimeperide (diabetes), mirtazapine (antidepressant), Haldol (antipsychotic), Flomax (urination), and metformin (diabetes). On December 12, 2023, at 8:10 a.m. unlicensed personnel (ULP)-E was observed administering medications from a medication caddy to R1. On December 13, 2023, at 9:02 a.m. licensed practical nurse (LPN)- D was observed by the surveyor setting up R1's medication caddy. LPN-D used a printed medication orders document as a guide for setting up the medications. LPN-D identified each medication and compared the medication label to the medication orders document. LPN-D skipped around on the document based on the medication	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 58 card pulled from the tote. LPN-D stated the remaining medications were as needed and she had completed the medication set up. LPN-D began putting the medications back in the tote to put away. The surveyor intervened and informed LPN-D R1's Artane had not been placed in the medication caddy. LPN-D went through the tote again and removed the Artane, checked the caddy and confirmed it was not in the caddy. LPN-D then set up the Artane in the caddy. R1's Medication Administration document identified the following: - December 2, 2023, through December 8, 2023, the following medications were documented as a "0" (identified as not administered): - on December 3, 2023 - Artane (treats muscle spasm, tremors) - aspirin (heart health) - clonidine (blood pressure) - December 9, 2023, through December 11, 2023, the following medications were documented as a "0" (identified as not administered): - on December 9, 2023 - clonidine - multivitamin - Zyprexa (antipsychotic) - on December 10, 2023 - clonidine - on December 11, 2023 - Zyprexa R1's physicians orders dated September 1, 2023, identified the following orders: - Multivitamin take one tablet by mouth daily - Aspirin 81 milligram (mg) tablet take one tablet by mouth daily - Artane 5 mg tablet take one tablet by mouth twice daily	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 59 - Clonidine 0.1 mg tablet take one tablet by mouth three times daily - Zyprexa 20 mg tablets take one tablet by mouth at bedtime. R2 R2 was admitted on November 6, 2023. On December 12, 2023, at 8:30 a.m. ULP-E was observed administering medications from a medication caddy to R2. R2's Service Plan dated November 6, 2023, identified R2 received medication management and medication administration. R2's service plan did not include medication set-up services. R2's prescriber orders dated December 12, 2023, included depakote (seizure medication also used for mood stabilizer), trazodone (antidepressant), Haldol (antipsychotic), vitamins, olanzapine (antipsychotic), amlodipine (heart), metformin (diabetes), lisinopril (blood pressure), and atorvastatin (cholesterol). On December 14, 2023, at 1:05 p.m. clinical nurse supervisor (CNS)-C stated she was unaware medication set-up needed to be included on the service plan. R2's Medication Administration document identified the following: - December 2, 2023, through December 8, 2023, the following medications were documented as a "0" (identified as not administered): - on December 4, 5, 6, 7, 8, 2023 - ketoconazole cream - December 9, 2023, through December 11, 2023, the following medications were documented as a "0" (identified as not	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 60 administered): - on December 9, 2023 - ketoconazole cream - multivitamin - on December 11, 2023 - ketoconazole cream R2's physician orders dated September 6, 2023, identified the following orders: - multivitamin take one tablet by mouth daily - Ketoconazole 2% cream apply to the skin twice daily until resolved. On December 14, 2023, at 1:05 p.m. CNS-C stated the medications would have been in the medication caddy; therefore, they were administered, and the staff did not document the administration. CNS-C stated LPN-D should have used the MAR and assured all medications were set up as ordered. The licensee's 7.08 Medication Management-Administration & Setup dated January 1, 2022, identified "A licensed nurse will set up medications in dosage boxes for the resident, usually on a weekly basis, and will make or direct changes between set ups when necessary. ULP will verify medications are set up correctly in the dosage box before administration to the resident by use of the medication profile. If any question of medication accuracy in the dosage box arises, the unlicensed staff will contact the licensed nurse and receive direct instructions on handling any necessary changes at that time, while in direct contact with the nurse." The licensee's 7.22 Medication & Treatment Record - -Documentation & Refusal policy dated January 1, 2022, identified "The following must be	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 61 documented in the resident's medication and/or treatment/therapy records after providing medication assistance or administration: a. The date, b. The time, c. The quantity of dosage, d. The method of administration of all prescribed legend and over-the-counter medications and or treatments/therapy e. Signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure over-the-counter medications were labeled with the resident's name for the licensee's one resident with over-the-counter medications. 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	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01890	Continued From page 62 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: On December 13, 2023, at 9:02 a.m. licensed practical nurse (LPN)- D was observed by the surveyor setting up R1's medication caddy. R1 had over-the-counter medications of multivitamin, dairy relief, and vitamin D3. The medications were not labeled with R1's name. LPN-D stated the medications were purchased for R1 by the licensee. She was unaware they should be labeled with R1's name. On December 14, 2023, at 1:05 p.m. clinical nurse supervisor (CNS)-C stated the medications should have been labeled with R1's name. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01910	Continued From page 63 remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document all required information in the resident's record upon disposition of medications for the licensee's two residents (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's service plan dated September 8, 2023, identified R1's services included medication administration. R1's [Licensee] Medication Disposal Form identified Januvia 50 (dosage) 11 pills were sent to the pharmacy for disposal and was initialed by	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01910	Continued From page 64 two staff. The form failed to identify the medication's prescription number or the date of disposition as required. R2 R2's service plan dated November 6, 2023, identified R2's services included medication administration. R2's [Licensee] Medication Disposal Form identified lisinopril 5 mg, six tablets were flushed down the toilet and was initialed by two staff. The form failed to identify the medication's prescription number or the date of disposition as required. On December 14, 2023, at 1:05 p.m. clinical nurse supervisor stated she was unaware the facility form lacked the required content. The licensee's 7.23 Medication Disposal policy dated January 1, 2022, identified "Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01960 SS=C	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01960	Continued From page 65 assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries in the resident's records were authenticated by the name and title of the person making the entry for one of one residents (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 12, 2023, at 8:10 a.m. unlicensed personnel (ULP)-E was observed checking R1's blood glucose. R1's service plan dated September 8, 2023, identified R1's services included blood glucose monitoring. R1's Blood Sugar Testing form identified blood glucose test results December 1, 2023, through	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01960	Continued From page 66 December 12, 2023. The document failed to identify the name and title of the employee documenting the blood sugar tests. On December 14, 2023, at 1:05 p.m. clinical nurse supervisor (CNS)-C stated the blood sugar testing and vital signs should have been authenticated. CNS-C was unaware the form did not contain a column for authentication. The licensee's 2.38 Resident Record - information and Content policy dated January 1, 2022, identified "All entries in the resident records must be current, legible, permanently recorded, dated and authenticated with the name and title of the person making the entry." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01960			
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee limited the rights of the licensee's two residents (R1 and R2) when the licensee required residents to follow certain house rules. This practice resulted in a level two violation (a	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02290	Continued From page 67 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 began receiving assisted living services on September 8, 2023. R1's diagnoses included schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), hypertension, diabetes, gastroesophageal reflux disease (stomach reflux), and fall risk due to tremors. R1's Service Plan dated September 8, 2023, indicated R1 received services including medication management, medication administration, blood glucose monitoring, assistance with activities of daily living (ADLs), housekeeping, and laundry. R1 Residency Service Agreement signed September 8, 2023, contained the statement "If the RESIDENT is participating in illegal, abusive, threatening or violent activities as outlined in the [licensee] Rules and Regulations Policy, the AGENT retains the right to immediately remove and/or evict the RESIDENT with the aide of the proper local law enforcement agency." R2	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02290	Continued From page 68 R2 began receiving assisted living services on November 6, 2023. R2's diagnoses included schizoaffective disorder or schizophrenia (chronic condition with acute exacerbation), major depression disorder, and substance use disorder. R2's Service Plan dated November 6, 2023, identified R2 received medication management, medication administration, assistance with ADLs, housekeeping, and laundry. R1 Residency Service Agreement signed November 6, 2023, contained the statement "If the RESIDENT is participating in illegal, abusive, threatening or violent activities as outlined in the [licensee] Rules and Regulations Policy, the AGENT retains the right to immediately remove and/or evict the RESIDENT with the aide of the proper local law enforcement agency." The licensee's undated, "[Licensee] Rules and Regulations Policy", identified the following: "A) Illegal Drugs and Substances · Random room search may be done by [licensee] staff if suspected of using illegal drugs and/or substances. · [Licensee] maintains a "zero tolerance" illegal drug and substance use. If a [licensee] resident is found to be using, selling, manufacturing, or storing any form of illegal drug or substance, this would be grounds for [licensee] to begin the termination process and/or not renew the housing agreement. · If a resident is found to be using, selling or storing illegal drugs, the local police will be notified, as well as the resident's social worker, case manager and family members, if appropriate.	02290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02290	Continued From page 69 · [Licensee] retains the right to perform random urinalysis screens with our residents if suspected of using. If a urinalysis test result is positive, the residents' social service worker and case manager will be notified immediately. This will also be grounds for starting the termination process and/or non-renewal of the housing agreement." On December 14, 2023, at 11:50 a.m. licensed assisted living director (LALD)-B stated she was aware the licensee was unable to immediately evict a resident and the contract needed to be updated. She was unaware searching rooms and requiring drug testing violated resident rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39459	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2023
NAME OF PROVIDER OR SUPPLIER DESTINY HOMECARE SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 9318 CHICAGO AVENUE SOUTH BLOOMINGTON, MN 55420			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
03090	Continued From page 70 affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, at 9:30 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. During a facility tour on December 11, 2023, at 11:15 a.m. with licensed assisted living director (LALD)-A, LALD-A stated the electronic monitoring sign should have been posted by the entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090			

Type: Full
Date: 12/11/23
Time: 11:52:33
Report: 1036231318

Food and Beverage Establishment Inspection Report

Page 1

Location:

Destiny Home Care Services
9318 Chicago Avenue South
Bloomington, MN55420
Hennepin County, 27

Establishment Info:

ID #: 0039396
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528887172
ID #:

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

The following orders were issued during this inspection.

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

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

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

OBSERVED A CONTAINER OF EGGS STORED ON A SHELF ABOVE RTE FOODS. ADVISED TO MOVE EGGS TO BOTTOM SHELF OR STORE IN A CONTAINER.

Comply By: 12/13/23

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OBSERVED AN OPENED PACKAGE OF HOTDOGS IN THE FRIDGE WITH NO DATE LABEL.
COMPLY WITH ABOVE RULE.

Comply By: 12/13/23

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO QUAT TEST STRIPS WERE AVAILABLE FOR MEASURING THE SANITIZER CONCENTRATION OF THE SANITIZER TABLETS. PROVIDE AND MAINTAIN.

Comply By: 12/13/23

Type: Full
Date: 12/11/23
Time: 11:52:33
Report: 1036231318
Destiny Home Care Services

Food and Beverage Establishment Inspection Report

Page 2

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
NO CURRENT CFPM AT ESTABLISHMENT. INSTRUCTIONS FOR APPLICATION SENT TO ESTABLISHMENT.
Comply By: 01/03/24

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
OBSERVED LEFTOVERS FOODS WITH NO DATE LABEL BEING COLD HELD IN THE KITCHEN FRIDGE. DISCONTINUE SAVING AND SERVING LEFTOVERS.
Comply By: 12/13/23

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
OBSERVED SIGNIFICANT DUST/DEBRIS ACCUMULATION ON TOP OF THE FRIDGE. CLEAN AND MAINTAIN.
Comply By: 12/13/23

Surface and Equipment Sanitizers

QUATERNARY AMMONIA: = 200PPM at Degrees Fahrenheit
Location: SANITIZER BASIN
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 36 Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -2 Degrees Fahrenheit - Location: KITCHEN FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: BASEMENT FRIDGE
Violation Issued: No

Type: Full
Date: 12/11/23
Time: 11:52:33
Report: 1036231318
Destiny Home Care Services

Food and Beverage Establishment Inspection Report

Page 3

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS STACY HAAG. INSPECTION CONDUCTED IN PRESENCE OF CHRISTIAN UDEH (IN PERSON) AND FAITH UDEH (VIA TELEPHONE), THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH THE PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

****IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.**

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

I acknowledge receipt of the inspection report number 1036231318 of 12/11/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Christian Udeh
Person in Charge

Signed: _____

Jeff Johanson