Electronically Delivered

February 21, 2024

Licensee
Destiny Home Care Services
8709 Bryant Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL27248015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 25, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. 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

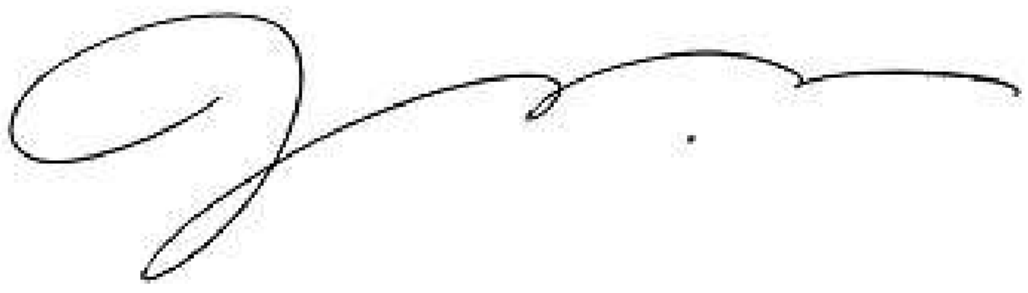
factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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.

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

If you have any questions, please contact me.

Sincerely,



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

PMV

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27248	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8709 BRYANT AVE S 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: SL27248015 On January 22, 2024 through January 25, 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 three (3) active residents recieving services under the assisted living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level 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 following services to residents: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 1 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 January 22, 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		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United	0 485		

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0 485	Continued From page 2 States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee's assisted living contract required residents to pay for meals. This had the potential to affect all residents. 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 the residents). The findings include: R1 was admitted on October 6, 2022. R1's Residency Service Agreement signed January 5, 2024, indicated three (3) meals and two (2) snacks would be provided daily as part of the agreement (page 3) and any additional snacks, meals, or beverages would be paid for by	0 485		

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0 485	Continued From page 3 the resident. R2 was admitted to licensee on June 9, 2023. R2's Residency Service Agreement signed June 15, 2023, indicated 3 meals and 2 snacks would be provided daily as part of the agreement (page 3) and any additional snacks, meals, or beverages would be paid for by the resident. On January 25, 2024, at approximately 9:45 a.m., licensed assisted living director (LALD)-F stated this was the residency agreement used for all residents and they were unaware of the requirement to exclude payment for meals as part of the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 510		

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0 510	Continued From page 4 by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 22, 2024, at approximately 10:00 a.m., licensed practical nurse (LPN)-B entered the dining room wearing gloves and retrieved R1's medication bin and an empty medication cassette from a locked file cabinet. LPN-B was observed to perform medication setup using a medication list as a guide. When medication setup was complete, LPN-B removed gloves. No hand hygiene observed. On January 22, 2024, at approximately 1:00 p.m., unlicensed personnel (ULP)-C entered the dining room wearing gloves and stated he had washed his hands prior to putting on the gloves. ULP-C was observed preparing and administering medication to R1. Following medication administration, ULP-C removed gloves and rinsed hands in kitchen sink (no soap was present at sink).	0 510		

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0 510	Continued From page 5 On January 24, 2024, at approximately 11:00 a.m., clinical nurse supervisor (CNS)-E was observed preparing an injectable medication for R1. CNS-E prepared and administered the medication then removed gloves after disposing of supplies. No hand hygiene noted. On January 25, 2024, at approximately 9:45 a.m., licensed assisted living director (LALD)-E stated handwashing should occur when removing gloves and employees will need additional training. The licensee's 8.09 Handwashing policy dated January 1, 2022, read "when conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning and after removing gloves: No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 660		

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0 660	Continued From page 6 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC); failed to ensure history and symptoms screening and a test for active TB (either a two-step tuberculin skin test (TST) or blood test) was completed prior to performing resident care for two of two employees (unlicensed personnel (ULP)-C, ULP-D). 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 the potential to affect a large portion or all the residents). The findings include: The facility TB risk assessment was completed on December 1, 2023, and indicated the facility was at a low risk for TB transmission. ULP-C was hired on May 2, 2023, and provided direct care services to the licensee's residents. ULP-C's record included a negative QuantiFERON Gold result (blood test to indicate the presence of TB disease) dated August 25,	0 660		

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0 660	Continued From page 7 2023. ULP-C's record lacked evidence of a history and symptom screening for TB. ULP-D was hired on November 22, 2023, and provided direct care services to the licensee's residents. ULP-D's record included a negative QuantiFERON Gold result dated January 6, 2024. ULP-D's record lacked evidence of a history and symptom screening for TB. On January 25, 2024, at approximately 9:45 a.m., operations manager (OM)-A acknowledged TB testing was completed after hire and history and symptom screens were not completed for ULP-C and ULP-D and they were unaware that testing and screening was required before providing resident care. 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 (residents) 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." The licensee's 8.16 Tuberculosis Screening policy dated January 1, 2022, read "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." No further information was provided.	0 660		

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0 660	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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 ensure the emergency disaster plan contained a facility specific hazard vulnerability assessment (HVA) and failed to	0 680		

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0 680	Continued From page 9 provide an annual review of the emergency preparedness program (EPP). This had the potential to affect all three residents in the facility, staff, and any 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 January 23, 2024, at approximately 9:00 a.m., operations manager (OM)-A provided a binder labeled Emergency Preparedness Plan. The binder contained a blank undated form titled Destiny Home Care Services - Emergency Operations Plan. The form lacked documentation indicating the plan had been initially approved or reviewed annually. Additionally, the binder lacked a completed HVA. On January 23, 2024, at approximately 1:15 p.m., OM-A stated the EPP was created to encompass all six facilities operated by licensee and they were unaware the HVA was missing from the binder. On January 24, 2024, at approximately 1:00 p.m., licensed assistant living director (LALD)-F provided a HVA tool, dated January 8, 2023. HVA tool indicated it had been created for [licensee] and did not specify location. The licensee's 9.01 Emergency Preparedness	0 680		

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0 680	Continued From page 10 Plan-Appendix Z Compliance policy dated January 1, 2022, read "[licensee's] EPP will include all required elements of appendix Z. The plan will be in writing and reviewed annually." No further 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 Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 790		

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0 790	Continued From page 11 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 January 22, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-F. It was observed that the portable fire extinguishers throughout the facility lacked records to show the required annual certification and monthly visual inspections were performed on the portable fire extinguishers. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician. During interview, on January 24, 2024 at 1:00 p.m. survey staff explained to LALD-F that the portable fire extinguishers must be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD-F verified the findings and stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the	01060		

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01060	Continued From page 12 facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes	01060		

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01060	Continued From page 13 a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to licensee on June 9, 2023, and began receiving assisted living services. R2's service plan, dated June 15, 2023, indicated R2 received services for medication assistance, dressing and grooming assistance, and behavior management. R2's Progress Notes, dated December 13, 2023, indicate R2 was transferred to the hospital. R2's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation;	01060		

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01060	Continued From page 14 - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On January 25, 2024, at approximately 10:00 a.m., licensed assisted living director (LALD)-F stated a written notice had not been provided with the required content, and the OOLTC had not been notified. In addition, LALD-F stated they were not aware of the requirement to provide a relocation notice to R2. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5),	01330		

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01330	Continued From page 15 (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-C, ULP-D) 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 residents). The findings include: ULP-C ULP-C was hired to provide direct care services for the licensee on September 19, 2023. On January 22, 2024, at 1:00 p.m., ULP-C was observed administering medications for R1. ULP-C's employee record lacked evidence training and/or competency testing was completed on the following required topics:	01330		

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01330	Continued From page 16 (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-D ULP-D was hired to provide direct care services for the licensee on November 22, 2023. The licensee's staff schedule identified ULP-D worked independently on January 24, 2024, and January 25, 2024. ULP-D's employee record lacked evidence training and/or competency testing was	01330		

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01330	Continued From page 17 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. On January 23, 2024, at 12:15 p.m., clinical nurse supervisor (CNS)-E 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:	01330		

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01330	Continued From page 18 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 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	01330		

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01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of two residents (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	01620		

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01620	Continued From page 20 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee October 6, 2022, and started receiving assisted living services. R1's Service Plan dated January 5, 2024, indicated services included dressing and grooming assistance, medication administration, and behavior management. R4's record included a 90-day nursing assessment dated April 20, 2023. R4's record included a 90-day nursing assessment July 20, 2023, indicating 91 days passed between re-assessments. R4's record included a 90-day nursing assessment dated October 20, 2023, indicating 92 days passed between re-assessments. No additional assessments were provided for R1, indicating 94 days had passed between last re-assessment and start of survey. On January 25, 2024, licensed assistant living director (LALD)-F stated she was unaware that more than 90 days had passed between assessments. The licensee's 6.01 Assessments, Reviews, and Monitoring policy dated January 1, 2022, read "Ongoing resident assessment and monitoring must be conducted as needed based on changes	01620		

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01620	Continued From page 21 in the needs of the resident and cannot exceed 90 calendar days from the last assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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01650	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents' service plans included all required content for two of two residents (R1, 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential of affect a large portion or all the residents). The findings include: R1's Service Plan Form was dated January 5, 2024. R1's Service Plan Form indicated R1 received services including dressing and grooming assistance, medication administration and behavior management. R1's Service Plan Form lacked a schedule of monitoring assessments for R1. R2's Service Plan was dated June 15, 2023. R2's Service Plan Form indicated R2 received services including dressing and grooming assistance, medication administration, and behavior management. R2's Service Plan lacked a schedule of monitoring assessments for R2. On January 25, 2024, at approximately 9:45 a.m., licensed assisted living director (LALD)-F stated the Service Plan Form had been revised but the assessment schedules had not been added with the revisions.	01650		

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01650	Continued From page 23 The licensee's 6.08 Service Plans policy dated January 1, 2022, indicated service plans would include the schedule and method for the next planned assessment or monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
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 section, "diversion of medication" means misuse, theft, or illegal or improper disposition of	01700		

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01700	Continued From page 24 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 January 22, 2024, at approximately 11:30 a.m., operations manager (OM)-A stated the licensee provided medication management services to all the licensee's residents. R1 On January 22, 2024, at approximately 12:15 p.m., unlicensed personnel (ULP)-C was observed administering medications to R1. R1 was admitted on October 6, 2022, and began receiving assisted living services. R1's Service Plan Form dated January 5, 2024, indicated R1 received services including	01700		

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01700	Continued From page 25 medication management and medication administration. R1's prescriber orders dated September 5, 2023, included vitamin D, amantadine (for involuntary muscle movements), haloperidol (for schizophrenia), trazodone (for sleep), and benztropine (for movement disorders). R1's Uniform Assessment Tool dated October 20, 2023, Review of Medications section failed to identify all medications ordered for resident and failed to include a review of the side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. R2 R2 was admitted to licensee on June 6, 2023, and began receiving assisted living services. R2's Service Plan dated June 15, 2023, identified R2 received services including medication management and medication administration. R2's record lacked evidence of prescriber's orders. R2's Uniform Assessment Tool dated June 6, 2023, Review of Medications section indicated R2 received the following medications: olanzapine (antipsychotic), vitamin D, and Tylenol. A review of the medication management plan and medication assessment failed to include a review of the side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. On January 25, at 9:45 a.m., licensed assisted living director (LALD)-F stated she was unaware	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27248	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8709 BRYANT AVE S 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 26 of missing content and will remind the clinical nurse supervisor to complete the assessments. 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 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		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication 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	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27248	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8709 BRYANT AVE S 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 27 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 per protocol for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's Service Plan signed January 5, 2023, indicated R1 received medication setup and medication administration services. R1's Medication Assessment for Safety in Self Administration dated January 1, 2024, indicated R1 was unable to self-administer medications and nurses would prepare medication to be administered by staff. ADMINISTRATION PROTOCOL ERROR On January 22, 2024, at approximately 12:15 p.m., surveyor observed unlicensed personal	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27248	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8709 BRYANT AVE S 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 28 (ULP)-C administering medication from a medication caddy. ULP-C did not double check or verify medication with a medication list or medication administration record (MAR) prior to administering medication. ULP-C stated he had been trained in medication administration by licensed practical nurse (LPN)-B. On January 23, 2024, at approximately 11:45 a.m., clinical nurse supervisor (CNS)-E stated they provided medication training and competency validation for ULPs. CNS-E stated staff is not trained to verify medications with a medication list prior to administration but are given instruction on how many pills to administer from pill caddy at each scheduled administration time. On January 24, 2024, at approximately 1:45 p.m., LPN-B stated CNS-E was responsible for providing training and competency validation for ULPs. On January 25, 2024, at approximately 9:45 a.m., licensed assisted living director (LALD)-F stated they were unaware medications were not verified prior to administration and stated they were "planning to change to a different process for medication administration." The licensee's Medication Management: Administration and Setup policy dated January 1, 2022. Read "ULP will verify medications are set up correctly in the dosage box before administration to the resident by use of the medication profile." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27248	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8709 BRYANT AVE S 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 29 days	01760		
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 interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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 occurs only occasionally). The findings include: R2 was admitted on June 6, 2023, and began receiving assisted living services. R2's Service Plan, dated June 15, 2023, indicated R2 received medication setup and medication administration services. R2's medical record lacked signed prescriber's orders for each medication that R2 received. On January 24, 2024, at approximately 1:00 pm.,	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27248	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY HOME CARE SERVICES	8709 BRYANT AVE S 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 30 licensed practical nurse (LPN)-B stated she was unaware R2's record was lacking prescriber orders. The licensee's 7.17 Medication and Treatment Orders - Receiving policy dated January 1, 2022, read "All orders for medications and treatments must be dated and signed by the prescriber and must be current and consistent with the nursing assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

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

Type: Follow-Up
Date: *01/31/24*
Time: 11:00:09
Report: 1004241016

Food and Beverage Establishment Inspection Report

Location:

Destiny Home Care Services
8709 Bryant Ave S
Bloomington, MN55420
Hennepin County, 27

Establishment Info:

ID #: 0037950
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 01/22/24 have NOT been corrected.

2-100 Supervision

2-102.12AMN

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

CERTIFIED FOOD PROTECTION MANAGER CERTIFICATION IS BEING USED AT MULTIPLE LOCATIONS. EACH LICENSED ESTABLISHMENT IS REQUIRED TO HAVE THEIR OWN CFPM.
*INFORMATION SUPPLIED WITH REPORT. REISSUED 1/31/24.

Issued on: 01/22/24 *Comply By: 02/22/24*

The following orders were issued during this inspection.

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 AN ADDITIONAL CONTAINER TO WASH, RINSE, AND SANITIZE WARE.
DISCUSSED WARE WASHING PROCEDURES WITH STAFF- *SEE NOTES.

Comply By: 01/31/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANITIZER CONTAINER (FOR DISHES)
Violation Issued: No

Food and Equipment Temperatures

Type: Follow-Up
Date: *01/31/24*
Time: 11:00:09
Report: 1004241016
Destiny Home Care Services

Food and Beverage Establishment Inspection Report

Process/Item: PICKLE JUICE
Temperature: 34 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	1	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 IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY MICHELLE WINTERS.

DURING TODAY'S FOLLOW-UP INSPECTION, 9 OUT OF 10 ORDERS WERE ABLE TO BE CLEARED FROM THE REPORT. ONE ORDER, , WAS ADDED DURING THE FOLLOW-UP INSPECTION AFTER CONFIRMATION OF THE NEED FOR EITHER A SANITIZING DISH MACHINE OR A FULL 3-COMPARTMENT SINK FOR WASH, RINSE, AND SANITIZING DISHES. ESTABLISHMENT WILL BE INSTALLING A NEW SANITIZING DISH MACHINE. UNTIL THE NEW UNIT IS INSTALLED, THEY WILL CONTINUE MANUALLY SANITIZING ALL DISHES IN A SEPARATE CONTAINER. THIS IS A TEMPORARY SOLUTION UNTIL THE NEW UNIT IS INSTALLED. THE INSPECTOR WILL CONTINUE TO FOLLOW-UP WITH THE ESTABLISHMENT TO CONFIRM AN APPROVED UNIT IS INSTALLED AND IN USE FOR DISHES.

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 1004241016 of 01/31/24.

Certified Food Protection Manager:_____

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: *01/22/24*
Time: 12:45:16
Report: 1004241006

Food and Beverage Establishment Inspection Report

Location:
Destiny Home Care Services
8709 Bryant Ave S
Bloomington, MN55420
Hennepin County, 27

Establishment Info:
ID #: 0037950
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528887172
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

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

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

ITEMS IN THE KITCHEN REFRIGERATOR MEASURED AT 49-51*F. TIME/TEMPERATURE CONTROL FOR SAFETY (TCS) FOODS MUST BE MAINTAINED AT OR BELOW 41*F. *TCS ITEMS DISCARDED DURING INSPECTION.

Comply By: 01/22/24

4-500 Equipment Maintenance and Operation

4-501.114C3 ***** Priority 1 *****

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

QUATERNARY AMMONIUM CONCENTRATION IN SANITIZING COMPARTMENT FOR DISHES MEASURED AT 0PPM. 2 TABS WERE ADDED TO THE SOLUTION DURING INSPECTION AND AT END OF INSPECTION STILL MEASURED AT <50PPM. PROVIDE AN EFFECTIVE SANITIZER IMMEDIATELY FOR DISHES/UTENSILS

Comply By: 01/22/24

4-300 Equipment Numbers and Capacities

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

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

NO SMALL DIAMETER PROBE THEREMOMETER ON SITE FOR USE. PROVIDE AND MAINTAIN.

Comply By: 01/22/24

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 SANITIZER TEST KIT ON SITE FOR USE. PROVIDE AND USE DAILY. *PERSON IN CHARGE STATED TEST KIT WOULD BE ORDERED.

Comply By: 01/22/24

5-200A Plumbing: approved materials/design

5-203.11A ***** Priority 2 *****

MN Rule 4626.1070A Provide at least 1 handwashing sink, or the number of handwashing sinks necessary to allow for the convenient use by employees during food preparation, food dispensing, and warewashing; and in or adjacent to toilet rooms.

KITCHEN HAS A 2-BASIN SINK. ONE BASIN MUST BE DESIGNATED AS A HANDWASHING SINK AND ONLY USED FOR HANDWASHING PURPOSES. USE OF BATHROOM HANDWASHING SINK FOR FOOD PREPARATION/HANDLING IS NOT SUFFICIENT OR CONSIDERED CONVENIENT.

Comply By: 01/22/24

6-300 Physical Facility Numbers and Capacities

6-301.11 ***** Priority 2 *****

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

NO HAND SOAP STOCKED AT KITCHEN HANDWASHING SINK AT BEGINNING OF INSPECTION. EMPLOYEE PROVIDED SOAP AT INSPECTORS REQUEST. ENSURE KITCHEN HANDWASHING SINK IS STOCKED AT ALL TIMES.

Comply By: 01/22/24

2-100 Supervision

2-102.12AMN

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

CERTIFIED FOOD PROTECTION MANAGER CERTIFICATION IS BEING USED AT MULTIPLE LOCATIONS. EACH LICENSED ESTABLISHMENT IS REQUIRED TO HAVE THEIR OWN CFPM. *INFORMATION SUPPLIED WITH REPORT.

Comply By: 02/22/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

KITCHEN REFRIGERATOR IS UNABLE TO MAINTAIN REQUIRED COLD HOLDING TEMPERATURES. HAVE UNIT SERVICED/REPAIRED AND DO NOT STOCK TCS ITEMS IN UNIT UNTIL IT IS VERIFIED TO BE ABLE TO MAINTAIN REQUIRED TEMPERATURES. *FOOD WILL BE STORED IN BASEMENT REFRIGERATOR

Comply By: 01/22/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

NO HANDWASHING POSTER/SIGN AT KITCHEN HANDWASHING SINK. PROVIDE AND MAINTAIN.

Comply By: 01/22/24

8-500A Embargo/Condemnation

8-501.03MN

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

TCS FOOD ITEMS IN THE KITCHEN REFRIGERATOR FOUND TO BE ABOVE 41*F, INCLUDING: SALSA, MEAT/TOMATO SAUCE, DELI TURKEY, LEFTOVER PASTA DISH, AND EGGS. *ITEMS WERE DISCARDED DURING INSPECTION

Comply By: 01/22/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 0PPM at Degrees Fahrenheit
Location: SANITIZER CONTAINER (FOR DISHES)
Violation Issued: Yes

Quaternary Ammonia: < 50PPM at Degrees Fahrenheit
Location: SANITIZER CONTAINER AFTER TABLETS ADDED
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: AMBIENT TEMPERATURE
Temperature: <39 Degrees Fahrenheit - Location: BASEMENT REFRIGERATOR
Violation Issued: No

Process/Item: TOMATO SAUCE
Temperature: 49 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: Yes

Food and Beverage Establishment Inspection Report

Process/Item: BUTTER
Temperature: 50 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: Yes

Process/Item: DELI TURKEY
Temperature: 51 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: Yes

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 MICHELLE WINTERS.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION (IF UNIT IS REPAIRED)
-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
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE PERSON IN CHARGE, CHRISTIAN, AND WITH THE NURSE EVALUATOR, MICHELLE.

*FLOORS ARE LINOLEUM TILES, WALLS ARE PAINTED DRYWALL, AND CEILING IS "POPCORN" TEXTURE. 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 REQUIRED TO BE DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*DISH MACHINE IS NOT FUNCTIONING, ESTABLISHMENT IS USING A SEPARATE CONTAINER OF SANITIZER SOLUTION TO SANITIZE DISHES. KITCHEN SINK IS A 2-BASIN SINK, RESULTING IN ONE BASIN NEEDING TO BE DESIGNATED AS A HANDWASHING SINK. ESTABLISHMENT CANNOT EFFECTIVELY UTILIZE A 3-COMPARTMENT SYSTEM FOR DISHES (WASH, RINSE, SANITIZE) WITH CURRENT SET UP. ESTABLISHMENT MUST DEMONSTRATE

THE ABILITY TO FULLY WASH DISHES, RINSE IN CLEAN WATER, AND SANITIZE (FULLY SUBMERGED).

*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 1004241006 of 01/22/24.

Certified Food Protection Manager:_____

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