DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 17, 2024

Licensee
Destiny Home Care Services
8007 Upton Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL33140015

Dear Licensee:

On September 13, 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 June 21, 2024. This follow-up survey determined your facility had corrected all of the state correction orders issued pursuant to the June 21, 2024 survey.

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

Also, at the time of this follow-up survey completed on September 13, 2024, we identified the following violation(s):

0650 - Employee Records - 144g.42 Subd. 8

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.

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 of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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.

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,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33140	A. BUILDING: _____ B. WING _____	R 09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8007 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****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: SL33140015-1 On September 12, 2024, through September 13, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on June 21, 2024. At the time of the survey, there were four residents; four receiving services under the Assisted Living license. As a result of the follow-up survey, 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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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}		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	0 650		

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0 650	Continued From page 2 Based on observation, interview, and record review, the licensee failed to ensure the employee record contained documentation of orientation and competency testing for two of two employees (unlicensed personnel (ULP)-J, ULP-K) according to MN Assisted Living Rules 4659.0190, Subp 6. 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-J On September 13, 2024, at 8:30 a.m. ULP-J was observed administering medications to R2. ULP-J stated she recently was trained and competency tested by registered nurse (RN)-C. ULP-J was hired on August 2, 2011, under the licensee's comprehensive home care license and began providing direct care services under the licensee's assisted living license on August 1, 2021. ULP-J was not included on the licensee's Employee List provided by the facility. ULP-J's employee record included training and competencies were completed with RN-C on June 5, 2024. The training and competencies failed to identify facility name, location, and license number as required. ULP-K	0 650		

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0 650	Continued From page 3 ULP-K was hired March 31, 2021, under the licensee's comprehensive home care license and began providing direct care services under the licensee's assisted living license on August 1, 2021. ULP-K's employee record included training and competencies were completed with RN-C on June 5, 2024. The training and competencies failed to identify facility name, location, and license number as required. On September 13, 2024, at 8:00 a.m. RN-C stated ULP-C and ULP-K's primary work locations were other facilities owned by the same company. RN-C stated she had completed training in groups at another home owned by the licensee. During the training, she completed orientation including information on the clients for each home owned by the company, and had reviewed the medications and treatments for each resident in each of the homes. She was unaware the training and competencies were required to identify the facility name, location, and license number, and none of the training included that information. RN-C stated she was unaware documentation of orientation, and competencies needed to be completed for each location. No further information was provide. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	{0 680}		

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{0 680}	Continued From page 4 (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: No further action required.	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes;	{0 780}		

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{0 780}	Continued From page 5 (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required.	{0 780}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}		

Electronically Delivered

July 24, 2024

Licensee
Destiny Home Care Services
8007 Upton Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL33140015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 21, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

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

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

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

0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00
0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	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: SL33140015 On June 17, 2024, through, June 21, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents; all four residents were receiving services under the provider's Assisted Living Facility license. An immediate correction order was identifyed on June 17, 2024, issued for SL33140015-0, tag identification 0470. On June 18, 2024, the immediacy of correction order 0470 was removed; however, non-compliance remained at a level 3, Widespread (l). An immediate correction order was identified on June 18, 2024, issued for SL33140015-0, tag identification 0820.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 000	Continued From page 1 On June 22, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of l.	0 000		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a working means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all residents. This practice resulted in a level two violation (a	0 460		

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0 460	Continued From page 2 violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On April 17, 2024, at 9:32 a.m. registered nurse (RN)-C stated the facility lacked a system for residents to summon staff 24 hours a day, seven days a week. She stated the residents were all ambulatory and would go to the staff if they required assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 470 SS=I	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;	0 470		

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0 470	Continued From page 3 (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that one or more awake staff were available in the assisted living, 24 hours per day, seven days per week, to be responsible for responding to the requests of residents for assistance with health or safety needs. This had the potential to affect all residents at the facility and resulted in an immediate correction order on June 17, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 17, 2024, at 7:45 a.m. upon arrival at the	0 470		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 4 facility, the surveyor pushed the doorbell and after no response the surveyor began knocking on the door. The surveyor knocked three times getting subsequently louder each time. At that time, the surveyor noted a figure walking in the room through a small frosted window on the door. The surveyor again knocked loudly. The door was opened by a person who identified themselves as R1. The surveyor requested to speak to the employee working. Unlicensed personnel (ULP)-D who was laying on the couch next to the front door, sat up and looked at the surveyor. The surveyor asked if he was the 'employee,' and the person stared at the surveyor without responding. The surveyor asked several times his name and if he was an employee, with no response. R1 stated "yes, he is the employee." On June 17, 2024, at 11:20 a.m. R1 stated ULP-D was sleeping really hard this morning. R1 had tried playing YouTube loudly to wake ULP-D up but was unsuccessful. R1 stated she heard the knocking from her bedroom and came to get the door thinking it was the day shift staff member. R1 stated she was "awake earlier than usual today" and had not seen ULP-D before today, so she was unaware if he was sleeping at other times, but she "thinks" he does. On June 17, 2024, at 1:47 p.m. a request was made for the video footage from the facility's surveillance camera at the time of surveyor arrival. At 1:54 p.m., licensed assisted living director (LALD)-A stated based on the observation of the surveyor, it was obvious the employee had been sleeping and disciplinary action will be taken. On June 17, 2024, at 2:11 p.m. ULP-E stated this was the first time she met ULP-D; however, R1	0 470		

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0 470	Continued From page 5 was a reliable resident and if she stated ULP-D was sleeping, then he was. ULP-D's employee record included a document signed by ULP-D on February 28, 2024. The document subject line was "Sleeping on the Job" and identified "This is a reminder to all employees, that sleeping on the job is unacceptable and against the policy here at [licensee name]. Each employee is responsible for the care, health, safety and welfare of clients, and who is asleep while on duty, is jeopardizing the safety of those in his/her care. Failure to remain alert and vigilant while on duty is an improper performance and compromises [licensee name]'s mission of public safety and trust to our clients and also puts you in danger. If an employee is asleep during the time they are on duty, the employee is engaging in unacceptable personal conduct sufficient to justify a suspension. All shifts must be alert and focus at all time. Each employee at [licensee name] has been trained to not sleep at any of the homes while on duty." No further information provided. TIME PERIOD FOR CORRECTION: Immediate On June 18, 2024, the immediacy was removed based on supervisory review. The scope and level remain at a level 3/Widespread (I).	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:	0 480		

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0 480	Continued From page 6 (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 17, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680		

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0 680	Continued From page 7 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness (EP) plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents, staff, and visitors of the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 8 The licensee's EP plan failed to include EP testing/annual testing requirements. On June 25, 2024, at 10:30 a.m. office coordinator (OC)-K stated the licensee had not implemented the facility's emergency preparedness plan/program annual testing requirements. The licensee's Disaster Planning and Emergency Preparedness policy dated January 1, 2022, indicated the licensee will provide annual emergency and disaster training to all staff. On an annual basis, the licensee will make available training regarding emergency and disaster response to all resident of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780		

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0 780	Continued From page 9 (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On June 18, 2024, at 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-B. During the facility tour, it was observed that a smoke alarm was installed immediately outside of sleeping rooms on the main level, but it was not interconnected upon testing.	0 780		

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0 780	Continued From page 10 It was also observed that the resident sleeping on the lower level, which was equipped with a smoke alarm, was not working upon testing. During the interview on June 18, 2024, at 12:00 p.m., LALD-B stated the smoke alarm in the sleeping room on the lower level was not working, and the smoke alarm outside of the sleeping rooms on the main level was not interconnected to the other smoke alarm in the facility. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: 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	0 800		

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0 800	Continued From page 11 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 18, 2024, at 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-B. During the facility tour, survey staff observed the following items: In the bedroom on the lower level, it was observed that the egress window was obstructed by a tree growing in the window well, and the tree obstructed the egress window from opening fully. In the living room on the lower level, it was observed the gypsum ceiling was cut open, and there was a large hole in the ceiling. In the upper-level bathroom, only two light bulbs worked out of four, and the supply air grilles on the floor were badly rusted. It was also observed the sheetrock wall next to the bathtub had considerable damage, with evidence of water damage. During the tour, LALD-B visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as	0 820		

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0 820	Continued From page 12 housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 18, 2024, at 11:30 a.m., survey staff toured the facility with the facility with the licensed assisted living director (LALD)-B. During the tour, survey staff asked LALD-B to open the windows in the resident bedrooms for	0 820	This immediate correction order identified on June 18, 2024, has had the immediacy lifted as of June 22, 2024, however non-compliance remained a scope and level of I.	

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0 820	Continued From page 13 measurement. The noncompliant measurements were as follows: In the bedroom occupied by R1 on the main level, the clear openable area of the opened windows measured 15 inches in height and 33 inches in width, with a total openable area of 495 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. In the bedroom occupied by R2 on the main level, the clear openable area of the opened windows measured 16 inches in height and 33 inches in width, with a total openable area of 528 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. In the bedroom occupied by R3 on the main level, the clear openable area of the opened windows measured 19 inches in height and 33 inches in width, with a total openable area of 684 square inches. The windows did not meet the minimum requirements for opening height. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-B that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-B verbally confirmed the findings.	0 820		

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0 820	Continued From page 14 On June 18, 2024, at 12:00 p.m., during the interview, survey staff explained to LALD-B that an immediate correction order was issued for the above finding. LALD-B acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional;	01370		

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01370	Continued From page 15 (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 five of five unlicensed personnel (ULP-D, ULP-E, ULP-G, ULP-H, and ULP-I) 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D was hired to provide direct care services for the licensee on February 28, 2024. On June 17, 2024, at 7:45 a.m. upon arrival at the	01370		

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01370	Continued From page 16 facility, ULP-D was the employee on duty, working independently. ULP-D's employee record lacked evidence training and/or competency testing was completed on the following required topics: (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; and (15) awareness of commonly used health technology equipment and assistive devices. ULP-E ULP-E was hired to provide direct care services for the licensee on April 25, 2023. On June 17, 2024, at 7:58 a.m. ULP-E was observed preparing medications for	01370		

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01370	Continued From page 17 administration. ULP-E's employee record lacked evidence training and/or competency testing was completed on the following required topics: (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; (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-G ULP-G was hired to provide direct care services for the licensee on May 27, 2024. On June 18, 2024, at 9:18 a.m. registered nurse (RN)-C stated she had trained ULP-G at another home owned by the licensee.	01370		

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01370	Continued From page 18 ULP-G'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; (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; and (15) awareness of commonly used health technology equipment and assistive devices. ULP-H ULP-H was hired to provide direct care services for the licensee on April, 23, 2024. ULP-H's employee record lacked evidence training and/or competency testing was completed on the following required topics:	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33140	A. BUILDING: _____ B. WING _____	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8007 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 19 (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; and (15) awareness of commonly used health technology equipment and assistive devices. ULP-I ULP-I was hired to provide direct care services for the licensee on June 22, 2022. ULP-I's employee record lacked evidence training and/or competency testing was completed on the following required topics: (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	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33140	A. BUILDING: _____ B. WING _____	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8007 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 20 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; and (15) awareness of commonly used health technology equipment and assistive devices. On June 18, 2024, at 10:24 a.m. RN-C stated the licensee had started new training folders and implemented a new process; however, it had not been completed for all the staff. The licensee planned to hold a training session for all staff to ensure all staff had training on all the required topics. The licensee's 5.02 Competency Training Evaluations policy dated January 1, 2022, identified: "Training and competency evaluations for all ULP's 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	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33140	A. BUILDING: _____ B. WING _____	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8007 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01370	Continued From page 21 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 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=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33140	A. BUILDING: _____ B. WING _____	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8007 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01380	Continued From page 22 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure five of five unlicensed personnel (ULP-D, ULP--E, ULP-G, ULP-H, and ULP-I) 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33140	A. BUILDING: _____ B. WING _____	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8007 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01380	Continued From page 23 ULP-D ULP-D was hired to provide direct care services for the licensee on February 28, 2024. On June 17, 2024, at 7:45 a.m. upon arrival at the facility, ULP-D was the employee on duty, working independently. ULP-D's employee record lacked evidence training and/or competency testing was completed on the following required topics: (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-E ULP-E was hired to provide direct care services for the licensee on April 25, 2023. On June 17, 2024, at 7:58 a.m. ULP-E was observed preparing medications for administration. ULP-E's employee record lacked evidence training and/or competency testing was completed on the following required topics: (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.	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33140	A. BUILDING: _____ B. WING _____	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8007 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01380	Continued From page 24 ULP-G ULP-G was hired to provide direct care services for the licensee on May 27, 2024. On June 18, 2024, at 9:18 a.m. registered nurse (RN)-C stated she had trained ULP-G at another home owned by the licensee. ULP-G's employee record lacked evidence training and/or competency testing was completed on the following required topics: (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. ULP-H ULP-H was hired to provide direct care services for the licensee on April, 23, 2024. ULP-H's employee record lacked evidence training and/or competency testing was completed on the following required topics: (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;	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33140	A. BUILDING: _____ B. WING _____	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8007 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01380	Continued From page 25 (5) safe transfer techniques and ambulation; and (6) range of motioning and positioning. ULP-I ULP-I was hired to provide direct care services for the licensee on June 22, 2022. ULP-I's employee record lacked evidence training and/or competency testing was completed on the following required topics: (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 June 18, 2024, at 10:24 a.m. RN-C stated the licensee had started new training folders and implemented a new process; however, it had not been completed for all the staff. The licensee planned to hold a training session for all staff to ensure all staff had training on all the required topics. The licensee's 5.02 Competency Training Evaluations policy dated January 1, 2022, identified: "Training and competency evaluations for all ULP's 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	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33140	A. BUILDING: _____ B. WING _____	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01380	Continued From page 26 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: The licensee failed to ensure medications were administered according to policy and accepted standards of practice for three of four residents (R1, R2, R3). 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	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33140	A. BUILDING: _____ B. WING _____	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8007 UPTON AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 27 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 17, 2024, the surveyor observed the following: - at 7:58 a.m. unlicensed personnel (ULP)-E removed a medication caddy for R1 from a locked cabinet, and put the medications into a small glass with R1's name on it. ULP-E then removed a medication caddy for R2 from a locked cabinet, and put the medications in a small glass with R2's name on it, and then ULP-E removed a bottle of atropine eye drops and put it into the small glass with the medications. ULP-E then removed a medication caddy for R3 from a locked cabinet, and put the medications into a small glass with R3's name on it. All the medications were put into the the glasses without ULP-E reviewing the MAR. ULP-E stated she always sets the medications up and puts them onto the cabinet. The residents come and take their medications when they wake up and are ready for them. ULP-E stated she would set up R4's medications later because she didn't wake up and take her medications until later in the morning. - 8:08 a.m. R2 came into the living room, retrieved the cup with her name on it, took the oral medication, opened the eye drops and placed a drop on her tongue (medication was used for oral secretions), placed the glass and eye drops back onto the cabinet. ULP-E returned the medications to the locked drawer. - 8:10 a.m. ULP-E left the building to retrieve a laptop from her car and returned to the living room, and then sat on the couch with her back to the medications still unsecured on the cabinet.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33140	A. BUILDING: _____ B. WING _____	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 28 - 8:32 a.m. R1 came out of her bedroom, went to the cabinet and retrieved the glass with her name on it, and took the medications. R1 returned the glass to ULP-E who put the glass away. - 8:55 a.m. R3 took the glass with his name on it and took the medications. ULP-E returned the glass to R3's drawer. On June 17, 2024, at 9:09 a.m. registered nurse (RN)-C stated staff should not set up the medications prior to administration. The staff were trained to administer one resident's medications at a time and staff should be reviewing the MAR when administering the medications. The licensee's undated, Medication Management - Administration & Setup policy identified "For active assistance with medications from the dosage box system, the ULP will use the MAR for documenting medications given from a dosage box and will refer to the medications profile listing the medication name, dosage, date, and time administered. It will also include the purpose of the medication and any special instructions if applicable" No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Follow-Up
Date: *06/27/24*
Time: 12:35:55
Report: 1004241166

Food and Beverage Establishment Inspection Report

Location:
Destiny Home Care Services
8007 Upton Avenue South
Bloomington, MN55431
Hennepin County, 27

Establishment Info:
ID #: 0037774
Risk:
Announced Inspection: Yes

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 previously issued on 06/17/24 have NOT been corrected.

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.

NO DATE MARKING FOUND ON OPENED PACKAGED FOOD ITEMS (DELI MEAT) IN THE REFRIGERATOR. ENSURE ALL OPENED PACKAGED TCS ITEMS ARE CLEARLY MARKED WITH THE DATE OF PREPARATION AND CONSUMED OR DISCARDED WITHIN 7 DAYS. REISSUED 6/27/24.

Issued on: 06/17/24 *Comply By: 06/17/24*

4-300 Equipment Numbers and Capacities

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

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

ESTABLISHMENT DOES NOT HAVE A FUNCTIONING DISH MACHINE OR A 3-COMPARTMENT SINK FOR MANUAL WARE WASHING. STAFF USE KITCHEN SINK AND ADDITIONAL CONTAINER TO WASH, RINSE, AND SANITIZE WARE. PROVIDE FUNCTIONING SANITIZING DISH MACHINE OR APPROVED 3-COMP SINK

Issued on: 06/17/24 *Comply By: 06/17/24*

4-300 Equipment Numbers and Capacities

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

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

NO QUATERNARY AMMONIUM TEST STRIPS ON SITE. ESTABLISHMENT HAS CHLORINE TEST STRIPS BUT USES QUATERNARY AMMONIUM FOR DOING DISHES. PROVIDE THE CORRECT TEST STRIPS AND USE DAILY. REISSUED 6/27/24.

Type: Follow-Up
Date: *06/27/24*
Time: 12:35:55
Report: 1004241166
Destiny Home Care Services

Food and Beverage Establishment Inspection Report

Issued on: 06/17/24 *Comply By: 06/17/24*

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO STATE CERTIFIED FOOD PROTECTION MANAGER. EMPLOY AT LEAST ONE FULL-TIME EMPLOYEE WITH STATE CERTIFICATION FOR EACH SEPARATE LICENSED LOCATION. REISSUED 6/27/24.

Issued on: 06/17/24 *Comply By: 06/17/24*

No NEW orders were issued during this inspection.

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

FOLLOW-UP INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY.

TODAY'S FOLLOW-UP INSPECTION WAS CONDUCTED TO ADDRESS AND CLEAR PREVIOUSLY WRITTEN ORDERS FROM A FULL INSPECTION CONDUCTED ON 6/17/24. DURING TODAY'S FOLLOW-UP INSPECTION, 6 OUT OF 10 ORDERS WERE ABLE TO BE CLEARED FROM THE REPORT.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1004241166 of 06/27/24.

Certified Food Protection Manager: NONE

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
CHRISTIAN

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us

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

Type: Full
Date: *06/17/24*
Time: 13:45:50
Report: 1004241157

Food and Beverage Establishment Inspection Report

Location:
Destiny Home Care Services
8007 Upton Avenue South
Bloomington, MN55431
Hennepin County, 27

Establishment Info:
ID #: 0037774
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.

3-300A Protection from Contamination: limit hand contact, tasting

3-301.11A ***** Priority 1 *****

MN Rule 4626.0225A Discontinue bare hand contact with ready-to-eat foods. Use deli tissue, spatulas, tongs, single-use gloves or other dispensing equipment.

OPERATOR STATED THAT STAFF USE BAREHANDS TO HANDLE READY-TO-EAT ITEMS WHEN PREPARING FOOD. DISCONTINUE PRACTICE AND USE GLOVES, TONGS, OR OTHER APPROVED MEANS TO PREVENT BAREHAND CONTACT WITH READY-TO-EAT ITEMS.

Comply By: 06/17/24

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

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

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

RAW SHELL EGGS FOUND STORED OVER PRODUCE IN THE REFRIGERATOR. STORE ALL RAW ANIMAL FOODS BELOW AND SEPARATE FROM READY-TO-EAT ITEMS.

Comply By: 06/17/24

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared 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.

NO DATE MARKING FOUND ON PREPARED ITEMS (RICE, SOUP) IN THE REFRIGERATOR. ENSURE ALL PREPARED ITEMS ARE CLEARLY MARKED WITH THE DATE OF PREPARATION AND CONSUMED OR DISCARDED WITHIN 7 DAYS.

Comply By: 06/17/24

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.

NO DATE MARKING FOUND ON OPENED PACKAGED FOOD ITEMS (DELI MEAT) IN THE REFRIGERATOR. ENSURE ALL OPENED PACKAGED TCS ITEMS ARE CLEARLY MARKED WITH THE DATE OF PREPARATION AND CONSUMED OR DISCARDED WITHIN 7 DAYS.

Comply By: 06/17/24

4-300 Equipment Numbers and Capacities

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

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

ESTABLISHMENT DOES NOT HAVE A FUNCTIONING DISH MACHINE OR A 3-COMPARTMENT SINK FOR MANUAL WARE WASHING. STAFF USE KITCHEN SINK AND ADDITIONAL CONTAINER TO WASH, RINSE, AND SANITIZE WARE. PROVIDE FUNCTIONING SANITIZING DISH MACHINE OR APPROVED 3-COMP SINK

Comply By: 06/17/24

4-300 Equipment Numbers and Capacities

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

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

NO QUATERNARY AMMONIUM TEST STRIPS ON SITE. ESTABLISHMENT HAS CHLORINE TEST STRIPS BUT USES QUATERNARY AMMONIUM FOR DOING DISHES. PROVIDE THE CORRECT TEST STRIPS AND USE DAILY.

Comply By: 06/17/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO STATE CERTIFIED FOOD PROTECTION MANAGER. EMPLOY AT LEAST ONE FULL-TIME EMPLOYEE WITH STATE CERTIFICATION FOR EACH SEPARATE LICENSED LOCATION.

Comply By: 06/17/24

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

3-304.12B

MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.

PLASTIC BOWL IS BEING USED AS A SCOOP IN THE UNCOOKED RICE. PROVIDE A SCOOP WITH A HANDLE AND ENSURE THE HANDLE IS STORED SO IT IS NOT IN CONTACT WITH THE FOOD.

Comply By: 06/17/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

FOOD SPLATTER AND DEBRIS OBSERVED THROUGHOUT KITCHEN ON WALLS, COUNTER TOPS, AND EQUIPMENT. CLEAN THOROUGHLY AND MAINTAIN CLEAN.

Comply By: 06/17/24

8-500A Embargo/Condemnation

8-501.03MN

MN Rule 4626.1810 The following items are condemned and shall be removed from the establishment immediately:

OPENED DELI TURKEY IN THE REFRIGERATOR FOUND WITH VISIBLE MICROBIAL GROWTH (NO DATE MARKING). DISCARD IMMEDIATELY.

Comply By: 06/17/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: DELI TURKEY
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: BUTTER
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
2	4	4	

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY STACY HAAG.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE REQUIREMENT
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-RECEIVING DELIVERIES PROCEDURES
-FOOD SERVICE PROCEDURES

-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE OPERATOR, CHRISTIAN, AND WITH THE NURSE EVALUATOR, STACY.

*FLOORS ARE STONE TILE, WALLS AND CEILING ARE SMOOTH PAINTED DRYWALL. COUNTERTOPS ARE LAMINATE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

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

INSPECTOR WILL RETURN FOR A FOLLOW-UP INSPECTION

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1004241157 of 06/17/24.

Certified Food Protection Manager: NONE

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
CHRISTIAN

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us